How to implement the NICE Staffing Guidance

The NICE Safe Staffing Guideline for adult inpatient wards in acute hospitals requires careful consideration to use it well and ensure it is introduced safely. Nursing Times hosted an event to hear from experts and senior nurses to find out how they intend to implement it

If you're not confident about how you are going to implement the NICE Safe Staffing Guideline for adult inpatient wards in acute hospitals, read on. One day after the guideline was published, Allocate Software and Nursing Times hosted an event that brought together Miles Scott, chair of the NICE Committee on Safe Staffing Levels and chief executive of St George's Healthcare Trust and Sue Colvill, director of employment services at NHS Employers. A group of directors of nursing, deputy/assistant directors and HR directors gathered to ask questions and debate how they will be implementing this pioneering work on nurse staffing levels.

The group of 26 senior nurses and HR directors divided into groups to discuss key themes and challenges arising from the NICE guideline.

"What are we going to do when we have a red flag situation? Do we have to close our wards? What impact will this have on other hospitals in our area?"

Judith Morris

Challenge 1: What do you welcome most and what do you wish the guideline had included?

Sharon Cullen, deputy director of nursing, Princess Alexandra Hospital NHS Trust: "We welcome that the advice is from NICE; this will help frame to our board what other organisations are doing as a baseline."

Julie Roberts, assistant director of nursing, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust: "It is much better than the draft – shorter and easier to read, and this means we can easily give it to staff."

Wendy Page, nurse director for the Clinical Support Health Group, Hull and East Yorkshire Hospitals NHS Trust: "It is concise and our staff of nurses are already recording and meeting a lot of the nurse safety indicators."

Julie Roberts: "Engagement is needed to communicate the standards to the team – it's very subjective as to how it is understood. We have to get to the grass roots of the staff."

Sue Smith from University Hospitals of Morecambe Bay and Lyn McIntyre of the Nursing Directorate both agreed it was a "great" piece of work

Miles Scott, chair of the NICE Committee Safe Staffing Levels

Miles Scott began his presentation by setting the context for the guideline's publication, pointing out that in the Francis Report into care failings at Mid Staffordshire, Sir Robert recommended NICE look into staffing levels and consider how best nursing could meet the increased demand for care provision.

Although this work had started on adult inpatient wards in acute hospitals, he said that work by NICE on staffing was already in train on midwifery and emergency departments, and the guideline on midwifery is expected to be published in January 2015.

He explained the process that the committee goes through – gathering evidence to look at what factors and managerial tasks need to be taken in account, as well as environmental aspects, such as ward layout, patient factors and staff factors.

For example, he referenced the staffing requirements of nursing care provided in a side room and said the outcome evidence is counter to what many professionals believe to be true – single rooms need more nurse time and this is because side rooms are used for the very sick, who, of course, need more nursing care. He said that as more hospitals are built with single rooms, the evidence may demonstrate the long-held professional view that single rooms do actually require more nursing care.

"What we wanted was a series of nursing indicators that are reported every month to give boards confidence or not that they are meeting the needs of patients, and then at least twice yearly to have nurse reviews into establishments," said Mr Scott.

Mr Scott then covered one of the national media's most talked-about issues arising from the publication of the guidance – the red flag events.

"Just because you have a red flag doesn't mean you have staffing levels wrong on that shift," he said. "It is just a signal that you need to review them."

He said that in devising the guideline, they were keen to keep the red flags "limited" and only wanted to put them in where the safety outcomes were "nurse sensitive". So for example, the committee had included pressure ulcers and falls, and were considering including hospital-acquired infections but decided that they weren't a reflection of purely nurse staffing levels.

"However, there is nothing to stop you devising your own red flags," he told the senior nurses in the room.

On the subject of minimum ratios of staff to patients, Mr Scott candidly talked about needing to balance the "tension" between the public desire for "specifity" and providing a precise number, and the need to supply a guideline that included evidence for its decisions and gave leeway for "professional judgement".

"We know there is a positive relationship between staffing levels and outcomes, but it is not linear," he said. "That means that more staff does not equal better outcomes. It is a curve and you need to identify where your ward is on that curve, and at what point it is in danger of slipping down the curve. At St George's, we felt that putting in 1:8 put our money where our mouth is, and would provoke debate."

He said any increased costs of staffing to meet this guideline would be offset by the benefits of providing good care, and would ultimately improve patient safety.

Challenge 2: Do you have the flexibility in your workforce to manage these requirements?

Simon Courage: "It is hard to create a flexible pool of staff if there are already vacancies on wards, and there are challenges of job satisfaction and not obtaining the same level of continuity, so it's important to get incentives right. You must make it a prestigious thing to be working in the pool. Depending on the type of trust you are, you have to look at how to use your bank and pool staff, and at redeployment. For example if you're in a remote rural area the bank can't as easily fill immediate demand peaks, so you'll be more reliant on an internal pool or redeployment than urban trusts.

Challenge 3: What are the barriers/challenges to implementation?

Joyce Fletcher, deputy director of nursing, The Black Country Partnership NHS Foundation Trust: "It is important to manage expectations of the staff as well, making sure people understand the possible mitigations. Make sure that there are steps that are clear in the ward of what they can do, especially when there isn't as much professional support out of hours.

