



**Safe, sustainable and productive staffing**

**An improvement resource for  
urgent and emergency care**

This document was developed by NHS Improvement on behalf of the National Quality Board (NQB).

The NQB provides co-ordinated clinical leadership for care quality across the NHS on behalf of the national bodies:

- NHS England
- Care Quality Commission
- NHS Improvement
- Health Education England
- Public Health England
- National Institute for Health and Care Excellence
- NHS Digital
- Department of Health and Social Care

For further information about the NQB, please see:

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## Summary

The National Quality Board (NQB) published [guidance](#) in 2016 “*Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time*” outlining its expectations and framework within which decisions on safe and sustainable staffing should be made to deliver safe, effective, caring, responsive and well-led care on a sustainable basis.

This improvement resource focuses on nurse staffing in urgent and emergency care (UEC) settings and is one of a suite of specialty resources underpinning the overarching NQB staffing improvement resource. It aligns with Commitment 9 of [Leading change, adding value](#): “we will have the right staff in the right places and at the right time” (NHS England 2016).

This improvement resource is informed by the National Institute for Health and Care Excellence (NICE) evidence review (Drennan et al 2014) and the findings of a supplementary evidence review (Dall’Ora et al 2016) commissioned for this work. The resource takes account of the nuances of local settings and the need for flexible multiprofessional workforce solutions, and aligns with national work to modernise UEC services in England.

We acknowledge that work is required to develop and refine current workforce planning tools to support decision-making, and recognise that further research is needed to better understand the impact of staffing in UEC settings on outcomes for patients.

## Recommendations

For decision-making in determining nurse staffing requirements in UEC settings this resource recommends:

1.	A strategic staffing review must be undertaken annually or more often if changes to services are planned.
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2.	Adopt a systematic approach using an evidence-based decision support tool triangulated with professional judgement and comparison with peers.
3.	Safe staffing requirements and workforce productivity should be integral to the operational planning process.
4.	Acuity and dependency may vary considerably within UEC settings. Staffing reviews should use decision support tools for the assessment and measurement of acuity, dependency and workload.
5.	Demand in UEC settings fluctuates through 24 hours, the week and with the season. Workforce planning should allow for this and reflect trends in activity. Contingency plans should give the necessary staffing flexibility to meet unexpected demand.
6.	Workforce planning should allow for role development/expansion and new ways of working while ensuring that fundamental care remains a priority.
7.	Staffing decisions should be taken in the context of the wider multiprofessional team.
8.	Organisations should have a local dashboard to assure stakeholders that staffing is safe and sustainable. The dashboard should include department-level quality indicators to support decision-making.
9.	Organisations should ensure they have an appropriate escalation process in case staffing is not achieving desired outcomes.
10.	Action plans to address local recruitment and retention priorities within UEC settings should be in place and subject to regular review.
11.	Flexible employment options and efficient deployment of staff should be maximised to limit the use of temporary staff.
12.	All organisations should have a process to determine additional uplift requirements based on the needs of patients and staff.
13.	All organisations should investigate staffing-related incidents and their effect on staff and patients, taking action and giving feedback.

# 1. Introduction

This is an improvement resource to support nurse staffing in urgent and emergency care (UEC) settings. The resource is based on the [National Quality Board's \(NQB 2016\) expectations](#) that to ensure safe, effective, caring, responsive and well-led care on a sustainable basis, trusts will employ the right staff with the right skills in the right place at the right time (Figure 1 below). It aligns with Commitment 9 of *Leading change, adding value: a framework for nursing, midwifery and care staff*.

