National Quality Board

Safe, sustainable and productive staffing

An improvement resource for adult inpatient wards in acute hospitals

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This is an improvement resource to support nurse staffing in adult inpatient wards in acute hospitals which is aligned to Commitment 9 of Leading Change, Adding Value: a framework for nursing, midwifery and care staff (2016).[1] It is based on the National Quality Board's expectations that to ensure safe, effective, caring, responsive and well-led care on a sustainable basis, trusts will employ the right staff with the right skills in the right place and at the right time. We have designed it to be used by all those involved in clinical establishment setting, approval and deployment– from the ward manager to the board of directors. NHS provider boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources (NQB 2016).

The resource outlines a systematic approach for identifying the organisational, managerial and ward factors that support safe staffing. It makes recommendations for monitoring and taking action if not enough staff are available on the ward to meet patients' needs. It builds on NICE guidelines[2] on safe and sustainable staffing for nursing in adult inpatient care in acute wards, and is informed by NICE's comprehensive evidence reviews of research (Griffiths et al 2014, Simon et al 2014) and subsequent discussion paper (Griffiths et al 2016a) relating to aspects of staffing levels, shift work and flexible staffing. Additional evidence reviews focusing

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[1] https://www.england.nhs.uk/ourwork/leading-change/
[2] https://www.nice.org.uk/guidance/sg1

specifically on staffing levels and outcomes, flexible staffing and shift work have been undertaken to inform this improvement resource (NHS Improvement Evidence Reviews One, Two and Three 2016).

Because adult inpatient wards vary so much, no standard definition of them exists. We therefore adopted NICE's definition[3] for consistency. We recognise that local wards vary and that leaders must take into account factors such as ward layout, geography and estate when calculating staffing needs. We recognise the need to consider the wider multidisciplinary team when looking at the size and composition of staff for any setting, but as there is little workforce modelling or planning evidence on how this has been successfully achieved, we concentrate on nursing and signpost evidence we found to inform multiprofessional workforce planning.

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[3] "Wards that provide overnight care for adult patients in acute hospitals, excluding intensive care, high dependency, maternity, mental health, day care, acute admission or assessment units or wards. Other than these exceptions, the guideline covers all general and specialist inpatient wards for adults in acute hospitals." https://www.nice.org.uk/guidance/SG1/chapter/6-Glossary

2. Right staff

There must be sufficient and appropriate staffing capacity and capability on adult inpatient wards to provide safe, high-quality and cost-effective care to patients at all times. Staffing decisions must be aligned to operational planning processes so that high quality care can be provided now and on a sustainable basis.

The nursing establishment is defined as the number of registered nurses and healthcare assistants who work in a particular ward, department or team (see section 2.3 uplift). The ward establishment may include allied health professionals and other support staff, dependent on the model of care being delivered. It is important to distinguish between the establishment and number of staff available to be rostered on any given day.

2.1 Evidence based workforce planning

Staffing reviews

Decision-making to determine safe and sustainable staffing must follow a clear and logical process that takes account of the wider multidisciplinary team. Although registered nurses and healthcare assistants[4] provide a significant proportion of direct care, other groups to consider include:

- medical staff
- allied health professionals
- pharmacists
- advanced clinical practitioners/clinical nurse specialists
- volunteers
- hostess/support staff
- administrative and managerial staff.

There is a difference between staff members who are part of the core ward establishment and those who are not. For example, occupational therapists who are rostered on the ward team would be part of the establishment, whereas those who provide a defined number of sessions to the ward would not.

A transparent governance structure, including ward to board reporting of staffing requirements, should be in place for determining staffing numbers and skill mix and monitoring its effectiveness.

