Safe staffing on the table

A group of chief nurses, directors of nursing and assistant directors of nursing met in London to tackle the thorny issue of safe staffing levels. Nursing Times captured their thoughts.

Allocate Round Table

Paul Scandrett, director of healthcare at Allocate, talked about his experience of working with the NHS since 2005 on staff scheduling issues and how this compares with his history of scheduling in public and private sector organisations.

“In the NHS there is a disconnect between the activity that is being delivered and how this is measured versus resources dedicated to it,” he said. “And a lack of objectivity about how many staff are needed to deliver a certain outcome.”

He said that the question of whether trusts had safe staffing was a complex issue. “It’s not just about the ratio of staff to beds. It’s far, far more complex than that. Often important, and well thought through work on establishment setting, is not translated into how many appropriate staff is on the ward day in day out based on the patients need,” he said.

Funded versus actual posts

One of the reasons many of the nursing directors present felt the issue of staffing levels has become complex is the disconnect between funded and actual posts. Janice Stevens summed this up: “I’ve visited many trusts over the last few years and seen staffing information presented to boards that is often a report on funded posts, plus or minus information on sickness and absence. I rarely see any detailed information being presented to boards that is a meaningful comparison of funded posts versus actual staffing levels, day by day. Using information on funded posts to provide assurance on staffing levels can provide a false sense of security. Also funded posts will often include posts that aren’t directly attributed to ward numbers, such as clinical nurse specialists.”

One nursing director said that often hospitals have the right establishments, but have a problem with supply. This confusion means that staff to patient ratios can be interpreted in different ways and the existing variation reveals the extent of the challenge. One nursing director explained that it was common to hear of one or two nurses managing around 27–30 patients in hospitals. Jenny Leggott said the simplicity of the 1:8 ratio is two or three years out of date because patient dependency appears to be on the rise. There are more complex treatments being carried out and more patients with complex needs.

The nurses wanted to move the debate from ratios to one more closely aligned to the reality of delivering complex care pathways. Sally Brittain talked about role and function – ensuring that staff know what is expected of them. “We have just planned all our specialist nurses,” she says. “It takes time to undertake a project of that size however it provides a greater understanding of the function of those roles and the contribution specialist nurse make to direct patient care within the ward teams.”

Steve Hams agreed that safe staffing is not just about having the right numbers of registered nurses. “Safe staffing is about achieving the best outcomes for patients. Why do we immediately think in terms of more nurses? We need to be more creative than just thinking we need more nurses and doctors. We are frightened as a profession to recognise that the contribution of other professional disciplines such as physiotherapy or an occupational therapy on positive outcomes of care.”

Attendees at the Nursing Times/Allocate Software Round Table, Covent Garden, London

Helen Blanchard, chief nursing officer, Worcestershire Acute Hospitals NHS Trust
Susan Bowler, director of nursing and quality, Sherwood Forest Hospitals NHS Trust
Sally Brittain, deputy chief nurse, Surrey & Sussex Healthcare NHS Trust
Simon Courage, product director, Allocate Software
Steve Hams, chief nurse, Medway NHS Foundation Trust
Liz Jones, head of healthcare marketing, Allocate Software
Fergus Keegan, deputy director of nursing, Kingston Hospital NHS Trust
Jenny Leggott, director of nursing, Nottingham City Hospital NHS Trust
Susana Tejerina, product marketing, Allocate Software
Louise Stead, director of nursing and patient experience, Royal Surrey County Hospital NHS Trust
Janice Stevens, managing director, West Midlands LETB, Health Education England West Midlands
Susan Tijerina, senior pre-sales consultant, Allocate Software
Peter Walsh, director of nursing, Central and North West London NHS Trust
Geraldine Walters, director of nursing, Kings College Hospital NHS Trust

“This is our trust, we ask clinical nurse specialists to do a day a month working on the wards to enhance the specialist knowledge of the staff.”

Suzie Loader

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**Administrative support**

There was concern that ward nurses were finding themselves carrying out more administrative tasks and therefore the link with patient outcomes was becoming less distinct. Ms Stevens said that many staff do jobs such as bed management, risk management and progress chasing. “These are well-paid nurses that still need matrons to bail them out when it’s not going so well. If that was done differently with real ownership and support, could those nurses spend more time with patients?” she asked. “Hospitals must be spending a significant amount of money on these roles. Is that the best use of money considering we need direct patient care?”

Some nurses felt these roles were useful because they managed “flow” rather than “care” and this in turn freed up time for other nurses to provide patient care. They were reticent about losing those posts. But Ms Stevens countered by asking whether a process that assures flow is the best use of clinical resources.

Ms Britisht and the panel were concerned about the impact of administrative provision of cover during ward clerk annual leave and the buddy system. “We don’t get complete cover for the ward unless we have a buddy to support the nursing staff,” she said.

**Administrative tasks**

The in-tray is the resting place for lots of administrative tasks that are generated elsewhere in the organisation,” she said. “So they need someone who is really slick at sorting out the administration, probably at band 4 level.”

Ms Leggott applauded the idea of greater support for ward sisters but said the issue of cost would have to be justified by examining the benefits.

Mr Hams agreed: “We want our ward sisters to focus on their role as a concierge service to help with the staffing we need to provide good care.”

**Pushing nurses as hard as we do, I am worried there is a lack of understanding of how to assure rather than just observe, was the consensus.**

Ms Stead said: “I am really pleased that the number of inspectors with clinical backgrounds will be increased in the new style inspections.”

Mr Scandrett said there were two nurses on the Keogh review, and argued they did understand the nuances of providing good care. She also made the case for patient safety representatives on the inspectorate saying it was about making the regulator appreciate the controls in place.

Some of the panel were anxious that simply saying a ward is “safe” does not go far enough and it falls staff, patients and the public into a false sense of security. The need for the NHS to have failsafes was a common belief amongst the panel.

**Workforce planning**

Members of the panel expressed concern that another reaction to Francis could be to overcommission and over-train staff. A few directors of nursing said they were recruiting from abroad as there simply wasn’t the supply here.

Dr Walters commented that there had been a boom and bust approach to workforce planning in the past, often necessarily driven by how much money is available rather than the need, which had not served us well as a profession.

Mr Hams mentioned the Safer Nursing Care Tool and said this was a good tool for workforce planning. But he also issued a warning that nursing directors should listen to their troops about the numbers they need on the frontline.

Another controversial issue that was discussed was eight-hour versus 12-hour shifts. Evidence was mixed around its effect on safety though staff prefer longer shifts. But ultimately the biggest issue was about how many staff were on those shifts.

Mr Scandrett said that in the NHS, scheduling staff is still often considered a science that is surrounded by mysticism. In Asda stores, they use their understanding of peaks and troughs in activity day to day and even season to season to ensure there is enough people to work on the tills. He argued the same principles should be applied to the NHS.

And there was an overwhelming belief that it is nursing that must own “getting that right” and making a difference.

Ms Stevens said: “Our challenge is that we haven’t got a clear narrative. Describing the staffing we need to provide good care will have a number of components, ‘a bundle’ if you like. We need to be able to clearly and simply articulate what it is we need and have the courage as a senior nursing voice to influence not just boards but the NHS as a whole.”

Peter Walsh concurred. Mr Walsh said that one of the greatest strengths of nursing was that it was focused on one person, the patient. If we work together as an MDT, how does it impact on patient care? If the government mandates 1:8, the next question will be why are we not meeting that?”

Ms Bowler said there were two nurses sorting out the admin-