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

Amid the calls for minimum staffing levels from the Safe Staffing Alliance in the wake of the Francis, Keogh and Berwick reports, a group of 11 senior nurses met with representatives from Allocate Software and Nursing Times to discuss it.

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.

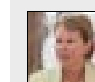
"In our trust, we ask clinical nurse specialists to do a day a month working on the wards to enhance the specialist knowledge of the staff."

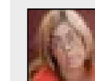
Suzie Loader

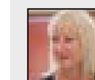
The nurses wanted to move the debate from ratios to one more closely aligned to the reality of delivering complex care pathways. Sally Brittain talked about role and function – ensuring that staff know what is expected of them. "We have just job planned all our specialist nurses," she says. "It takes 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."

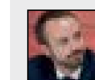
Steve Hams agreed that safe staffing is not just about having the right numbers of registered nurses. "Safe staffing is about achieving the best outcomes for patients. Why do we immediately think in terms of more nurses? We need to be more creative than just thinking we need more nurses and doctors.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

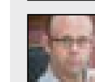
Attendees at the Nursing Times/Allocate Software Round Table, Covent Garden, London

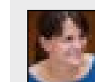

Helen Blanchard, chief nursing officer, Worcestershire Acute Hospitals NHS Trust

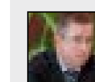

Susan Bowler, director of nursing and quality, Sherwood Forest Hospitals NHS Trust

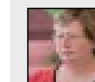

Sally Brittain, deputy chief nurse, Surrey & Sussex Healthcare NHS Trust

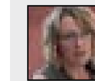

Simon Courage, product director, Allocate Software

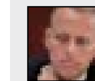

Steve Hams, chief nurse, Medway NHS Foundation Trust

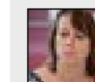

Liz Jones, head of healthcare marketing, Allocate Software

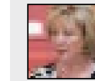

Fergus Keegan, deputy director of nursing, Kingston Hospital NHS Trust

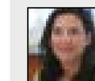

Jenny Leggott, director of nursing, Nottingham University Hospital

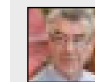

Suzie Loader, director of nursing, Northampton General Hospital

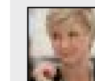

Paul Scandrett, director of healthcare, Allocate Software


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


Susana Tejerina, 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

"My ward sisters struggle- with paperwork and spread sheets. Their in-trays are the resting place for lots of adminstrative tasks"

Dr Geraldine Walters

"Safe staffing is having direct care with the most impact for patients," he said.

"Just because I have two or three RNs does not mean someone is less likely to have a fall on my ward. To get the best outcomes, we need to consider the team around the patient" Mr Hams said.

He explained staffing levels are a source of fear. "As a profession we are frightened. There is good evidence around the 1:8, but if we work together as an MDT, how does that impact on patient care? If the government mandates 1:8, the next question will be why are we not meeting that?"

Suzie Loader also suggested a more creative approach to skill sharing. "In our trust we ask clinical nurse specialists to do a day a month on an appropriate ward, hoping it will enhance the specialist knowledge of the staff they work with."

"In the NHS, there is a lack of objectivity about how many staff are needed to deliver a certain outcome."

Paul Scandrett

Administrative support

There was concern that some 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 frees 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 Brittain highlighted the example in her trust of the provision of cover during ward clerk annual leave and the buddy system. "We don't get complete cover for the ward area, but you get some cover to support the nursing staff," she said.

Susan Bowler was concerned about reducing the support roles. "If we keep pushing nurses as hard as we do, I am worried about their health and wellbeing."

Mr Hams said leadership played a significant part in improving outcomes for patients. "The best ward we have has a ward leader who is 'utterly inspiring'. There have been about 600 days free without a hospital-acquired pressure ulcer. It's not just about numbers, it's about quality and the time."

Helen Blanchard agreed that strong leadership is vital: "This contributes to patient outcome and quality of care. Good ward sisters have great value."

Jenni Middleton talked about the need to support ward sisters by giving them the time to become good leaders. She spoke to the group of The Health Foundation's work with University College Hospital in London, where ward sisters are supported by a central concierge service.

Dr Geraldine Walters had seen a presentation on the project and described how described how ward managers involved in the pilot were asked what made things difficult, such as recruiting people and getting the sink fixed. The results revealed many frustrations such as taking three weeks to get estates to mend something, and ward sisters spending their time filling in requisition forms.

The concierge service created a team a ward sister could ring to shortlist candidates for interviews or get repairs sorted – anything not directly related to care.

Dr Walters said that she recognised the burden of administrative tasks that fell to ward managers and was interested to see the outcomes of the project would be. At King's an attempt was being made to tackle the problem by allocating PA support to each ward manager.

"I see my ward sisters struggling with spreadsheets and paperwork, which takes them ages. Their 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 teams to lead great care at the bedside."

Peter Walsh concurred strong leadership was vital but said he was concerned about promoting clinicians into management posts without support. He emphasised the importance of getting staffing right first time and investing in staff.

Risk and assurance in the NHS

Mr Hams said Francis had been great for enabling nurses like him to have a voice and credibility, and be listened to by the boards about risk and assurance.

There was some concern about the heavy toll that regulatory visits take on teams, and a belief that as regulators visit on a given day they just get a snapshot, which may be inaccurate.

Louisa Stead said: "The focus of our recent inspection seemed to be more on the numbers of staff on duty rather than the quality of care they were delivering."

Fergus Keegan agreed: "It's insulting people can just stroll off the street, walk around for a a bit and feel they have an informed view. It takes a deeper line of enquiry to get to the underlying issues."

Every nurse director should get the CQC to understand 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."

Ms Bowler 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 lulls 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 service 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 of 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."

"In this brave new world, we will never get a better chance to collectively come together and influence the board."

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