"We need to be careful how we present this because we are asking NHS staff to do so much"
Joyce Fletcher

Simon Courage, product director for healthcare staffing, Allocate Software

Simon Courage focused on the "how to" of implementation, urging the senior nurses in the room what they should consider, and how to practically go about making it happen on their wards.

"Assessing the needs of individual patients for each shift is paramount when making staffing decisions," he said in opening his presentation. "This is the big change the NICE guidelines bring, compared to previous approaches."

He said it was vital to look at how many patients a ward has by classification, the amount of care needed per classification, how many nurses that requires and to break this down by shift.

"We must move the conversation from historical reporting to answering what is safe, are we delivering it and how do I know?" he said. "We must be careful that following this guideline doesn't become about ticking boxes."

Mr Courage also said it was essential to have appropriate processes to gather the data. "If the data is not accurate, it might as well not exist," he said. "Our experience of moving to a real-time view of required vs actual staff is that a census of patients should be done for every shift, so three a day if it's eight-hour shifts you operate. The more frequently you do it, the more helpful the information."

He also said that this would enable senior nurses to see how well their teams were using the classification and if they understood it. "With the Allocate system you can track who did the census, so if acuity is always higher when, say, Sue does it, you can have a chat with her and see if you need to give her more training in patient classification."

He said that technology could help, but that data accuracy was the biggest challenge, and this must be intelligently monitored in real time. He also commented that the way in which NICE outlines the responsibility of the nominated nurse in charge would help.

On the red flags and indicators he said "implemented correctly the red flags will provide a really useful early alarm bell, but they must be simple to administer and monitor and not become an industry and admin burden for nurses on shift. Monitoring outcomes remains key; we welcome the indicators in the guideline. Together it will help organisations ensure their own internal smoke alarm is better than the CQC's smoke alarm" he said.

Looking at how trusts could respond to the challenge set by the guideline, Mr Courage said it is worth organisation reviewing how they can safely respond to the staffing flexibility required by the guideline This could include new ways of using bank, or having a pool of substantive staff to move around wards with gaps.

"In the US, they use bank staff as a positive to meet increased demand," Mr Courage said. "Now we have this Guideline, we have an opportunity to reconsider how we use flexible staff to meet demand peaks"

Key findings from the NICE guidance

- **Patient need:** The needs of actual patients on a ward should be at the heart of setting nurse numbers for each shift
- **Establishment setting:** Hospitals should use this patient information as part of bi-annual establishment review
- **Red flags:** Wards need to monitor and respond to defined 'red flags' in real-time
- **Outcomes:** Nurse indicators must be monitored to help identify staffing issues
- **Numbers:** No less than two registered nurses per shift, and where less than one RN to eight patients are present senior nurses should monitor red flags and nurse indicators closely and satisfy themselves that their staffing levels are safe
- **Decision support:** Organisations should use a NICE decision support toolkit to help establish the required numbers of nursing hours, this should support professional judgement not replace it
- **Ward roster:** senior nursing managers are accountable for the nursing staff roster that is developed from the ward nursing staff establishment. Needs to reflect patient need.

Delegates debated how and what should be done to implement the NICE guideline

Sue Colvill, director of employment services, NHS Employers

Although Sue Colvill recognised that the numbers were important and that evidence shows that, she urged delegates not to forget other important aspects of providing safe care, such as staff engagement.

She said motivated staff created safe care, and they were ultimately motivated most of all by their relationship with their direct line manager. She said this relationship was improved when managers behaved consistently and predictably, were demonstrably competent in their role and were fair, honest and had integrity.

"You must create a trust fund during the good times," she said. "And be honest with staff when the news you have to give is difficult. Kill the spin and create a trusting culture."

You could introduce more flexible ways of working with the senior staff, explaining mortality rates increase on the weekends and at nights and that more senior staff are needed there during these times. Programmes that are human resources or nursing led need to be more patient focused. You need to look at this guideline and think how to translate models that already exist to a mental health setting.

"Tell staff they can cancel non-essential tasks, and give staff guidance on what those tasks are and make sure the ward is safe but make sure it is fully explained to the staff, and that they are also explaining it to patients and their visitors."

Challenge 4: What do you think of the red flag events and how will you handle them?

Jackie Bird, director of nursing, The Christie NHS FT: "If there are less than 2 RN on a ward – how do you bring professional judgment? For example, if there is only one patient on a six-bedded ward,

two RN wouldn't be efficient. She advocated for open honest publications on a monthly basis including patient improvement stories, and lots of transparency.

Challenge 5: How will you engage the board with this guideline?

Lucy Connolly, assistant chief nurse, Chelsea and Westminster NHS Foundation Trust: "Boards still need a lot of education, and the most powerful way of engaging them is around patient stories. Use the evidence in the guidelines alongside a patient story to influence the board.

Sue Smith, chief nurse, University Hospitals of Morecambe Bay NHS Foundation Trust: "You need to take each of the people on the board individually into consideration and think what type of evidence (for example data, a story or finances) and think how they would need to be convinced."

With thanks to all the nurses and HR directors who attended this event on July 16