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[4] Healthcare assistants (HCAs) work under the supervision and guidance of a registered nurse and are also known as nursing assistants (NAs), healthcare support workers (HCSWs) or nursing auxiliaries. For consistency we refer to healthcare assistants throughout this document.
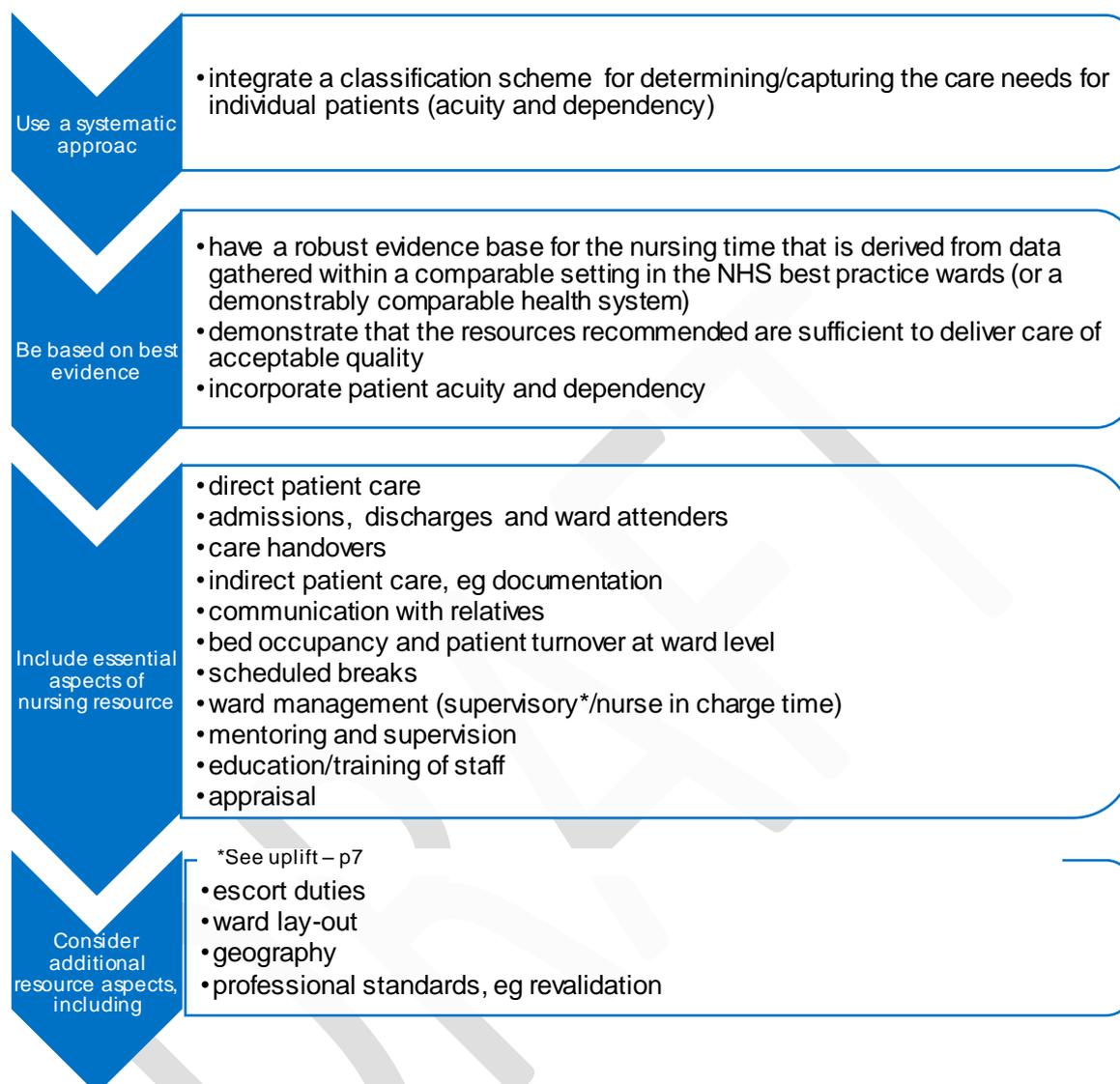
Boards should carry out a strategic staffing review at least annually, aligned to the operational planning process or more frequently if changes to services are planned. The key elements of this planning approach are:

- using a systematic, evidence-based approach to determine the number and skill mix of staff required

- exercising professional judgement to meet specific local needs, but ensuring this does not duplicate elements included in the tool being used, for example if the tool takes account of patient turnover an additional allowance for this would be duplication

- benchmarking with peers (eg CHPPD via model hospital)

- taking account of national guidelines, bearing in mind they may be based on professional consensus.

