
Mike Farrar

ENSURING STAFF ARE SAFE AND SOUND

The high profile drive to increase the safety of patients while in NHS care has led to a boost in staff recruitment, but how can boards know if they've got it right? This was the question asked at the latest *HSJ* roundtable. Alison Moore sat in

There can be no hotter topic in the NHS at the moment than getting the "right" staffing in place to deliver care which is both safe and of a high quality.

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.

The combined effect of this has been to make many trusts re-examine their staffing levels and recruit more healthcare professionals – especially nurses. But how can boards assure themselves that they have the right staffing in place in their organisation? That was the question posed at an *HSJ* roundtable, in association with Allocate Software.

Chair Mike Farrar, former chief executive of the NHS Confederation, said at the moment there was an emphasis on external bodies offering assurance to the public – but this might be short term, he said, and ultimately there had to be a focus on professional assurance.

PARTICIPANTS

Simon Courage product director for healthcare staffing, Allocate Software
Sue Covill director of employment services, NHS Employers
Mike Farrar former chief executive, NHS Confederation (chair)
Katherine Fenton chief nurse, University College London Hospitals Foundation Trust
David Grantham director of workforce and organisational development, Kingston Hospital Foundation Trust
Kevin McGee chief executive, George Eliot Hospital Trust
Patricia Miller director of operations, Dorset County Hospital Foundation Trust
Mark Newbold chief executive, Heart of England Foundation Trust
Paul Scandrett director of healthcare, Allocate Software
Adam Sewell-Jones deputy chief executive, Basildon and Thurrock University Hospitals Foundation Trust
Sue Smith executive chief nurse, University Hospitals of Morecambe Bay Foundation Trust
Jonathan Spencer deputy chair, East Kent Hospitals University Foundation Trust

"How can we, as the leaders in the health system, effectively demonstrate through our own systems and processes that are there 24/7, 365 days a year, that we can offer assurance?" he said.

And what was the commissioners' role in this: if extra resources were needed to ensure safe staffing, would they be put in?

Adam Sewell-Jones, deputy chief executive of Basildon and Thurrock University Hospitals Foundation Trust, raised the issue of confidence. "How confident will the public be, especially in an organisation like ours which has had some negative media, when we put out some internal assurance?"

He warned against reducing safe staffing to a tick-box system: while staffing levels might be an indicator of safety, organisations should not fixate on them and there was a risk of "making an industry" out of collecting and measuring data.

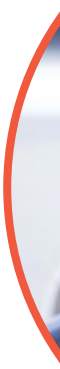
David Grantham, director of workforce and organisational development at Kingston Hospital Foundation Trust, highlighted the good performance of its maternity department, which has an innovative staffing model using maternity support workers. However, despite the good outcomes this model does not meet the recommended midwife-births ratio.

"We need to have an explicit discussion with our commissioners on whether they want us to spend money on meeting these numbers. At the end of the day 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 employment 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, competence, 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 University Foundation Trust, who has experience as an insurance regulator. "I absolutely take the view that the



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primary responsibility rests with the board of the organisation," he said. "The board is much more in touch with what is happening on the ground. We have just done a big review of ward staffing in East Kent."

Key points were the importance of aligning rosters with demand across the day and week; overcoming staff resistance; and recognising that skill mix needed to differ in different areas, he said. But for board members there was the question of how they could get assurance that what was being posed to them was appropriate and balanced. Several sources of information were necessary but the judgement of ward sisters was important.

Patricia Miller, director of operations at Dorset County Hospital Foundation Trust, agreed it was the board's responsibility to assure itself that staffing levels are appropriate but warned that trying to link staffing levels to patient experience and outcomes was complex.

Her trust was working to see how early warning signs could be incorporated into a real time heat map of the organisation, highlighting pressures. The answer in staffing terms might not be as simple as having a nurse-patient ratio of one to eight – it could be that nurses would need to be diverted to areas which were "hotter". But this was a decision which would ideally be 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 Hospitals of Morecambe Bay Foundation Trust, highlighted the lack of benchmarking data available to trusts.

"Let's start sharing data. We need to understand how we can present a picture at board and ward level where we can say these two 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 the ward leadership.

Katherine Fenton, chief nurse at University College London Hospitals Foundation Trust, warned that mandatory staffing levels could become the ceiling rather than the floor and would not take account of differences between wards. "In some wards one in eight is too many but in others you want one in three," she said. "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."

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 the real question we need to ask is what is safe, what does safe mean to your organisation?" he said. But an important question was how organisations would react when shift-by-shift measurements showed there were issues.

Chief executive of Heart of England Foundation Trust Mark Newbold said: "It's an unwise chief executive office who tinkers with the establishment level." His organisation measured staffing levels three times a day, looking at patient flow and the situation in the emergency department. That information in aggregated form then went to the board.

"I think in the future we need to look at whether our wards are seeing the kind of patients they should be seeing." Problems could occur when patients were put on wards where staff did not have the appropriate skills to nurse them.

Flexible staffing

Heart of England has opened a convalescent ward, working with a local housing association and staffed by non-healthcare workers, he said. "We have patients move from a ward where staff think the patients can't walk and within 36 hours they are walking and making their own meals," he said.

Kevin McGee, chief executive of George Eliot Hospital Trust, said: "I think we are really struggling as a service and on individual boards about what is safe and what is not. At board level there is always a balance to be struck between hard metrics and soft metrics. I can look at the dashboard in the morning telling me how many staff on each ward and I can walk round the wards and it can feel really different.

