Nurse staffing and skill mix at night: getting it right

Miss Susan Osborne CBE
Chair Safe Staffing Alliance
Independent Nursing and Management Consultant
July 2\textsuperscript{nd} 2014
PRESENTATION CONTENT:

- Nurse staffing and skill mix: National update
- Ensuring safe staffing 24/7
- Nurse staffing and skill mix at night
- Looking forward to the NICE recommendations on staffing
Nurse staffing and skill mix: National update
The Public Inquiry into Mid Staffordshire NHS FT (Francis)

- Inquiry chaired by Robert Francis QC
- Report published in February 2013
- 290 recommendations

“The Trust Board was weak. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust’s attention. It did not tackle the tolerance of poor standards and the disengagement of senior clinical staff from managerial and leadership responsibilities. These failures were in part due to a focus on reaching targets, achieving financial balance and seeking foundation trust status at the cost of delivering acceptable standards of care”.

Robert Francis QC, Press briefing, 6/2/13
The experience of safe staffing
Keogh Mortality Review

• “inadequate numbers of nursing staff in a number of ward areas, particularly out of hours - at night and at the weekend...compounded by an over-reliance on unregistered support staff and temporary staff

• “reported data did not provide a true picture of the numbers of staff actually working on the wards”

• Recommended ambition that “nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards”
The experience of safe staffing
Berwick patient safety review

- Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context. (This includes, but is not limited to, nurse-to-patient staffing ratios, skill mixes between registered and unregistered staff, and doctor-to-bed ratios.)
- Boards and leaders of organisations should utilise evidence-based acuity tools and scientific principles to determine the staffing they require in order to safely meet their patients’ needs.
- Health Education England should assure that they have commissioned the required training places to meet future staffing requirements working with Government and NHS England to ensure appropriate planning and resources.
The Cavendish Review

An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings

July 2012
National Quality Board (NQB) Guidance

National Quality Board guidance published on 19/11/13 – Good Practice Guide.
Includes ten expectations and twenty case studies
Six themes –
1. Accountability and responsibility
2. Evidence-based decision making
3. Supporting and fostering a professional environment
4. Openness and transparency
5. Planning for future workforce requirements
6. Role of commissioning

Work in progress with CQC regarding the monitoring of implementation of the expectations
Hard Truths Commitments

Department of Health response to the Francis Inquiry Hard Truths. The Journey to Putting Patients First; includes the requirement that:

‘from April 2014, and by June 2014 at the latest, NHS Trusts will publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools’.
Cavendish Review

• Cavendish review – found inconsistent training and blurred role definitions and boundaries
  – Recommended ‘certificate of fundamental care’ and ‘higher certificate of fundamental care’, to be completed before working unsupervised
  – Robust career development framework needed for health and social care support workers

• Regulation – recommended by Francis, supported by RCN and Willis Commission, but rejected by Government
  – RCN: voluntary system will not prevent varying standards and the most worrying situations will still slip through the net
  – Consistent, mandatory regulation is the most effective option for safeguarding patients and developing staff
● Nurse staffing and skill mix at night
Story so far…….

• **1960/70s DHSS**
  - District Health Authorities (DHAs) each with a Chief Nurse
  - DNS/DNE managed N&M workforce
  - Senior & Nursing Officers (NO)
  - Apprenticeship model
  - SRN & SENs
  - Nursing Auxiliaries.

• **80s DH - SS**
  - Demise of Health Authority Chief Nurse role – no longer required as a Board member
  - Griffiths /NHS Trusts/ general management. Purchaser/Provider split.
  - DNS role change from management to influence. Voting powers on Board. Management of workforce responsibility of General Managers
  - Focus on performance - reviews by external consultants resulted in e.g.: 12 hour shifts to reduce WTEs, Ward rounds – no tea, no RN on Consultant ward round, Drug rounds < 2 > 1
• **90s – DH, HCC**
  - Project 2000 – supernumerary status. No supervisory time added to RGNs.
  - University Deans Vs Hospital DNS
  - Clinical Grading introduced – demise of Senior Nursing Officers, Nursing Officers, night sister. Ward sister has 24 hour clinical responsibility. Student workforce replaced by Health Care Assistants (HCAs). Enrolled nurses phased out.
  - Clinical Nurse Specialists introduced with a shift of workload from Drs to Nurses/Midwives e.g. I.V. drugs, nurse led clinics, minor surgery.
  - The Named Nurse.
  - Nurse Consultants introduced.
  - European Working Time Directive.