2.2 Decision support tools

All tools should:

Use a systematic approac	• integrate a classification scheme for determining/capturing the care needs for individual patients (acuity and dependency)
Be based on best evidence	• have a robust evidence base for the nursing time that is derived from data gathered within a comparable setting in the NHS best practice wards (or a demonstrably comparable health system) • demonstrate that the resources recommended are sufficient to deliver care of acceptable quality • incorporate patient acuity and dependency
Include essential aspects of nursing resource	• direct patient care • admissions, discharges and ward attenders • care handovers • indirect patient care, eg documentation • communication with relatives • bed occupancy and patient turnover at ward level • scheduled breaks • ward management (supervisory*/nurse in charge time) • mentoring and supervision • education/training of staff • appraisal
Consider additional resource aspects, including	*See uplift – p7 • escort duties • ward lay-out • geography • professional standards, eg revalidation

NICE has endorsed several tools that help nurse staffing establishments for adult inpatient wards which can be accessed at:
https://www.nice.org.uk/guidance/sg1/resources

In addition boards should ensure there is:

- no local manipulation of the identified nursing resource from the evidence-based figures embedded in the tool. Except in the context of a rigorous independent research study as this may adversely affect the recommended establishment figures derived from the use of the tool

- quality control of the data

- staff are trained to use the tool

- independent and systematic validation so that the tool is applied consistently across the organisation and as directed by the tool's evidence base

- adherence to the guidance on the number of datasets and content required for setting ward establishments

- transparency of the results and agreed routes for decision-making

- an agreed allowance for planned and unplanned leave (uplift as outlined below)

- staff are able to respond effectively to changes in patient need and other demands for nursing time that occur often but are not necessarily predictable: for example, patient deterioration, admissions and end-of-life care. Capacity to deal with unplanned events should be built into the ward establishment. This is commonly referred to as 'responsiveness time'.

2.3 Allowing for uplift

Whilst ensuring that leave is managed efficiently and responsibly, nursing establishments for adult inpatient acute wards should include an 'uplift' to allow for the efficient and responsible management of planned and unplanned leave and to ensure that absences are able to be managed effectively.

An inpatient ward establishment will include uplift for:

- annual leave in line with Agenda for Change or local terms and conditions
- study leave
- parenting leave
- sickness/absence/compassionate leave.

Local factors must be considered when calculating the percentage allowances for inclusion in uplift. It is important that the level of uplift is realistic and reviewed at least annually. Some principles you may wish to include when setting your uplift include:

- operating a central pool for parenting leave (calculated at ward level and then managed centrally)

- leave entitlements will vary with long service enhancements

- planning should be based on the organisation's target level of sickness/absence, for example 3% to 4%, and aligned to plans to implement improvements

- estimates for study leave should include mandatory and elements of core/job specific training

- learning activities such as fulfilling link-nurse roles and participation in quality improvement collaboratives

- a greater allowance for study leave uplift will need to be made if there is a higher proportion of part time staff[5]

- as ward based teams become more multiprofessional, consideration should be given to applying this allowance across the whole team.

*Uplift should also allow for a proportion of supervisory time for the lead sister/charge nurse/team leader within the care team. The extent of supervisory time should be determined locally, with an appropriate impact assessment and analysis. Cognisance should be taken of the Mid Staffordshire Inquiry Report recommendation:

"Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal."

http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

The following resources can aid your decision making in relation to supervisory aspect of the ward sister /charge nurse / team leader role:

A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles (RCN and Warwick University 2015)

https://www.england.nhs.uk/6cs/groups/safe-staffing/

Stepping In, Stepping Out, Stepping Up Research Evaluating the Ward Sister Supervisory Role (REWardSS). A survey to provide baseline activity in relation to ward sister/charge nurse supervisory roles (RCN 2015)

https://www.rcn.org.uk/professional-development/publications/pub-005026

Making the business case for ward sisters to be supervisory to practice (RCN 2011)

https://www2.rcn.org.uk/__data/assets/pdf_file/0005/414536/004188.pdf

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[5] For example, if all staff are required to attend two days of mandatory training, four days will be needed if two individuals share a whole time post

