Royal College of Nursing

Response to NHS Improvement's draft sustainable safe staffing improvement resource in urgent and emergency care

1. Background

This document is our response to NHS Improvement's engagement exercise in relation to the draft sustainable safe staffing improvement resource in urgent and emergency care. We have been members of the working group who supported NHS Improvement on drafting the resource. We have consulted with our members on the draft resource, giving them the opportunity to feedback any comments.

In this response we comment on the specific resource. Once we have had the opportunity to review the full suite of draft improvement resources we will be able to provide overarching views on the set as a whole.

2. Summary

The draft sustainable safe staffing improvement resource for urgent and emergency care is a step towards trying to define and improve safe and effective staffing in urgent and emergency care. Our members clearly feel there is a need for this resource but raise concerns about its overall usefulness.

The resource follows the draft publication of the NICE guideline that was later decommissioned and not published in its final form. In this sense, this resource, falls somewhat short of the proposals outlined by NICE. This may go some way to explaining why our members did not see this resource as useful as in other settings.

More work, and evidence is clearly needed to fill the existing gap to define what staffing levels should be in urgent care and we suggest a collaborative approach with partners such as the RCN/RCEM/RCP/Intensive Care Society/UK Critical Care Nurses Alliance.

3. Member engagement

To ensure we engaged with our membership as widely as possible we surveyed our general membership. We received 60 responses.

As well as surveying members, we also engaged with RCN forums and professional networks for informal feedback. A summary of the feedback we received is included below:

Accessibility of resource

- 25% of respondents read the survey in less than 10 minutes, 61% between 11-30 minutes, and 14% over 30 minutes.
- 82% said it was easy to understand and in plain English.
- 82% said it was easy to navigate.

- 57% thought the resource could be understood by all health care staff with half of respondents neither agreeing nor disagreeing with this statement.
- On the whole respondents did not feel the resource was too long.
- 86% of respondents agreed that nurses need to be able to access this document in different formats including print, on the web, on tablets and on mobile phones.

Usefulness of resource

- 93% of respondents thought it was important to have the resource in place.
- 46% of respondents said the resources provided them with a better understanding of the evidence relating to staffing levels in urgent and emergency care.
- 75% agreed it was clear to them how the resource can be used alongside other ward based metrics.
- Only 52% understood how the resource aligned with the Care Hours Per Patient Day metric and model hospital.
- 50% felt the resource will better enable them to compare staffing levels with their peers.
- 48% of respondents agreed with the statement that the resource helped them better understand what safe staffing means in urgent and emergency care.
- Although there is a very small sample size, only 28% said the resource was useful which indicates that this resource has not been as well received as some of the other resources. We believe this may be as a result of the content not being aligned to the work of NICE.

Impact on staffing levels

- The majority of respondents (60%) said registered nurse staffing levels would stay about the same. 21% of respondents said registered nurse staffing levels would increase and 4% and 18% said they did not know.
- In relation to support staff, 54% of respondents said staffing levels would stay the same and 28% said they would increase. 4% said staffing levels would decrease and 15% said they did not know.
- 14% thought there would be a change in staff deployment or skill mix, 57% said no and 29% said they did not know.

Workforce planning tool

- 25% said they were using a workforce planning tool. 36% said they were not using a tool and 39% did not know. Of those who provided the name of a tool they said they were using the BEST or a bespoke tool.
- 42% said they felt their current workforce planning tool did not meet the requirements of the resource.

4. Content of resource

Below are some additional comments on the resource:

- **Supernumerary status**
  - There should be a sister/charge nurse who is not counted in the establishment and who can act in a supervisory capacity throughout the shift. This role needs to be protected and should not be used to provide backfill when there are insufficient staff on a shift.
  - The experienced sister/charge nurse should also have the ability to provide this supervisory leadership across all areas of a department and not be primarily focused on operational delivery.

- **Right staff**
  - On page 8 it states 'use a systematic evidence-based approach to determine the number of staff required'. More clarification is needed to define what that means as there is no validated tool to determine this.
  - The nursing establishment is defined as the number of registered nurses and health care support workers. However, it is also important to consider grades/bands of nursing staff in order to reflect the skill mix within the department rather than just registered nurses and health care support workers.
  - In section 2.3 this resource determines how to set uplift, using the RCN guidance and the evidence review. Determining uplift is key in getting staffing levels right and therefore the principles in setting uplift should be carried across to other resources where uplift was not included.
  - We welcome the inclusion of the range of factors to be considered in setting the right uplift. The need to factor in study time must include time for Advance Clinical Practice and Advance Nurse Practitioners.
  - Also uplift will be required to ensure trainee & qualified ACP/ANP's meet their requirements and have a job plan that reflects their peers e.g. personal study time and time to facilitate the four pillars of advanced practice – leadership, research, education as well as clinical.
  - We support advanced practice and the opportunities for registered nurses being on MDT rotas who are able to provide senior clinical decision making. However, they should not be counted twice e.g. they cannot be on the middle grade rota in emergency departments and also be in the nursing numbers for that shift.

