COMMUNITY HOSPITALS ASSOCIATION

Q COMMUNITY

Special Interest Group on Community Hospitals

RESOURCE PACK #4 SAFER STAFFING

SAFE STAFFING means THE RIGHT STAFF ON SHIFT

Q is led by the Health Foundation and supported by partners across the UK and Ireland

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INTRODUCTION

The Community Hospitals Association (CHA) has designed a suite of Resource Packs as a way of sharing some of the learning in an accessible way. This Resource Pack focuses on the topic of Safer Staffing in Community Hospitals.

Safer Staffing has remained a topic of much debate within health and social care particularly in relation to Nursing. 10 years on from the Francis Report Safer Staffing remains a wicked issue (Francis Report 2013). While covered in regulation and guidance there is no single solution that covers every clinical setting and this is particularly true of the variety of services and models of care in community hospitals. Staffing levels in services in community hospitals are context specific, led by the regulations and influenced by factors such as patient need, model of care, design of the building etc.

This Resource Pack has been compiled because of requests from members of the CHA and our Special Interest Group in Q.

STRUCTURE OF RESOURCE PACK #4

WE HAVE SET OUT THIS RESOURCE PACK TO COVER THE FOLLOWING:

- Our Methods
- The context for Safer Staffing in terms of legislation and regulation requirements
- The differences across devolved countries such as Scotland and Wales
- The principles of Safer Staffing
- Evidence and tools.
- What is different about Community Hospitals?
- Case Studies from CHA Community Hospitals COVID-19 Study
- What Next?
- References

OUR METHODS

TO CREATE THIS COVID STUDY AND OTHER RESOURCE PACKS, THE CHA HAS ASSEMBLED INFORMATION FROM SEVERAL SOURCES INCLUDING MEMBERS AND OUR SPECIAL INTEREST GROUP

In 2021/22 the CHA conducted a study on the role of community hospitals during COVID-19, asking staff to describe quality improvements and initiatives that made a positive impact. We interviewed 85 staff and managers working in community hospitals from 20 provider organisations so this has generated reports and resources as well as 31 case studies which have now been shared widely. Staff used these terms during the interviews including "camaraderie," "resilience," "all in it together," and "the team is like a family." Staff were open and honest about the difficulties and challenges during the pandemic, as well as sharing the improvements that were made for the benefit of patients and staff.

Safer Staffing is a topic that generates questions and interest from members across the United Kingdom. Case studies from our study on the contribution of community hospitals during COVID-19 demonstrate innovative ways of supporting safer staffing.

Safer staffing Discussion

A Community Hospitals Special Interest Group virtual discussion relating to Safer Staffing in April 2023 was well attended and the contributions of Professor **Alison Leary** MBE FRCN Chair Healthcare and Workforce Modelling, London South Bank University and **Helen Hughes**, Chief Executive of Patient Safety Learning, generated a lively discussion highlighting the unique complexities of this subject within community hospitals. The debate on this topic has influenced the design of this Resource Pack.

THE RECORDING OF THE SAFER STAFFING PRESENTATIONS AND DISCUSSION CAN BE VIEWED HERE

WHAT WE DID

85
PRACTITIONERS

85 STAFF INTERVIEWED USING APPRECIATIVE INQUIRY

20
ORGANISATIONS

20 ORGANISATIONS TOOK PART REPRESENTING 168 COMMUNITY HOSPITALS

31
CASE STUDIES

31 CASE STUDIES SELECTED AND DEVELOPED

Legal Context

Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that providers should deploy enough/sufficient staff and support them accordingly. This is a principle rather than an absolute measure.

> *The intention of this regulation is to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.*
>
> *To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the above regulations.*
>
> *Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise.*

Devolved Nation Wales

Wales issued Statutory Guidance in Nurse Staffing Levels in 2016. This defined the Required Ward Establishment as:

> *The total number of staff to provide sufficient resources to deploy a planned roster (determined using the triangulation method in section 25c) that will enable nurses to provide care to patients that meets all reasonable requirements in the relevant situation. This includes a resource to cover all staff absences e.g. absence due to maternity and sick leave; and other staff functions that reduce the time available to staff to care for patients. Supernumerary persons such as students and ward sisters/ charge nurses/managers should not be included in the planned roster.*

This guidance sets out clear processes and builds in reviews for acute medical and surgical wards but does not cover all clinical areas including rehabilitation wards and other services within Community Hospitals.

