Safe Staffing Levels

May 18th 2015
Miss Susan Osborne CBE
Chair Safe Staffing Alliance (SSA)
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 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
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 published July 2014

New fundamental standards developed for more robust CQC inspections but with no mandated ratios means CQC unable to issue enforcement notices for safe staffing.
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

CARE CAPACITY = total resources required

Service Utilisation (how many?)

Acuity - HPPD (how much care?)

Context variables & indirect (other work?)

Staffing Model
NICE A&E Recommendations

Provide enough A&E nursing staff to meet the following minimum ratios and adjust if necessary:

- 1 registered nurse to 1 cubicle in triage
- 1 registered nurse to 4 cubicles in minors and majors
- 1 registered nurse to 2 cubicles in the resuscitation area.

Provide enough A&E nursing staff to meet nurse-to-patient ratios for following situations when needed:

- Major trauma (2 registered nurses to 1 patient)
- Cardiac arrest (2 registered nurses to 1 patient)
- Priority ambulance calls (1 registered nurse to 1 patient)
- Family liaison (1 registered nurse to 1 patient’s family/carers).

Ensure that 1 band 7 (or equivalent) registered nurse is included on every shift at all times to lead, supervise and oversee the shift.

All A&E nursing staff have time allocated for:

- Training and mentoring student nurses on placement in the A&E department or non-registered nursing staff; supervising and assessing the competencies of non-registered nursing staff; taking part in clinical governance activities (for example, audit).

Chief Nurse approves the A&E nurse staffing establishment

Senior nursing managers (for example, A&E matrons) accountable for the A&E nursing staff roster.

A&E nursing staff establishments will be discussed with commissioners at least every 12 months.

Guidance was based on evidence from 18 reviews of which 2 were from the UK with the remaining 16 from US, Australia and Canada.
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.
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.

*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

Quick Fixes

Corrective actions or fundamental solutions

Side Effects (unintended consequences of the fix)

Addiction loops

Symptom correcting process

Efforts on quick fix

Capacity of system to fix itself

Time

Problem correct process

Problem symptom

Balancing

Source of problem or root cause

P. Senge, The Fifth Discipline 1985
SSA 5 Key Manifesto Messages

1. **Numbers matter: ‘Never more than 8’**.
   It is unsafe to care for patients in need of hospital treatment with a ratio of more than eight patients per registered nurse (excluding the nurse in charge) during the day on acute wards. There is evidence that risk of harm to patients is substantially increased when staffing levels fall below this ratio and must be considered as a ‘red flag’ event and immediate action taken.

2. **Enforce national standards**
   Statutory levels should be set and guidance issued based on patient dependency, acuity and complexity in different settings.

3. **Invest to save**
   Nursing is a 24-hour seven-day-a-week activity and budgets for staffing must be protected to reflect that. **Investment must be made to the nursing workforce in order to save by improving clinical outcomes.**

4. **Transparency**
   There must be genuine transparency over nurse numbers. Currently a vast amount of data is being collected which tells us about ‘fill-rates’ not the staffing levels themselves or clinical outcomes.

5. **Sustainability**
   The solutions to this challenge are effective planning of care and workforce, clear and recognised standards, investment to meet these standards and transparency in the system.
“Each of us individually does not count much. But together we are the strength of millions who constitute Solidarity”
THANK YOU FOR LISTENING

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