"There is a real balance between permanent staff, and bank and agency staff. It depends where your organisation is. For some it is really hard to recruit to full establishment."

Paul Scandrett

'My experience is that productivity improvements and quality of care improvements are not mutually exclusive'
Paul Scandrett

But detailed information about staffing and outcomes could also help organisations plan for the future, said Simon Courage, product director for healthcare staffing at Allocate Software. Staffing numbers could be predictive of outcomes and organisations could use information about staffing numbers to intervene and prevent poor outcomes.

But it was not enough to have a system which flagged up when the right numbers were not in place: there then needed to be a process to fix this, he said.

"From a board assurance perspective the key thing is the board feeling assured that people are looking at staff on a day to day basis and there are excellent processes in place."

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

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

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 round the table were offered extra money to address safety and quality issues how would they spend it? Mr Farrar suggested a series of choices: system redesign; more staff; improving the quality of staff; or spending it on the "science" – the intelligence from data – of getting more productivity. "If you could spend it on only one of the four where would your priority be?" he asked.

No one spoke out for simply spending money on additional staff. Professor Fenton said: "I think we need really good information systems to understand what we are doing and what we have got. I would probably put more staff last."

Mr Spencer said the review of staffing in his own trust had tied increases to what the organisation wanted to achieve – such as reductions in pressure ulcers and falls. Some of these brought financial benefits such as achieving the best practice tariff for stroke. But he pointed out that with the current financial pressures, any extra cash would simply "fill a hole" between demand and resources.

But was there any way trusts could compromise a little bit on quality in return for savings? Mr Newbold was clear that he would not reduce staffing just because commissioners had requested it. "The discussion has to be if you want more than you are buying then you have to talk about resources. Tinkering with safety and quality will not solve the problem.

"I don't think any of us as acute providers should be allowed to tailor down the quality a little because the money is running out."

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 are still applying judgement. The data only tells us something about what it looks like in theory. When we walk round it may feel different.

"If I was in Monitor or the CQC's position I would be

Adam Sewell-Jones

Sue Smith

Jonathan Spencer

asking two questions – do you have any system? And what do you do with the knowledge you have?"

Mr Courage 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 and not the end of it."

But Mr Grantham asked what was happening at weekends and out of hours – who was responding to data then? There could be a need for someone to have the authority to move staff around or call in additional staff – how was that managed? Mr Scandrett noted that the issues were compounded at weekends when there were often more temporary staff at exactly the same time that less senior staff and ward leaders were rostered.

Professional judgement

Mr Farrar summed up the tone of the debate: just looking at staff numbers was not going to be a solution. Other aspects were important – was it a process to allow real time adjustment to numbers in each area? Was it the ability to predict problems and address them early? Learning from past experiences to be preventative rather than reactive to a crisis?

Professor Fenton suggested this was where the service could eventually get to but added that professional judgement should always be involved.

But who needed this data and what should they do with it? Mr Sewell-Jones raised the issue of not overloading boards with historic data when there were professional leaders around the board table who could give assurance.

Mr Spencer suggested the director of nursing and senior staff needed to moderate information for the board and highlight issues – though board members also needed to get out and about and see the situation for themselves. Mr McGee agreed boards needed to get information from different sources – the metrics, the professional opinion of medical and nursing directors but also from walking around to see if this tallied.

But Mr Farrar pointed out how boards were sometimes shocked when they got information from an external source such as Dr Foster.

Ms Smith said at her previous trust – North Tees and Hartlepool – governors had offered very useful feedback. "That temperature check is really important. It does not exist everywhere but where it does it works really well."

Mr Courage pointed out that short term issues, such as spikes in admissions, could affect how well a trust was coping with the staff it had. But other problems could be caused by the trust's own actions such as not managing staff leave well.

And, drawing the roundtable to a close, Mr Scandrett highlighted the role of ward managers and leaders in day-to-day decisions 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 assurance but listen to and support these staff. ●

PAUL SCANDRETT
SAFETY QUESTIONS BOARDS MUST ANSWER

Just over 12 months ago we, like many of you, were digesting the detail behind the 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 electronic rostering beyond its proven productivity benefits to also ensure it was used to manage safety and quality.

This wasn't a new concept. Our strapline since 2008 has been "Right People, Right Place, Right Time" and in January 2013 we had launched our next generation demand based staffing tool, called SafeCare, that took account of the acuity and dependency of patients ward by ward.

The Shelford Group were making a positive difference in terms of establishment setting and indeed we have seen greater investment in numbers. Francis has provided a once in a generation opportunity to make a difference to how care is delivered and I believe for the change to be sustainable there is a need to also understand the challenges of getting staffing levels right shift by shift. We've had this discussion many times with directors of nursing, but in the past it was not easy to engage with the wider board.

Part of our response was to work with *HSJ* and *Nursing Times* to create two roundtables. The first in July 2013 saw 11 nurse directors come together and the second, covered by this article, involved a cross functional group of board members.

Over the same period we visited over 80 trusts uncovering the processes and policies that can hamper shift by shift safe staffing.

Do you really know what safe means in your organisation? Does it mean every shift is safely staffed, or most? 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.

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One final thought. While a great deal of the immediate attention and new reporting requirements have concentrated on the nursing workforce, the Keogh reviews and Care Quality Commission 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.

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