Devolved Nation Scotland

The Health and Care (Staffing) (Scotland) Act was passed by the Scottish Parliament in 2019, however work was paused to allow everyone to focus efforts on the COVID-19 pandemic. The Act is applicable to all health and care staff in Scotland. The legislation is designed to support the wellbeing of health and care staff and patients and will be completed by spring 2024. The Health and Care (Staffing) Act is the first workload and workforce planning legislation for the NHS and social care in Scotland. It aims to ensure appropriate staffing levels are in place to support high quality care for patients and service users. The legislation is also designed to embed a culture of openness so that workers are informed about decisions relating to staffing and feel able to raise any concerns. The Scottish Parliament will also publish guidance for Care Homes in 2024.

Regulatory Context

The Care Quality Commission (CQC) who regulate providers, gives guidance that providers should provide sufficient staff to meet needs, and have a clear system for determining numbers and skill mix.

- Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs and therefore meet the requirements of Section 2 of these regulations (the fundamental standards).
- Providers should have a systematic approach to determine the number of staff and range of skills required in order to meet the needs of people using the service and keep them safe at all times. The approach they use must reflect current legislation and guidance where it is available. In determining the number of staff and range of skills required to meet people's needs, they should consider the different levels of skills and competence required to meet those needs, the registered professional and support workers needed, supervision needs and leadership requirements.
- Staffing levels and skill mix must be reviewed continuously and adapted to respond to the changing needs and circumstances of people using the service.
- There should be procedures to follow in an emergency that make sure sufficient and suitable people are deployed to cover both the emergency and the routine work of the service.

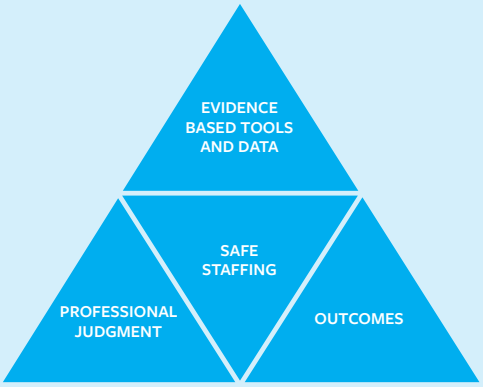
Principles of Safe Staffing

The principles of Safe Staffing have been shared widely and multiple tools and approaches generated by experts in workforce and Nursing (examples are shared in the Useful Documents section at the end of the pack).

THE PRINCIPLES CALL FOR TRIANGULATION OF 3 FACTORS:

1. **Evidence based tools and data,**
2. **Outcomes and**
3. **Professional judgement**

These have been presented diagrammatically in different forms but adhere to the same overall content.



NHSE Developing Workforce Safeguards

Professional judgement is often cited as the difficult part of the triangulation. Different individuals, teams and organisations may have vastly different thoughts on what professional judgement may be telling them for the same settings. There is also a lack of consensus on what professional judgement may be looking at – is it minimum numbers, skill mix, in or out of hours, Nursing or the whole multi-professional team, dependency, acuity, complexity, evidence based outcomes, patient safety or any combination of this list and more.

Professional judgement can be defined as:

> *Charged with making decisions to protect and enhance patient well-being, a nurse relies on nursing judgment to render effective patient care. Nursing judgment is the culmination of education, experience, and insight that allows nurses to execute the best action possible on behalf of patients.*
>
> (de Tantillo and Santis 2019).

Evidence

The RCN describes Nursing as a safety-critical profession.

There is ample documented evidence regarding the impact of registered Nurse staffing levels on patient outcomes and staff retention (Rafferty et al 2007, Aiken et al 2014). A literature search will identify evidence from across the globe and in multiple clinical settings supporting the importance of high RN staffing ratios. Staff wellbeing and development are also key factors in this.

The Patient Safety Learning Hub has numerous entries relating to Safer Staffing and Patient Safety.

