Gateway reference: 03803

Skipton House
80 London Road
London
SE1 6LH

4 August 2015

Dear Colleague,

Next steps in guidance for safe staffing

Following Jane's letter of 11 June 2015 (attached as Annex A), we are pleased to write to update you on the safe staffing plans that the Secretary of State has announced will now be led by the new body, NHS Improvement, working with the Chief Nursing Officer.

The previous letter set out the key principles that would inform the development of this work on ensuring the NHS is safely staffed, specifically that we:

- take a multi-professional approach that takes into account all staff involved, not just nurses;
- take into account that there are many care settings that are not in a hospital and span organisational boundaries;
- remember that this is not just about filling rotas or looking only at numbers or input measures;
- recognise that there is no one-size fits all approach for new models of care and the mix of staff we need;
- that the work should be underpinned by the need for career progression for non-registered staff, nurse retention and flexible working;
- recognise that, other than in acute wards, there is as yet little research or evidence into what safe staffing looks like for other care settings.

In line with these principles, this letter sets out in more detail our next steps for delivering this important programme of work. These next steps are guided by the need to:

- improve experience of care for patients and staff;
- improve the effective and safe clinical outcomes of our patients; and
- achieve an improved efficiency and productivity in every pathway of care and staffing guidance.

There can be no compromise on the issue of staffing and its impact on patient safety (as set out in the letter of 11 June) and we need a methodology that properly assesses and publishes what appropriate levels of staffing should be, taking full account of the changes that can be made with new technology and modern multidisciplinary work practices. In his speech on 16 July the Secretary of State confirmed that, as previously proposed, the patient safety function will transfer from NHS England to a new body, NHS Improvement. One of the early priorities will be to develop additional guidance on safe staffing levels, in conjunction with the CNO. Dr Mike Durkin will lead this work ensuring there is a multi-professional approach to safe staffing.

Over the summer NHS Improvement, with the CNO, will identify leads for each of the programmes (Mental Health, Learning Disability, Urgent and Emergency Care, Primary and Community Services and Maternity) and work with them to scope the plan and delivery. This will involve identifying what evidence reviews and other support is needed, finalise the expert members of each and confirm links with key stakeholders including patients.

To ensure that the outcomes of the programmes' work are robust they will be independently reviewed by NICE, CQC and Sir Robert Francis QC to ensure they meet the high standards of care the NHS aspires to and of which patients, their families and communities deserve. Staffing guidance will be published by the National Quality Board taking into account the feedback from an oversight advisory group and the independent reviews.

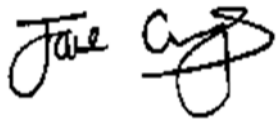
It is important that there is systematic oversight by a multi-stakeholder advisory group for these programmes. The group's role will be to assure that there has been effective widespread engagement and to quality assure the outputs of the programme. It will also review the impact on patient outcomes, together with the economic, workforce development, and operational impact.

We are finalising the membership of this group and the details are set out in Annex B. We are requesting nominations from academia and providers and also from those interested in leading or contributing to the programmes of work. If colleagues are interested in joining us, please contact Julie Lockwood on julie.lockwood1@nhs.net saying which role you are interested in.

It is important to reiterate that this work does not replace the important work and guidance previously developed by NICE and we will continue to work with NICE throughout this programme to ensure the ongoing access to their expertise and support for delivering safe staffing.

We will bring together and set out in one place all of the existing guidance and emphasise the importance of the NQB guidance and 10 expectations published in November 2013. In future, as further NQB guidance is generated it will be published and available for all stakeholders.

We hope that this letter helps to bring you up to date with the next steps on guidance for safe staffing in all settings, and how you can get involved, as we continue to work to improve the clinical outcomes and safety of our NHS.



Jane Cummings
Chief Nursing Officer England

Dr. Mike Durkin
For NHS Improvement

Annex A – 11th June letter

Gateway reference: 03587

Jane Cummings' Office
NHS England
Skipton House, 6B7
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SE1 6LH

11 June 2015

Dear Colleague,

Ensuring the NHS is safely staffed

I am writing to update you on the next steps on our shared work programme to improve the safety and quality of NHS staffing. But let me first tackle head on three misconceptions.

First, nothing we are doing changes the NICE guidance that has already been issued. 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (July 2014) and 'Safe Midwife Staffing in Maternity Settings' (January 2015) are important parts of our approach to ensuring safe and high quality care. The next phase of the NHS's role in this area is focusing on new care areas and will not involve going back on the guidance already published.

Second, nothing in this work programme in any way challenges or contradicts the CQC's important role to inspect and rate hospitals and indeed providers across health and adult social care. They make their own judgements on what is or is not safe, and are free to form their own independent judgements about safety and safe staffing.