Table 1: Considerations in setting uplift

Element	Example %	Rationale
Annual leave	14.7	This is the average annual leave across the nursing workforce, in line with Agenda for Change, and taking account of local patterns of length of service
Sickness/absence	3	This is the target/aspiration level for the organisation and should be aligned to plans to implement improvement
Study leave	3	This includes mandatory and core/job-specific training and learning activities such as link nurse roles
Parenting leave	1	In some organisations this is managed centrally. It includes maternity, paternity and adoption leave. This is driven by local workforce demography
Other leave	0.5	This includes carers leave, compassionate leave, etc
Total	22.2	

2.4 Professional judgement

Staffing decisions based solely on professional judgment – the expert opinion of clinical staff – are considered subjective and may not be transparent. But professional judgement remains an essential element of staffing decisions. For this reason we advocate a triangulated approach, which uses a decision support tool in conjunction with clinical quality indicators and professional judgement/scrutiny.

For the principles of professional judgement, see Appendix 1.

Professional judgement should include consideration of:

- **Ward layout/facilities:** The configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, wards with a high proportion of single rooms might make adequate surveillance of vulnerable patients more difficult. Some ward layouts are associated with significantly more walking between patients than others

- **Escort duties:** It is important to understand whether the tool you are using already takes account of escort duties. Where it is not included but is likely to affect the numbers of staff required, a local data collection and analysis exercise may be useful in determining a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care needs

- **Multiprofessional working:** Consider the make-up of the care team for the ward. Would specific AHPs or support roles meet the needs of patient groups at particular periods of the day more appropriately? Conversely the absence of administrative support staff such as ward clerks may increase nurses' workload at particular times. Thinking about how services can be designed for the future, and talking and listening to staff, can enable organisations to develop models that are more likely to be sustainable.

- **Shift pattern:** Remember that the type of shifts (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These should be monitored to understand the impact and effect on staff and patients.

Where it is hard to construct a strong evidence base, it is important to apply professional judgement to staffing requirements. However, some decision support tools may already cover these and therefore it is essential to understand the tool being used to avoid duplication.

2.5 Comparing staffing levels with peers

Peer comparisons can act as a platform for further enquiry. While you need to exercise caution, comparing staffing with peers can act as a 'sense check', particularly on assumptions and professional judgements. Benchmarking can also help stimulate the sharing of best practice.

Care hours per patient day (CHPPD) provide a useful metric for making these comparisons. CHPPD gives a picture of the total ward care workforce but is split between registered nurses and healthcare support workers (see box below).

$$\text{Care hours per patient day} = \frac{\text{Hours of registered nurses and midwives alongside Hours of healthcare support workers}}{\text{Total number of inpatients (midnight census)}}$$

While the summary CHPPD measure includes all care staff, the registered nurse hours must always be considered in any benchmarking alongside quality care metrics (Griffiths et al 2016b) in order to assess the impact on patient outcomes. See Appendix 2 for more detail.

The Model Hospital dashboard makes it possible to compare peers using CHPPD. Finding peers that are close comparators is important as aspects such as patient acuity, dependency, turnover and ward support staff will differ. You should take

account of local factors, eg specialty mix, as well as differences in the accuracy and completeness of data collection.

'Section 5: Measure and improve' has more detail on the importance of reviewing comparative data on staffing and skill mix in the wider context of patient and staff perception of adequacy of staffing levels, alongside indicators of safety, effectiveness, patient experience and measures of productivity.

Until staff are confident using CHPPD, some rough 'ready reckoner' conversions may help them check for obvious anomalies (see Appendix 3).

3. Right skills

Appropriate consideration should be given by decision-makers to the skill mix required to deliver services as safely, efficiently and effectively as possible. Clinical leaders and managers should be appropriately developed and supported to deliver high quality, efficient services, and staffing should reflect a multiprofessional team approach. Clinical leaders should use the workforce's competencies to the full, developing and introducing new roles where they identify a need or skills gap.

Our workforce, like many in other large sectors and industries, is facing numerous challenges and the landscape of transformation, as set out within the Five Year Forward View is being delivered so we have health and care services that can adapt to the future. In this changing landscape we know that we cannot rely on the traditional solutions to some of our major workforce pressures and we need to think differently moving forwards.