Safety data is a key part of the Workforce Safeguards outlined above and it was the Francis Report 2013 that made recommendations to improve patient safety that brought the recent focus (Francis 2013). It is important to remember safety as well as quality of care and outcomes when looking at viable solutions.

Tools

There is a range of tools that can be used in clinical practice.

The **Safer Nursing Care Tool** and the **Mental Health Optimal Staffing Tool** developed by the Shelford Chief Nurses were designed to guide decision making together with professional judgement by chief nurses. These are very much focused on the acute model of service delivery but have been adapted and adopted by some Community Hospitals.

There is a **staffing guide for Stroke Wards** which includes a staffing calculator which is specific to needs of that client group.

Workforce Standards for the District Nursing Service were developed. This separated workload from caseloads and talked about the impact of growing caseloads on work deferred or left undone. It highlighted that:

> *Work should be allocated with a focus on risk, unpredictability, complexity and acuity of the situation and not simply task competency.*
>
> *Based on the data, there was a consensus too on the ratio of skill mix, considering the experience, knowledge and skills of the team members: 60% experienced RNs; 20% newly registered nurses; and 20% Nursing Support Workers. Support workers include many different groups such health care assistants and Nursing Associates.*

This work did identify red flags which should prompt a review, these are:

- District Nursing services unable to close a caseload, leading to unremitting and unsustainable demand.
- Deferring work every day or most days should be a red flag and escalated.
- Deferring any high priority work at all (for example end of life care, people with blocked catheters) should be escalated as a safety concern.
- High turnover and high sickness absence should also be considered a red flag for both patient safety and system resilience.

This work also highlighted the importance of professional judgement saying:

> *Route planners and other resource allocation applications should not override the priority of clinical care and professional judgement.*

This list is by no means exhaustive and there are many other tools and approaches in use in practice. There is staffing software which can help with task allocation and caseloads as well as producing a correctly skill mixed rota.

However, despite all the guidance, evidence, regulation and tools in use there is no straight forward guidance or formula that calculates what is needed for Community Hospitals.

WHAT IS DIFFERENT ABOUT COMMUNITY HOSPITALS?

There are approximately 500 Community Hospitals across the UK. Some sit within the NHS, some are independent. In one a Community Hospital may be a stand-alone bedded unit; in another it may be multiple wards with an Urgent Care Centre and a base for community services and another may be a collection of wards on an old DGH site which is used by multiple providers.

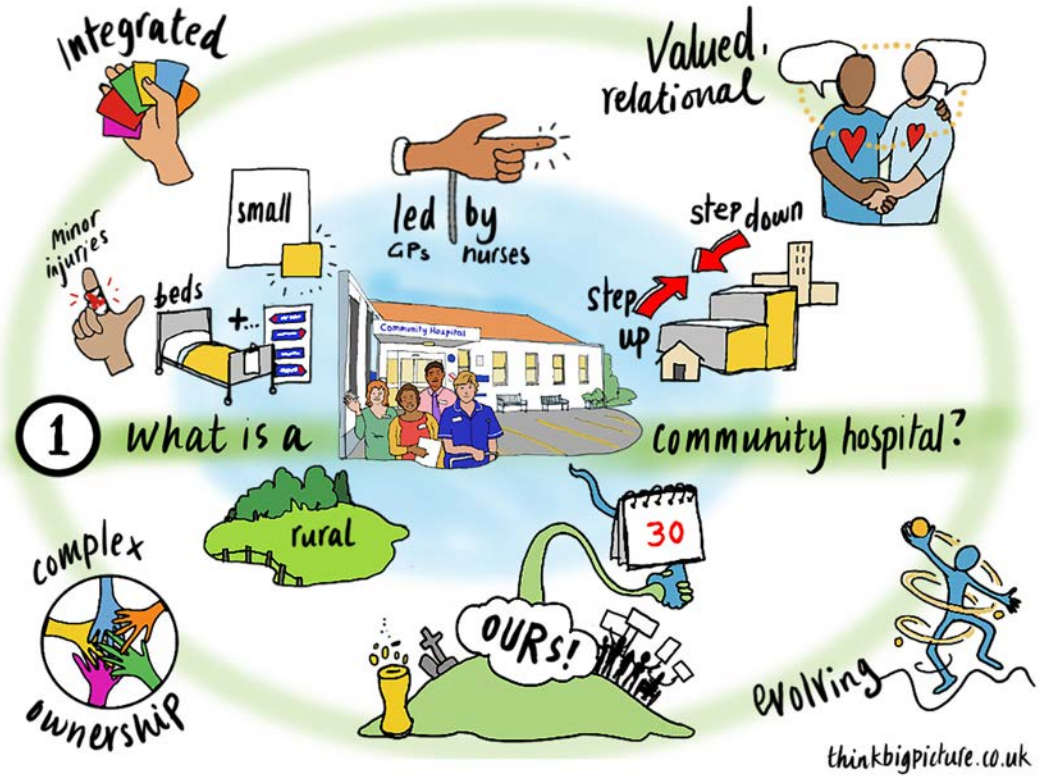
They may be called different things for example, Community Hospitals, Intermediate Care Units, Community Wards. They may care for a variety of people with different conditions such as Stroke, dementia, frailty, multiple long-term conditions.