• **2000s – DH, Monitor, TDA, CQC**
  - Health Authorities reduced. Chief Nurse voting rights at Board level. PCGs & PCTs with various senior nurse grades with little authority. Foundation Trusts, Academic Health Sciences Centres introduced.
  - 2001 – Blair - Modern Matron
  - Agenda for Change - Introduction of ‘gateways’ but not used - demise of senior nurses. Hospital at Night schemes – reactive not proactive – Band 7 could be running the hospital at night with very junior staff in clinical areas.
  - Introduction of all graduate profession.
  - Introduction of Nurse Prescribing
  - Down banding of Nurse Consultant & CNS posts.
To Current

- **2010s**
- **Fragmented DH**
  - change in CNO role split Commissioning & Public Health.
  - Further reduction of Health Authorities and Chief Nurses.
  - Commissioning to CCGs/G.P.s – nurse heirarchy weak, low graded staff, inconsistent senior nurse structure resulting in mixed challenge to healthcare organisations.

- **Poor achievement of targets**
- **Nurses not given a 1% pay rise**
- **Night duty remains diluted and very reactive not proactive often managed by a Band 7 Sister as part of the Hospital at Night initiative and some have Outreach Teams led by Band 7 & Band 6 nurses and junior doctors supported by the most junior staff in clinical areas.**
The Catalogue of Disasters

- Francis Report and Hard Truths
- Winterbourne View
- The Keogh Review
- Don Berwick Report
- The Cavendish Review
- Clwyd-Hart Review
- Priory Rehabilitation Centre, Bury
• Ensuring safe staffing 24/7
The evidence for safe staffing
Safe patients, safe nurses

SAFE STAFFING

PATIENT SAFETY

• Lower mortality rates
• Lower hospital-acquired infection rates
  Fewer falls
• Lower failure to rescue rates
  • Fewer medicine errors
  • Better patient experience

NURSE SAFETY

• Lower stress levels
• Lower illness rates
• Lower absence rates
  • Better morale
  • Improved retention rates
  • Lower burnout rates

Kane et al (2007), Aiken et al (2002) ... and many more
Skill mix
More than just a number...

Skill Mix

- Leadership
- CPD
- Education and Training
- Appropriate Delegation
- Regulation
- Safe Staffing Levels
- Specialist Skills
- Experience
- Role Definition
Desired staffing features

- Demand driven (i.e. what patients need not what budgets dictate)
- Identifies the labour hours required to meet the demand (acuity)
- Identifies the skill mix required
- Can be applied across multiple settings
- Can be readily adjusted when demand changes
- Is transparent to the users
- Generates high quality, trustworthy data
- Is auditable
- Data input is manageable
Base staffing calculation

DEMAND = total work to be done

Service Utilisation (how many?)

Acuity - HPPD (how much care?)

Context variables & indirect (other work?)

CARE CAPACITY = total resources required

Staffing Model
Service Utilisation = 28

Acuity HPPD = 5.65

Context variables & indirect = 7 hours

= REQUIRED Resources = 60298
**Total Activity by Category**

- **Clinical assessment**: 10.3%
- **Discharge Planning**: 9.4%
- **Patient Teaching/Counselling**: 6.2%
- **Communication non-patient**: 6.7%
- **Documentation**: 1.4%
- **Observation**: 24.5%
- **Medications**: 4.0%
- **Procedures/treatments**: 5.7%
- **Patient mobility/comfort**: 7.3%
- **Hygiene**: 10.8%
- **Nutrition**: 1.8%
- **Elimination**: 1.9%
- **Environmental tasks**: 0.4%
- **Bed management**: 2.4%
- **Managing staffing/data entry**: 1.3%
- **Doctors' rounds**: 0.4%
- **Staff breaks**: 1.0%
- **Teaching/supporting staff, quality**: 1.8%
- **HIA Total tasks**: 01/03/2010 - 14/03/2010
Bed Occupancy (bed count = 6 in 6)

Bed Utilisation (head count = 9 in 6)
THE FAILURE BOUNDARIES

ADAPTED FROM COOK & RASMUSSEN’S DRIFT INTO FAILURE MODEL
Effect of reduced LOS and increasing acuity on nursing intensity

LOS = 7 days: Total 23.5 hours per episode

 LOS 3 days: 18 hours per episode; Total over 7 days 44 hours
Sentinel Information Set Indicators
(with tolerances and triggers)

