Quantity and quality

Could Scotland’s new mandatory staffing tools work elsewhere in the NHS? Bee Friend reports

In anticipation of the Francis report, the Safe Staffing Alliance, made up of key nursing figures, issued a call for mandatory nurse staffing levels.

Scotland is pressing ahead with the idea and the use of tools to calculate the required nurse staffing levels will become mandatory in April. In general, the move has been welcomed, but concerns have been raised about dependency levels, how often the tools are applied and whether they can respond quickly enough to changing workload or clinical pressures.

Details are still being worked out, but from April 1 the 14 Scottish health boards must include the tools in their service delivery agreements.

There will be 12 tools, covering 95 per cent of service areas, from adult inpatient and community, to neonatal, maternity and children’s services. Each tool has three elements addressing specialty-specific workload, local quality measures and professional judgement. The latter includes skill mix considerations.

The compulsory use of these staffing tools comes against a backdrop of criticism about how nurse staff levels are determined.

Norman Provan, RCN Scotland associate director for employment relations, says decisions ‘have often been made solely on the basis of affordability’.

‘The nursing and midwifery workforce projections will be included in boards’ local delivery plans, which should underpin the message about the importance of using the tools in a systematic way.’

Dependency

The development of a tool involves activity and statistical analysis, as well as investigation of patient dependency and the level of nursing needed for that dependency.

Fiona Mackenzie, manager of the Scottish Government’s nursing and midwifery workload and workforce planning programme, is overseeing the tools’ introduction. The professional judgement element of each tool is completed by nurse managers over two weeks, she says. ‘It is retrospective and looks at what was needed on a shift. So it is not what was budgeted for or what they usually have, but what the senior charge nurse or team leader felt was needed.’

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So why make the tools mandatory? ‘To ensure we had a workforce that was based on the actual patient need,’ explains Ms Mackenzie. ‘That is why we did not want minimum staffing, which could mask serious understaffing. We wanted something that would provide safe staffing levels, but would also cover efficiency and productivity issues.

‘We are making the application of the tools mandatory, so we at least have a baseline for staffing levels. It will mean that everyone will have evidence on which to base the staffing establishment. It incorporates professional judgement, so is not just numerical – it is qualitative too.’

She says one concern raised by health boards was that the figures arrived at for the number of whole-time equivalent posts required did not fully reflect dependency needs. Work has been continuing to reassure them it does.

‘What we are saying in Scotland is that the figure we come up with in terms of staffing numbers in relation to workload is as evidence-based as you will get. It has to be considered with professional judgement and using measures of quality. It is not about affordability. It is about safe, effective person-centred care.’

A learning toolkit will be posted on the NHS Education for Scotland website to support nurses looking at workload data and workforce planning.

The RCN is on the workload and workforce planning programme’s steering group and has been lobbying to ensure that safeguards accounting for acuity are included.

Mr Provan says: ‘Each tool should have a built-in minimum frequency with which it should be applied.’
For example, acuity-driven areas such as neonatal intensive care might apply the tool daily, whereas A&E might run it weekly and mental health rehabilitation annually.

Another key concern for the RCN is that the tools should be applied if there are service changes. Mr Provan adds: ‘The tools need to be applied in every clinical area independently. But I suspect the service might not agree with that.’

He says that in a health board with 30 medical wards spread over five hospitals, for example, it would be unacceptable for the board to run the tool in a few wards and then apply the outcome to all the medical wards assuming they are the same.

The RCN is lobbying management to find a way to co-ordinate when the tools are applied across the 14 boards, as this will help with benchmarking.

The best care
Mr Provan says: ‘This is not only a safety issue, but a quality issue – recognising that you require appropriate staff to provide good quality services. It is not a safety issue in that the tools will bring out a minimum number of people on the wards. The aim is to achieve our quality ambition of providing the best services we can.

‘The principle that these tools are developed nationally and then applied systematically across the whole of the healthcare system in Scotland is an inherently good one – rather than each of the health boards doing their own thing.

‘We are ahead of the game. I would not want to give the impression that everything is perfect, because it is not. Some boards have been cutting staff, including nursing staff, in recent years, which we feel has been done on the basis of affordability. Making the tools mandatory should help with that and ensure they are being applied properly.’

Unison has welcomed the tools. Scotland lead nursing organiser Matt McLaughlin says that properly implemented and supported, the tools would help members ‘to make the case for additional clinical resources at times of increased demand and peak acuity’.

‘However, we are concerned that the tools will not be intuitive enough to ensure that sudden changes in workload or clinical pressure are identified and responded to quickly enough,’ he says.

‘Local managers, staff and unions will need to commit to working together if the tools are to deliver what they promise’.