Our ability as professions to adapt and innovate is critical to achieving high-quality care in the right place and at the right time. By modernising, we can shape a workforce that is fit for purpose for the next decade and beyond and demonstrate positive outcomes and experience for those for whom we care.

3.1 Role of nursing within multiprofessional team

Nurses in adult inpatient settings work closely with a range of other healthcare professionals and the following steps should be considered in determining who is best placed to safely meet the patients' care needs. To utilise the workforce efficiently and effectively it is important to identify the skills needed to deliver the care required and deploy the right staff to deliver that care. Therefore careful consideration should be given to the wider multiprofessional team when making decisions about who should deliver care to address patients' needs. The following questions are designed to support this thinking in a staged process. A future AHP strategy will be launched in January 2017.

1. WHAT IS THE CARE/TREATMENT TO BE PROVIDED?

2. WHAT COMPETENCIES ARE REQUIRED TO DELIVER THAT CARE/TREATMENT?

3. WHICH STAFF MEMBER (TAKING INTO CONSIDERATION THE WIDER MULTIDISCIPLINARY TEAM) IS COMPETENT AND BEST PLACED TO DELIVER THAT CARE/TREATMENT?

4. CAN ASPECTS OF THE CARE/TREATMENT BE SAFELY DELEGATED WITH APPROPRIATE EDUCATION AND TRAINING (IF SO, TO WHOM?)

5. WHAT ARE ALL MEMBERS OF THE TEAM RESPONSIBLE FOR?

3.2 Skill mix

Nursing teams include registered nurses and healthcare assistants. Some also include ward clerks and housekeepers. The appropriate mix of registered nurses and support staff should be informed by the use of decision support tools, evidence reviews and professional judgement.

New roles, such as the nursing associate, are intended to support nursing teams to work more effectively. There will be regular updates from the pilot sites on the progress of the nursing associate initiative. Trust boards and clinical managers should ensure they keep up to date with these reports.

Within adult inpatient settings a range of specialist, advanced and consultant nurses and allied health professionals provide expert advice, intervention and support to ward-based teams. It is important therefore when considering the 'right skills' to meet patient needs that, as well as the staff allocated to each ward/unit, a wider view is taken of access to the relevant expertise across a trust.

Some organisations operate a 'link nurse' model whereby members of the ward team assume a lead role for a particular area of practice: for example, education, nutrition, tissue viability, safeguarding or diabetes. It is important that these members of staff have the relevant education, training and dedicated time to function safely and effectively in these roles.

3.3 Staff training, development and education

All members of the clinical team must be appropriately trained to be effective in their roles. The sister, charge nurse or team leader is responsible for assessing the training requirements of individual team members, prioritising and developing a plan to meet these using available resources.

This assessment enables opportunities to be identified for upskilling staff to address gaps in patient care. Education and training needs can be met through, for example, local skills training, e-learning, seminars, shadowing, clinical placement exchanges and rotation programmes. Compliance with appraisal and mandatory training should be incorporated into the local quality dashboard.

Registered professionals require periodic revalidation. Although individual nurses are responsible for ensuring they revalidate, many organisations have adopted a partnership approach.

Ward leaders need to be prepared for the role and given ongoing support. It is important to ringfence time in the roster for managerial work and for supervision of staff. Allocated time will be agreed locally and needs to reflect both administrative work and clinical leadership.

3.4 Recruitment and retention

Recruitment and retention strategies at organisation and ward level are vital as part of the overall workforce plan.

Ward leaders can identify or anticipate problems with recruitment and retention by monitoring, managing and planning for:

- vacancy rates

- sickness absence

- turnover

- the team's age profile.

- outcome from retention/exit interviews.

Staff should be recruited using a competencies and values-based selection process aligned to the NHS Constitution and local policy.

Factors important in attracting new staff and retaining existing staff are:

- personal circumstances, aspirations, preferences and career stage

- clinical specialty/workload

- ward and/or organisational culture

- leadership/team dynamics

- to be proactive in supporting all staff in their development to identify talent early, and help secure leadership positions, recognising the particular needs of BME staff

- flexible working arrangements/shift patterns

- quality of clinical learning environment

- preceptorship programmes/ongoing education and training opportunities

- geographical location, eg ease of travel access and cost of living.