• Care rationing
• Patient perceptions of care
  - felt cared about and cared for
  - symptom management
  - preparedness for discharge
• Complaints
• Harm incidents
• Unexpected transfers to ICU/HDU/OT
• Nightingale factors
  • Outliers
  • Flow markers
  • Tools on time
  • HPPD variance
  • Less than 24 hours stay
  • LOS
  • Budget vs actual
  • Cancellation of services
  • Flow markers (pts in/out)

• Skill mix
• Staff hours provided
• Agency/Bank
• Discretionary effort
• Extra shifts
• Staff satisfaction
• Access to education
• Freedom from abuse
• Making a difference to pts
• Looking forward to the NICE recommendations on staffing
Responding to Francis
Next steps on staffing levels

• No to nurse: patient ratios but...
  – Trusts to publish staffing levels
  – Regular workforce reviews
  – NQB safe staffing guidance
  – NICE commissioned to produce guidance and validate workforce planning tools – acute adult inpatients work due July 2014

New fundamental standards developed for more robust CQC inspections
Challenges remain...
Warding off a critical shortage of nurses

- A likely fall of 30,000 nurses by 2016 in England, but with growing demand, a likely shortfall of 47,500.
- Worst case scenario sees a shortfall as large as 194,000.
- A small chance of supply meeting demand, if demand falls 2010-2016.

Source: Centre for Workforce Intelligence (2013)
Loss of specialist nursing & leadership skills

Francis effect with renewed recruitment will not be enough to reverse significant skill mix dilution in recent years. Loss and devaluation of senior specialist and leadership roles. Around 4,000 band 7 and 8 lost since 2010.

FTE qualified nursing, midwifery and HV staff, NHS hospital and community services, Apr 2010 – Nov 2013 (HSCIC, 2014)
The evidence for safe staffing
Mortality rates

- Aiken, Rafferty et al. (2014): increase in each nurse’s workload by one patient increased odds of mortality by 7%. Every 10% increase in bachelor’s degree nursing associated with 7% decrease in odds of mortality.

As workloads in hospitals increase, so does mortality ...

But as nurse education increases, mortality decreases

*Adjusting for patient and hospital characteristics
UNISON 2014 - Key Findings
“Running on Empty: NHS staff stretched to the limit”.

• 75% of all midwives and 71% of all nurses (general and mental health) said they did not have adequate time with each patient.
• 59% of all nurses on a night shift said there were elements of care they were unable to give.
• 92% supported minimum staffing levels, with 65% supporting a legally enforceable minimum.
• 45% of staff were looking after 8 or more patients during their shift, this increased to 53% on night duty.
• Despite National Quality Board guidance, only 24% of workplaces displayed number of staff on duty.
• Just over half (51%) were not confident about raising concerns locally, which, in a post Francis era, is worrying.
SHIFTING THE BURDEN TEMPLATE

Symptom correcting process

Efforts on quick fix

Capacity of system to fix itself

Time

Quick Fixes

balancing

Problem symptom

Corrective actions or fundamental solutions

Source of problem or root cause

Side Effects (unintended consequences of the fix)

reinforcing

Addiction loops

P. Senge, The Fifth Discipline 1985
Safe Staffing Alliance (SSA) - A nursing alliance with a firm and simple message: Never More Than 8 - numbers matter

• The Safe Staffing Alliance has a straightforward message when it comes to nurse staffing and that is: numbers matter.

• There is enough evidence out there to show a direct link between numbers of registered nurses and the quality of care delivered to patients.

• We have brought together some of that evidence on the SSA website: www.safestaffing.org.uk

• After studying the evidence it is clear that a staffing ratio of one registered nurse to eight patients (excluding the nurse in charge) is the level below which there is a significant risk of harm. So, for example, a 24-bed ward must have at least three registered nurses on duty plus a nurse in charge, and be supported by three or four healthcare assistants. This does not guarantee good care but anything less is known to increase the risk of poor care and constitutes a safety hazard.

• There is already recommended staffing levels for children’s services, intensive care and maternity services. We want to take that a step further with a clear fundamental standard for elderly patients who are, after all, the majority of patients on our general wards. We owe them nothing less.

• Visit the SSA website and download our Never More Than 8 leaflet and sign up to in support of our campaign.
“Each of us individually does not count much. But together we are the strength of millions who constitute Solidarity”
“You don’t need an engine when you have wind in your sails”

Paul Bate, 2004
THANK YOU FOR LISTENING

Miss Susan Osborne CBE Chair Safe Staffing Alliance (SSA)

www.safestaffing.org.uk
Twitter:@SusanSSA