Many will be nurse led, at least out of hours. Some will have their medical cover from a GP, some will have Advanced Clinical Practitioners, others will have input from acute based consultants.

Therapy support may be limited to Monday to Friday or cover the full week. Services such as palliative care may or may not in-reach.

Out of hours the Registered Nurse may be the decision maker in one Community Hospital but in another could have access to a night sister.

This means that the very uniqueness of Community Hospitals adds to the complexity of any safer staffing discussion. One size will never fit all. Professional judgement based on knowledge of the service as part of the Workforce Safeguards triangle will be needed to understand and articulate what safer staffing is locally.



CASE STUDIES FROM CHA COMMUNITY HOSPITALS COVID-19 STUDY

While safer staffing did not emerge as a theme from the project, there were many examples of community hospitals taking an innovative approach in times of crisis. Some of that thinking continues to apply and Community Hospital teams continue to learn from each other and adapt and adopt what others have trialled.

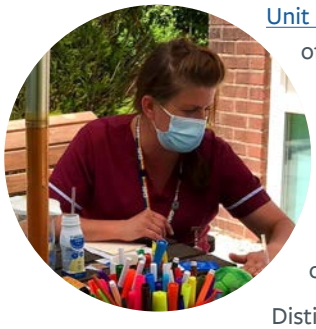
These are some examples which focus on Role Development and Definitions, Staff Support and Wellbeing and Technology. Our thanks to all the staff and organisations that took part in this study, and who shared their experiences of working in Community Hospitals during COVID-19.

THE REPORT AND CASE STUDIES CAN BE READ IN FULL HERE >>

Role Development and Definition

Enhanced Care: A New Model

Launceston Community Hospital undertook to look after additional cohorts of patients with dementia, something their staffing did not support. They developed new roles to support this including General Workers recruited from local furloughed staff and built on the existing new Meaningful Activities Coordinator role to support the needs of this group.



Advanced Clinical Practitioners

Hereford and Worcestershire Health and Care NHS Trust enhanced the role of Advanced Clinical Practitioner across Community Hospitals. This ensures patients received the correct level of clinical care while also providing increased support to more junior clinicians.

Supporting Hospital Discharge During Reset

Teddington Memorial Hospital introduced an in reach role using an experienced clinician. Not only did this support system flow built also allowed the hospital team to ensure the right staffing and equipment was in place to maintain safe care. This has also been identified as a sustainable model for future working.

An Enhanced Model of Care (CATU)

Cornwall developed a new service during the COVID-19 pandemic. The Community Assessment and Treatment Unit (CATU) encompassed the acknowledgement of what a frailty nurse led service could deliver alongside GP, therapy and MDT colleagues.

The service runs 24/7 with admissions from all providers within the community. It used and recognised the higher level of practice delivered and incorporated with the support of an appropriate admission criteria.

Distinctive admission and exclusion criteria support the guidelines to enable senior nurses to use their expert knowledge and assessment skills.