Ward and organisational leaders need to work to boost retention across generations by understanding what motivates people to stay in their jobs. More details can be accessed through the *Mind the Gap* report (Health Education England 2015). https://www.hee.nhs.uk/sites/default/files/documents/Mind%20the%20Gap%20Report_0.pdf

Strategies to improve retention can prove cost-effective because experienced staff are retained while agency and recruitment costs are avoided. Leadership and adequate resources strongly influence turnover intention (Hayes et al 2012).

4. Right place, right time

Staff should be deployed in ways that ensure patients receive the right care, first time, in the right setting, in a sustainable way. This will include effective management and rostering, with clear escalation policies if concerns arise.

4.1 Productive working

Work processes should be routinely[6] reviewed at both the hospital and ward level to reduce unwarranted variation and increase productive direct care time with patients.

A number of methods are used in hospital wards to increase productivity, often based on LEAN methods that focus on eliminating waste and promoting activities that 'add value'. Examples include:

- the Productive ward (NHS Institute for Innovation and Improvement)

- Transforming Care at the Bedside (Institute for Healthcare Improvement) http://www.ihi.org/engage/initiatives/completed/tcab/pages/default.aspx

- Virginia Mason Production System (NHS Improvement and Virginia Mason Institute) https://improvement.nhs.uk/resources/virginia-mason-institute/

There is some evidence for the potential benefits of the productive ward programme, particularly an increase in time available for 'bedside care'. The programmes appear to be suited to environments that are already looking to make improvements and where staffing is stable and leadership strong (Hamilton et al 2014) – it is important that all organisations capitalise on the opportunities provided by such programmes.

Examples: releasing clinical staff time for patient care

- The appropriate employment of technology: eg the safe staffing app developed by Nottingham University Hospitals NHS Trust to enable real-time monitoring of nurse staffing levels accessible on mobile devices which reduces time spent communicating staffing levels to numerous stakeholders.

- Multiprofessional documentation: eg shared multiprofessional documentation to avoid duplication of information recording by different healthcare professionals.

- New or redesigned ward roles: eg a ward-based pharmacist reviewing and adjusting the medication may reduce the risk of falls longer term for patients at risk rather than employing a 'special'.

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[6] Annually, or more frequently where there have been changes to services

4.2 Efficient deployment and flexibility

The Carter report (2016) recommends use of electronic rostering systems for effective staff utilisation: https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

Best practice guidance for effective e-rostering is available from NHS Employers: http://www.nhsemployers.org/your-workforce/plan/agency-workers/reducing-agency-spend/e-rostering and the Carter Review https://improvement.nhs.uk/uploads/documents/Rostering_Good_Practice_Guidance_Final_v2.pdf

Factors to consider when rostering clinical staff include:

- in-charge capability/competence
- skill/band mix
- admission and discharge profile
- day attenders
- theatre schedule
- patient focused activity, eg case conferences and team huddles
- opportunities to increase the time spent providing direct care through the utilisation of technology and support services.

Flexible working

Flexible working within and between wards is essential in ensuring that patient care needs are met. Additionally flexible working options suit many nursing staff and is important in their retention. Organisations can offer this in different ways:

- part-time working
- compressed hours
- job share
- self-rostering/range of shift patterns
- flexi-time
- annualised hours
- term-time contracts
- flexible retirement schemes.

NHS Employers' guidance should be followed in developing opportunities for flexible working: www.nhsemployers.org/your-workforce/retain-and-improve/managing-your-workforce/flexible-working

Most ward-based staff work in shifts. Shifts should be planned with best practice principles in mind. These can be found at http://www.nhsemployers.org/your-workforce/plan/agency-workers/reducing-agency-spend/e-rostering. While many trusts use shifts of varying lengths to accommodate patient need and staff preferences and because of potential efficiency gains from reduced handover periods, there may be losses in efficiency associated with longer shifts. Managers planning rosters should aim to organise shift patterns to reduce cumulative fatigue and maximise recovery time (NHS Improvement Evidence Review Three 2016).

