Making staffing safer

Chief nurses, senior directors and chief executives met to discuss the thorniest topic of recent times - safe staffing – in a round table event with Nursing Times’ sister publication Health Service Journal

INTRODUCTION

Just over 12 months ago we, like many of you, were digesting the detail behind the 190 recommendations in the Francis report. Our objective was to understand the impact on our 251 customers, and identify how we could support them. We immediately recognised that we had a part to play in helping all our customers evolve the way they embraced e-Rostering beyond its proven productivity benefits to also ensure it was used to manage both safety and quality. This wasn’t a new concept. Our strapline since 2008 has been “Right People, Right Place, Right Time” and in July 2013 we had launched our next generation demand-based staffing tool, called SafeCare, which took account of both the acuity and dependency of patients called SafeCare, which took account of both the acuity and dependency of patients.

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Over the same period we visited 80 trusts uncovering the processes and policies that can hamper shift-by-shift safe staffing. These were things such as leave management, flexible working and effectiveness of temporary staff. The National Quality Board’s guidance has also had a profound impact. But do you really know what safe means in your organisation? Does it mean every shift is safely staffed, or most of them are? If you do define this, and data demonstrates you have unsafe areas, are you and the workforce ready to do something about it? Today, I am seeing boards engage more deeply, but this is a journey and even across nursing we experience a fair amount of confusion on the question of what safe is shift-by-shift.

One final thought: While a great deal of the immediate attention and new reporting requirements have concentrated on the nursing workforce, the Kogheh reviews and CQC have paid equal attention to the medical workforce, probing and judging where there are enough doctors to cover key 24/7 services. Boards must also ask what assurance and visibility they have on the availability of both the consultant and junior doctor workforce.

The Francis inquiry and the government’s response to it have highlighted the need for safe staffing, while the National Quality Board report on staffing at the end of last year emphasised the accountability of boards for ensuring safe levels of staffing were in place at all times.

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“You need to know on a day to day basis how many warm bodies you need to deliver a service and you have to be able to escalate” Katherine Fenton

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**Allocate Round Table**

**“Assurance is not just about the numbers...but values, competence development, planning, engagement and team working”**

Sue Covill

the outcome measures are what matter. A real worry is that we could be looking at some of the wrong things.”

NHS Employers’ director of employ-
ment services Sue Covill said: “For me one of the really strong messages around assurance is that it is not just about the numbers. It is about looking at values, compe-
tence, development planning and engagement and also team working.”

There was strong evidence that all of these correlate to patient experience, she added.

But there was firm support for internal assurance from Jonathan Spencer, deputy chair of East Kent Hospitals. “The board is much more in touch with what is hap-
pening on the ground. We’ve just done a big review of ward staffing in East Kent.”

Key points were aligning the supply with demand across the day and week, over-
coming staff resistance and recognising that skill mix must differ in different areas, he said. But for board members there was the question of how they could get assurance that what was being pos ed to them was appropriate and balanced. Sev-
eral board members noted that they were not being asked to look at anything that would give them the level of assurance that was being pos ed to them.

Patricia Miller, director of operations at Derriford Hospital in Plymouth, agreed it was the board’s responsibility to assure itself that staffing levels are appropriate but warned that linking staffing levels to expe-
rience and outcomes was complex.

Her work was focusing on how early warning signs could be incorporated into a real time heat map of the organisation, highlighting pressures. The answer might not be as simple as having a nurse-patient ratio of one to eight – it could be that such ratios would need to be diverted to areas that were “hotter”. But this was a decision which would be ideally taken by ward sisters and matrons at handover, without the executive team having to become involved.

Sue Smith, who has recently taken over as executive chief nurse at University Hos-
pitals of Morecambe Bay FT, highlighted the lack of benchmarking data available.

“Let’s start sharing data. We need to understand how we can present a picture at board and ward level where we can say that the wards have the same number of staff, the same number of patients but one has really good outcomes and the other does not,” she said. The reason could be how it was organised or ward leadership. “Allocate Software, director of healthcare Paul Scandrett said that, compared with other international healthcare systems, the NHS did not fully understand the unit cost of care and therefore found it hard to focus on what level of quality it wanted to deliver from the resources it put in. “When people talk about safe staffing, we need to ask is what is safe, what does safe mean to your organisation?” he said. But an impor-
tant question was how organisations would react when shift-by-shift measure-
ments showed there were issues.

Chief executive of Heart of England FT Mark Newbold said: “It is an unwise chief executive officer who tinkers with the establishment level.” His organisation measures staffing levels three times a day, looking at patient flow and the situation in the emergency department. “The informa-
tion in aggregated form went to the board. Kevin McCue, chief executive of George Eliot Hospital Trust, said: “I think we are really struggling as a service and on indi-
vidual boards about what is safe and what is not. At board level there is always a bal-
ance to be struck between hard metrics and soft metrics. I can look at the dash-
board in the morning, telling me how many staff are on each ward and I can walk around and it can feel really different.”

Mr Farrar asked about the balance between resources and workforce: were trusts having to compromise?

Mr Scandrett said: “Having looked at thousands of rosters, my experience is that productivity improvements and quality of care are not mutually exclusive.” Ward managers who make best use of their staff were crucial in delivering both.

In the independent sector there is greater emphasis on looking at how much it costs to deliver an improvement in care. Adopting this approach, backed up by data, could help trusts in conversations with their commissioners about how much improved care would cost.

Mr Sewell-Jones said his trust had taken a decision to post a deficit to allow it to address quality and had recruited 200 more nurses to enable this. But the trust needed to look for benefits not just in terms of quality but in productivity if this was to be sustainable.

But if those around the table offered extra money to address safety and quality issues how would they spend it?

Mr Farrar agreed that the board and high-
light issues – though board members should get out to see the situation.

Drawing the round table to a close, Mr Scandrett highlighted the role of ward managers and leaders in day-to-day deci-
sions on staffing. In his work with trusts, he saw how boards had a positive impact through supporting those in these roles in delivering both safe care and safe staffing levels. Boards should not just seek assur-
ance but listen to and support these staff.

Mark Newbold was clear that he would not reduce staffing just because commission-
ators asked it. But the discussion is to do with what is safe and what is not.

Mr Farrar commented on how strongly the issue of flexibility in staffing had come out. “We have to have a knowledge base and information. But we need to be applying judgement. The data only tells us some-
thing about what it looks like in theory. When we walk round it is a little different.”

“If I was in Monitor or the CQC’s posi-
tion I would be asking two questions – do you have any system? And what do you do with the knowledge you have?”

Simon Courage, product director of Allocate Software, said that safety was not about the raw numbers – it was about understanding needs as well, bringing in issues such as acuity and skill mix. “Data is not the only answer. Where the data can help is to pinpoint areas. The data is the start of that conversation. Not the end.”

But Mr Grantham asked what happened at weekends and out of hours. Who responded to data then? There could be a need for someone to have authority to move staff quickly, he suggested, rather than how was that managed? Mr Scandrett noted that there were fewer weekend urgencies when there were often more tempo-
rary staff at the same time that fewer senior staff are on call at weekends.

Mr Farrar summed up the debate: just looking at staff numbers was not going to be a solution. Other aspects were impor-
tant: allowing real time adjustment to numbers in each area; the ability to predict problems and address them early; and learning from past experiences to be pre-
ventative rather than reactive to a crisis.

Mr Spencer suggested the director of nursing and senior staff needed to mod-
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