The service takes patients with a Frailty scores above 5 with a focus on people aged 65 and over. Patient Group Directives sit alongside the service which is an enabler to higher level practice.

There is 7 day HCA, Administrative and Housekeeping staff and a higher number of Band 6 Senior Staff Nurses to provide senior cover 24/7.

The service maintains a strong record of admission avoidance to Acute Hospital and provides placed based care closer to home for patients and families.

The service continues to evolve and develop providing a rich learning environment for preceptee Nurses and International Colleagues.

Staff Support and Wellbeing

Birmingham Community Healthcare NHS Foundation Trust

Birmingham took a system approach with specific actions taken in Community Hospitals. They ensured that staff were given additional training including Naso-gastric tube training and sub-acute clinical skills training to support the change in profile of patients they were seeing. They redeployed corporate staff to function as Family Liaison when visiting was not permitted ensuring clinical staff could focus on clinical work. They increased therapy input to create improved support for end of life care. They also put in place a rapid feedback loop "Writing on the Wall" for redeployed staff to provide support which led to morning Huddles being put in place.

Repurposing Abbey View Ward

Tewkesbury Community Hospital redeployed staff and repurposed a ward to provide end of life care. They introduced staff buddies to provide support on an individual basis to redeployed colleagues, put in place training and competencies to help team members gain knowledge and increase confidence and used some staff as family liaison. A side effect is that theatre staff have acquired new skills which allows them to work differently making theatre accessible to more patients.

Understanding and meeting the needs of all staff during COVID-19

Alnwick and Berwick Community Hospitals put in place a weekly survey to hear the concerns and needs of staff and help them to raise concerns. This supported patient and staff safety but also wellbeing which is an important part of staff retention.

Leadership journey to support a 7 day service

Oxford Health NHS Foundation Trust Community Hospital Matrons moved to 7 day working. Each week one Matron took the operational lead of being the link to external services. This increased and visible leadership supported both Community Hospitals and the wider system to maintain safe patient flow.

Wellbeing Conversations

Sussex Community NHS Foundation Trust had senior leadership team members based on Community Hospital sites. While this was supportive of the teams on each site it did reduce the peer support for the senior team. They introduced weekly wellbeing chats which enhanced their working relationships with each other and ensured wellbeing was given the right level of focus at every level.This built in resilience and enhanced team morale.

Managers as buddies

Oxford Health NHS Foundation Trust allocated a senior manager to each Community Hospital to provide visible senior presence and leadership but also to listen to staff concerns.

Team Leader Huddles

Nairn Town and County Hospital and GP Practice put in place daily huddles to ensure there was the correct support in terms of staffing and equipment for Community Hospitals. This provided a forum for open discussion and problem solving and greater collaborative working.

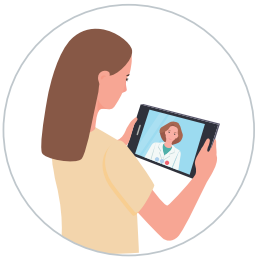
Technology

Virtual Nurses Station

Skegness Community Hospital were aware of the importance of senior nursing advice and support to junior colleagues. When faced with several senior nurses who were required to shield, they created a Virtual Nurses Station using technology to allow them to remain accessible to colleagues who needed their input to maintain a safe shift and provide quality care to patients.

Virtual Home Assessments

Sussex Community NHS Foundation Trust used iPad technology to support home assessment using family members. This ensured clinical focus was directed effectively while still ensuring high quality rehabilitation and safe discharge.



Using Alexa in Dementia Care

A Community Hospital Team within Betsi Cadwaladr University Health Board used Alexa to introduce games and quizzes to patients. This provided stimulation and distraction and was important in maintaining patient safety as well as ensuring resources were used effectively.

Cleaning to music

Oxford Health NHS Foundation Trust took a creative approach to twice daily cleaning on the wards by introducing music. Not only did it lighten the mood, important to staff wellbeing but also indicated to everyone who could participate, including patients that now was the time. This safely supplemented the clinical and housekeeping resources.

WHAT NEXT?

While none of these examples on their own are a safer staffing solution they do provide an insight into the use of professional judgement within Community Hospitals and the innovation that can follow. Examples such as these enable sharing and learning and through adoption and adaption increase the body of knowledge which can support safer staffing decision making.