Additional research on 12-hour shift patterns in registered nurses and healthcare support workers can be accessed at: https://www.england.nhs.uk/6cs/groups/safe-staffing/

Staff deployment

Ward establishments need some capacity to respond to peaks in patient need or unanticipated staffing shortages. Capacity can be increased with overtime, temporary staffing and dedicated 'float pools' of staff across hospitals to be deployed where demand is greatest. Float staff may be deployed on a 'home' ward and redeployed on demand. There is no clear evidence on the relative effectiveness of different staffing policies. Policies which lead to frequent deployment of agency staff may incur significant expense. Specific training and support of staff who 'float' to other units is likely to maximise effectiveness and make the positions more attractive (NHS Improvement Evidence Review Two 2016).

Rest breaks

Local policies for managing rest periods must meet working-time regulations. Staff breaks should be taken during the shift rather than at the beginning or end of a shift. This reduces risks of staff fatigue, safeguarding staff health and wellbeing.

4.3 Minimising agency staffing

Flexible use of the establishment

Temporary staff are a valuable and valued part of the workforce and can be a useful contingency for filling both anticipate and unanticipated staff shortages. They should be recruited from in-house staffing banks. Only if this is not possible should a framework agency[7] be approached. Relying on high levels of agency staff is unlikely to represent an effective or sustainable solution to ensuring that there are the right staff, with the right skills, in the right place at the right time. Temporary staff should have received local training and induction to ensure they are familiar with how the organisation works.

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[7] https://www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

Escalation processes

Organisations should have a protocol for frontline staff to escalate concerns about the safety and effectiveness of care to a senior level.

5. Measure and improve

Trusts should collect ward and organisation-level metrics to monitor the impact of staffing levels on the quality of patient care and outcomes, the use of resources and on staff themselves. The aim is to continuously improve patient outcomes and use of resources in a culture of engagement and learning.[8] Evidence-informed ward-based metrics may focus on:

- patient outcomes (eg infections, falls, pressure ulcers)

- patient and staff experience (eg family and friends test and complaints)

- staffing data (eg appraisal, retention, vacancy, sickness)

- process measures (eg hand hygiene, documentation standards)

- training and education (eg mandatory training, clinical training).

A local quality dashboard for safe and sustainable staffing that includes ward-level data should be in place to support decision-making and inform assurance. This should be reviewed on a monthly basis and take account of the budgeted establishment and expenditure to date including temporary staffing. Interpretation of any metrics at a ward or unit level is essential and can be effectively monitored on a ward-by-ward basis. Learning lessons to improve the quality and safety of patient care is a prime function of the dashboard review. It is also important to understand metrics on a pathway basis, where harm can occur at different stages. For example, patient safety thermometer data on pressure ulcers and infections cannot always be easily attributed to one professional group's actions or omissions.

Interpreting any metrics at a ward or unit level can be challenging. Staffing data can usually be directly linked to a ward, and processes carried out on a ward (such as rounding, taking observations, or medication administration) can also be effectively monitored ward-by-ward. However, patient pathways will typically include more than one ward or unit, and it is often not possible to link outcomes directly to a single ward or unit.

5.1 Measure patient outcomes, people productivity and sustainability

While NICE guidance identified evidence of '*increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts*' they clearly stated there is '*no single nursing staff-to-patient ratio that can be applied across all acute adult inpatient wards*'. We have found no new evidence to inform a change to this statement (NHS Improvement Evidence Review One 2016). However, NICE guidance recommended indicators for monitoring safe nurse staffing on acute wards including 'red flags'. The NQB guidance built on these to outline some practical

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[8] https://www.kingsfund.org.uk/publications/leadership-engagement-for-improvement-nhs

issues, including understanding how metrics like compliance with mandatory staff training act as an indicator of 'right skills' but a proxy for staffing pressures.

Section 2.4 has further information on peer comparisons which supports professional judgement as well as the use of CHPPD in this.

It is important to identify the aspects of quality that are linked to safe staffing in adult ward environments. The literature highlights that falls and medication errors are strongly linked to staffing (NICE evidence review, 2014), with other areas including omissions in care, missed or delayed observations and unplanned admissions to ITU providing insights into staffing capacity and capability. However, these indicators can be challenging to monitor consistently and a thorough audit program must be in place to do so.