Finally, this is not about saving money; more about using the money we have as efficiently and effectively as possible. I would not suggest anything that would compromise patient safety. It would be against all I have repeatedly highlighted since I became CNO and is fundamental to our profession. It would also be a false economy – compromising safety just causes distress to patients, adds to the cost of care and a growing litigation bill.

But to see NICE's work as the totality of our focus on safe staffing is to miss the point. The ultimate outcome of good quality care is influenced by a far greater range

of issues than how many nurses are on any particular shift, even though that is important.

As we continue to develop our approach to safe staffing for those working in mental health, urgent and emergency care, learning disability and community services there are six things that will help to guide us. These are six reasons why we now need to take a different approach.

First, we must take into account all the staff involved, not just nurses. In urgent and emergency care, as in other care settings, we need to look at doctors, paramedics and other Allied Health Professionals (AHPs) as well as nurses. As the NHS Five Year Forward View acknowledges, healthcare is increasingly delivered by a multi-professional workforce – for example, nurses, care assistants, psychiatrists, psychologists, activity leaders and AHPs are all crucial to a well-run mental health service. Getting the right mix of staff in these multi-disciplinary teams is vital.

Second, many care settings are not in a hospital and span organisational boundaries. It would therefore be inappropriate to develop a staffing structure for one type of organisation and then expect it to span multiple institutions and roles.

Third, we must remember that this is not just about filling rotas or looking only at numbers or input measures. It is also about how much time nurses spend with or supporting patients, their families and carers and what the outcomes for those people are.

Fourth, as you know we are working to develop new ways of providing care. Just as there is no one-size fits all approach for these new models of care, there will be no identikit approach to the mix of staff we need. The number of staff caring for patients on an orthopaedic ward in Cornwall or Doncaster is a good guide to how safe those wards are – we are not changing the current NICE guidance in acute hospitals for this reason. But the different settings for other types of care mean there is no one right answer.

Fifth, underpinning these will be the work outlined in my letter of 3 June, which sets out the need for career progression for non-registered staff, nurse retention and flexible working.

Sixth, we must recognise that, unlike in acute wards, there is as yet little research or evidence into what safe staffing looks like for other care settings. We need to find a new approach to testing what is right, which includes looking at what evidence exists, commissioning new research and national and international best practice.

I believe if we use these principles it will guide us in our planned next steps. We will continue to use NICE for commissioning evidence reviews where appropriate and also bring in other independent professionals and experts to guide us. This will include professional organisations such as the RCN, RCM, QNI, AHP organisations and medical Royal Colleges.

The Mental Health Taskforce has agreed to lead the work on establishing what is the right balance of staff in the many settings treating those with mental illness. They will

report back by the end of the year and take into account the mental health staffing guidance that has recently been developed with colleagues from the Mental Health Directors of Nursing Network and commissioned through the Compassion in Practice Strategy.

NICE has already done some excellent work on nurse staffing in urgent and emergency care. We will ask the new Urgent and Emergency Care Vanguards to build on this guidance, developing it to take into account other professionals from clinical pharmacists to care assistants, junior doctors to GPs, paramedics to other AHPs whom we should include. This work will help to inform us about the appropriate balance of staff for the Emergency Department as well as alternative urgent care services of the future.

For the areas of work such as learning disability and community care, we will establish work programmes to support the development of guidance by working with the new learning disability fast-track sites and the Five Year Forward View vanguards.

We also recognise the importance of safe staffing in nursing homes, which collectively have more than two hundred thousand beds (more than in acute hospitals) and a high turnover of nursing staff.

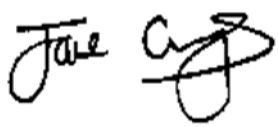
The National Quality Board and its members will help oversee this programme, working closely with the NHS TDA, Monitor, Health Education England, the Care Quality Commission and the Department of Health.

At the Provider Directors of Nursing meeting we held on 9 June, it was clear that those present agreed with our approach and offered to support the work. I will confirm the governance and organisational arrangements in the next few weeks, ensuring that key stakeholders are involved.

I look forward to working with you on this, and will ensure there is regular communication about our ongoing work as it progresses, together with opportunities for you to support and contribute.

Many thanks.

Yours sincerely,



Jane Cummings
Chief Nursing Officer
England

Annex B – Proposed initial membership of the Oversight and Advisory Group will include:

- Chief Nursing Officer (Chair)
- Director of Patient Safety
- TDA and Monitor Directors of Nursing
- HEE Director of Nursing
- Chief Professional Officer for Allied Health Professionals
- Chief Scientific Officer
- Chief Pharmaceutical Officer
- CQC
- NICE
- DH
- Centre for Workforce Intelligence
- NHS Employers
- RCN
- Academy of Medical Royal Colleges or co-opted medical lead depending on clinical area discussed
- Academic leads
- Economist lead
- Provider Directors of Nursing to include Acute, Mental Health and Learning Disability and Community Provider Trusts
- Programme Lead for each work area as defined above
- Workforce lead - Lord Carter review