Sharing innovation alongside the development and use of "red flags" locally could allow a national discussion on principles of safer staffing that might help ensure safety, quality and outcomes are at the heart of all Community Hospital safer staffing discussions.

ACKNOWLEDGEMENTS

THANK YOU TO THE ORGANISATIONS WHO AGREED TO TAKE PART IN OUR CHA Q PROJECT ON THE ROLE OF COMMUNITY HOSPITALS DURING COVID-19. THE 20 ORGANISATIONS ARE LISTED BELOW. WE ARE GRATEFUL TO THE 85 STAFF AND MANAGERS WHO AGREED TO BE INTERVIEWED, AND HAVE CONTRIBUTED THEIR EXPERIENCES AND VIEWS. THANK YOU.

PROVIDER TITLE
Northern Ireland
Northern Health and Social Care Trust
England
Birmingham Community Healthcare NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Derbyshire Community Health Services NHS Foundation Trust
Gloucestershire Health and Care NHS Foundation Trust
Herefordshire & Worcestershire Health and Care NHS Foundation Trust
Hounslow & Richmond Community Healthcare NHS Trust
Lincolnshire Community Health Services NHS Trust
Northumbria Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Somerset NHS Foundation Trust
Southern Health NHS Foundation Trust
Sussex Community NHS Trust
Tetbury Hospital Trust
Torbay and Southern Devon NHS Foundation Trust
Scotland
Highland Health Board
Lanarkshire Health Board
Wales
Betsi Cadwaladr University Health Board
Cwm Taf University Health Board
Hywel Dda University Health Board

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de Tantillo L, De Santis JP. Nursing Judgment: A Concept Analysis. ANS Adv Nurs Sci. 2019 Jul/Sep;42(3):266-276.

NHS Developing workforce safeguards (2018)
https://www.england.nhs.uk/wp-content/uploads/2021/04/Developing-workforce-safeguards.pdf

National Quality Board (2016)
https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

Nurse Staffing Levels (Wales) Act 2016 Statutory Guidance
https://www.gov.wales/sites/default/files/publications/2019-04/nurse-staffing-levels-wales-act-2016.pdf

Rafferty et al (2007) Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records
https://www.sciencedirect.com/science/article/abs/pii/S0020748906002446?via%3Dihub

Aiken et al (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/fulltext

Nursing Judgement: A Concept Analysis (2019) de Tantillo, L. Santis, J. ANS Adv Nurs Sci 2019 Jul/Sep;42(3):266-276.
https://pubmed.ncbi.nlm.nih.gov/30531353/

How to ensure the right people, with the right skills, are in the right place at the right time
https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf

Compassion in Practice (2012)
https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

Hard Truths: The Journey to Putting Patients First (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)
https://www.nice.org.uk/guidance/sg1

Carter Report (2016)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

Leading Change, Adding Value (2016)
https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf

Shape of Caring (2015)
https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf

Safer Staffing Tools

Safer Nursing Care Tool
https://www.england.nhs.uk/nursingmidwifery/safer-staffing-nursing-and-midwifery/safer-nursing-care-tool/

Staffing Guidance (Stroke)
https://stroke-education.org.uk/staffing/

Workforce Standards for the District Nursing Service, The Queen's Nursing Institute's International Community Nursing Observatory
https://www.qni.org.uk/wp-content/uploads/2022/02/Workforce-Standards-for-the-District-Nursing-Service.pdf

Links

Patient Safety Learning Hub
https://www.patientsafetyhlearning.org/the-hub

https://www.pslhub.org/learn/improving-patient-safety/workforce-and-resources/safe-staffing-levels/

The Patient Safety Report on the Future – A Blueprint for Action
https://www.patientsafetylearning.org/resources/blueprint

CHA

CHA Reports and Case Studies http://www.communityhospitals.org.uk/quality-improvement/reports.html

CHA Q Special Interest Group https://q.health.org.uk/community/groups/community-hospitals/

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COMMUNITY HOSPITALS ASSOCIATION

'The national voice for Community Hospitals'