- **Recruitment and retention**
  - There is a welcome recognition of an ageing workforce in the resource and the need to carry out age profiling (RCN involved in this work via the NHS staff council to support organisational work around this see: http://www.nhsemployers.org/your-workforce/need-to-know/working-longer-group for tools/guidance).
  - Important recognition of these issues and how they contribute to safe sustainable staffing. Sickness absence data should be scrutinised for trends/causes/hotspots and acted on.

- Staff survey results are also useful in identifying and anticipating problems.
- The RCN 'healthy workplace initiative' is a useful tool to support local work on retention.
- In relation to preceptorship programmes for newly qualified staff, time should be protected for supervisory practice, education and time away from clinical area with preceptor.
- In relation to page 24 Page, temporary Bank and agency staff are a valued part of the workforce. There should be process in place on their induction and assessment of their competencies.

- **Flexible working**
  - We welcome the reference to flexible working.
  - There should be a cross reference to Agenda for Change section 34. This issue is of utmost importance, particularly in relation to retaining an ageing workforce. Lack of flexible working opportunities have been identified by the RCN and others as a key 'push factor' for many older nurses to leave NHS employment.
  - The resource should cross refer to Agenda for Change section 27 on working time regulations. We would argue that the 'minimum' under the working time regulations stated on page 18 (i.e. 20 minutes where you work over six hrs, which is not aggregated under the regulations) would not be enough on a long day.

- **Measure and improve**
  - Other metrics include staff turnover rate. There should be a process for exit interviews in order to receive feedback from staff leaving the department and how these are evaluated and actioned.
  - Staff incidents are also important indicators (e.g. evidence to support increased risk of needlestick injuries related to poor staffing https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447200/). The supporting evidence associates poor outcomes with excess working hours and overtime, cumulative working hours with no rest days, missing breaks within shifts and short breaks between shifts. These should be captured as part of measuring and improving.
  - Staff survey data particularly in relation to stress/work pressure; mandatory training etc. can also help as a measure and we understand form the CQC that staff survey data is the best proxy/indicator for the inspection outcomes. Additionally, the Health and Safety Executive's Stress Indicator tool (as advocated by the NICE workplace guidance on mental health at work) could also be referenced.

- **Patient, carer and staff feedback**
  - As the voice of the workforce, the resource could identify the role of the RCN as a Royal College / union and other unions in supporting this work i.e. partnership working particularly in relation to the impact of organisational change; identification of problems, identification of

solutions and supporting the implementation of improvement measures. This can be through established mechanisms such as Joint Negotiating Consultative Committees and Health and Safety Committees.

- **Evidence review**
  - We would suggest that the evidence review is not a static document and that as new evidence comes to light, NHS Improvement disseminates this information.

5. Relationship with other guidance

We advocate a triangulated approach to setting staffing levels, based on patient acuity, and the use of professional judgement is key. However, there is also a role for evidence based guidance and professional consensus on staffing levels.

Notably, this resource excludes the ratios that were included in the published NICE draft which are known widely by those who work in these settings as the staffing levels more akin to those required to deliver safe and effective staffing.

Our research that we published in September 2017, *Safe and Effective Staffing: Nursing Against the Odds* shows the reality that staffing levels of those working in Emergency Departments are often far from the standards set out by NICE. In fact, our staffing levels research showed that across acute hospitals most of the staffing challenges were more severe, impacting negatively on the workforce.

More work, and evidence is clearly needed to fill the existing gap to define what staffing levels should be in urgent care and we suggest a collaborative approach with partners such as the RCN/RCEM/RCP/Intensive Care Society/UK Critical Care Nurses Alliance.

There are a few outstanding issues as a result of the NICE draft guideline:

- NICE specifically stated that the child and mental health provision would be addressed and this is not fully explored in the resource.
- The exploration of skill mix and acuity in emergency departments was highlighted through the NICE work and this requires further development in the resource. NICE considered many areas both internal and external to emergency departments addressing this as an influence and this is not incorporated into the resource.
- NICE was far more expansive when considering the breakdown of roles and the relevance of uplift to management, care delivery, standards, skill mixing, acuity, educational engagement, agency, bank, student mentoring and supervision. This requires further exploration to make fuller recommendations relating to staffing in urgent and emergency care.

- Although NICE did not fully explore issues outside emergency departments (the external organisational issues) this is more strongly referred to in the NICE work and seems unrepresented here given the complexities in the relationship between patient flows and safe and effective staffing.
- NICE was not planning to address recruitment and as such this resource is a good addition to address the escalating situation.
- We agree that the improvement resource should also be read in conjunction with the National Quality Board guidance, *Right Staff, with the right skills, in the right place at the right time*.

Policy and Public Affairs UK and International
December 2017

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.