Leading Change, Adding Value: a framework for nursing, midwifery and care staff (2016)[9] was co-produced and endorsed system-wide and is a vehicle to help achieve the 'Triple Aim' of better outcomes, better patient and staff experience, and better use of resources; leading to significant improvements and empowering local leaders to drive quality in their own areas. Commitment 9 is the workforce commitment 'We will have the right staff in the right places and at the right time'. Commitment 6 addresses that better staff health and wellbeing is associated with improved outcomes and experience for those individuals and populations that we serve.

5.2 Report, investigate and act on incidents

Trusts should follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis[10] for serious incidents.[11] As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified.

NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance,[12] [13] and any other incident where a patient was or could have been harmed,[14] as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (eg for omitted medication),[15] clinical audits[16] or locally agreed monitoring information, such as delays or omissions of planned care.

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[9] https://www.england.nhs.uk/ourwork/leading-change/
[10] https://www.england.nhs.uk/patientsafety/root-cause/
[11] https://www.england.nhs.uk/patientsafety/serious-incident/
[12] http://www.nice.org.uk/guidance/SG1
[13] https://www.nice.org.uk/guidance/ng4
[14] https://www.england.nhs.uk/patientsafety/report-patient-safety/
[15] https://www.safetythermometer.nhs.uk/index.php?option=com
_content&view=article&id=3&Itemid=10

NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems highly likely to harm a patient. Professional judgements must be made in relation to patient need and staff resources, including skills, to meet that need. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

Staff in all care settings should be aware that they 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.[17] Policies[18] should be in place supporting staff who raise concerns as and when they arise.

5.3 Patient, carer and staff feedback

The views of patients, carers and staff can give vital insights to staffing capacity, capability and morale, using mechanisms such as national and local surveys, patient or staff stories, complaints and compliments. The findings of incident and serious incident investigations should also be considered alongside the suggested list of quality indicators so that the nature and causes of any issues can be rapidly identified and acted on. Some national and local surveys include questions with direct or indirect bearing on staffing (for example, asking patients if they think there were enough staff to meet their needs, and whether they had to wait for call bells to be answered, etc) but wider feedback on the overall experience of receiving or delivering care is also likely to be affected by staffing.

Organisations need to be cognisant of feedback from regulators and agree through their governance processes their formal actions in response to this. These may include:

1. feedback from CQC inspections
2. HEE quality visits[19]
3. NHS Improvement diagnostic reviews
4. CCG reviews.

Further detail on patient, carer and staff indicators recommended by NICE and the NQB can be seen in Appendix 1.

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[16] http://www.hqip.org.uk/national-programmes/
[17] http://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives
[18] http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing
[19] HEE Quality Framework:
https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf

Culture

The importance of the organisational and ward level culture should not be underestimated. Further work will be developed by NHS Improvement around leadership and staff engagement.

6. Conclusion and recommendations

This improvement resource is based on the National Quality Board's expectations to ensure safe, effective, caring, responsive and well-led care, on a sustainable basis that ensure the right staff with the right skills are in the right place at the right time. We have designed it to be used by all those involved in clinical establishment setting, approval and deployment from the ward manager to the board of directors.

It builds on NICE guidelines on safe staffing for nursing in adult inpatient wards, and it is informed by NICE's comprehensive evidence reviews of research and subsequent evidence reviews focusing specifically on staffing levels and outcomes, flexible staffing and shift work.

Recommendations
In determining nurse staffing requirements for adult inpatient settings:
A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.
A strategic staffing review must be undertaken annually or sooner if changes to services are planned.
Staffing decisions should be taken in the context of the wider registered multiprofessional team.
Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process
Action plans to address local recruitment and retention priorities should be in place and subject to regular review.
Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit temporary staff.
A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.
Organisations should ensure they have an appropriate escalation process in case staffing is not delivering the outcomes identified.
All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff.
All organisations should investigate staffing related incidents, their outcomes on staff and patients and ensure action and feedback

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Appendices (supporting material) (avaliable from https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-adult-inpatient-acute-care)

1. Principles of professional judgement

2. The NICE guideline on safe staffing for nursing in adult inpatient wards and red flags

3. CHPPD 'ready reckoner'