**Figure 1: NQB's expectations for safe, sustainable and productive staffing (2016)**

Safe, Effective, Caring, Responsive and Well- Led Care		
<p><b>Measure and Improve</b></p> <ul style="list-style-type: none"> <li>-patient outcomes, people productivity and financial sustainability-</li> <li>-report investigate and act on incidents (including red flags) -</li> <li>-patient, carer and staff feedback-</li> </ul>		
<ul style="list-style-type: none"> <li>-implement Care Hours per Patient Day (CHPPD)</li> <li>- develop local quality dashboard for safe sustainable staffing</li> </ul>		
Expectation 1	Expectation 2	Expectation 3
<p><b>Right Staff</b></p> <ul style="list-style-type: none"> <li>1.1 evidence based workforce planning</li> <li>1.2 professional judgement</li> <li>1.3 compare staffing with peers</li> </ul>	<p><b>Right Skills</b></p> <ul style="list-style-type: none"> <li>2.1 mandatory training, development and education</li> <li>2.2 working as a multi-professional team</li> <li>2.3 recruitment and retention</li> </ul>	<p><b>Right Place and Time</b></p> <ul style="list-style-type: none"> <li>3.1 productive working and eliminating waste</li> <li>3.2 efficient deployment and flexibility</li> <li>3.3 efficient employment and minimising agency</li> </ul>

In line with the overarching NQB guidance, leaders of organisations hold responsibility and accountability for ensuring their patients receive high quality, safe, dignified and compassionate care. This improvement resource is designed to be used by all those involved in clinical establishment setting, approval and deployment, from clinical leaders to board directors.

The resource outlines a systematic approach to identifying the organisational, managerial and local factors that support safe staffing in UEC settings. It makes

recommendations for monitoring and action if staffing resources are not meeting patients' needs.

This resource considers the nuances of local UEC settings and the need for flexible multiprofessional workforce solutions. Although it includes principles for safe and effective staffing, it does not set staffing ratios – there is no evidence base to support a specific ratio. Instead, staffing requirements should be decided using patient acuity and dependency data alongside throughput, and the skills and experience of the wider multiprofessional team. The only exception to this approach is the need to refer to the [Guidelines for the provision of intensive care services](#) published by the Faculty of Intensive Care Medicine and the Intensive Care Society in 2015, for the staffing levels of resuscitation areas in emergency departments (EDs), as detailed in Section 2.2.

It is also useful to identify and recognise the role professional organisations and unions can provide in supporting this work. A partnership approach with staff-side representatives is important in developing and monitoring workforce policies and practices, and in influencing the organisational culture.

The NHS Improvement [safe and sustainable staffing improvement resources](#) for adult inpatient wards, children's and young people's nursing, district nursing service, mental health and learning disabilities settings may be relevant to aspects of care in UEC settings.

## Background

This resource has been developed in parallel with broader work across the NHS in England to modernise and redesign UEC services (NHS England 2014, 2017).

The [National Institute for Health and Care Excellence \(NICE\)](#) reviewed the evidence for safe staffing for nursing in accident and emergency departments and consulted on draft guidance in 2015. While this work did not progress beyond the consultation, this improvement resource is informed by the findings of the NICE evidence review.

We supplemented this by commissioning an evidence review on the impact of introducing new roles and changing skill mix on patient, staff and cost outcomes for UEC (Dall'Ora et al 2016).



We recognise the need to consider the contribution and value of the wider multiprofessional team when looking at the number and composition of staff for any setting. But with little published workforce modelling or planning evidence on how multiprofessional workforce plans can be achieved in UEC settings, this resource concentrates on nursing, with signposts where we have found evidence to inform multiprofessional workforce planning.

## 2. Right staff

The UEC environment requires a multiprofessional workforce. Medical staff, allied health professionals (AHPs), pharmacists and other staff work alongside nurses to provide high quality patient care and treatment. Developing roles such as physician associates, advanced clinical practitioners (ACPs) and nurse associates will strengthen this workforce.

The interdependence of the roles in the multiprofessional team has a direct influence on the number and skill mix of the team's required nursing component. This makes it inappropriate to prescribe definitive nurse-to-patient ratios. However, in workforce planning and review, the required nursing establishment does need to be calculated. This should inform not only current requirements but also future workforce development; influencing succession planning and training strategies.

Staffing decisions must align with operational planning processes so that high quality care can be provided at all times on a sustainable basis, taking into account predicted fluctuations in UEC settings.

The nursing establishment is defined as the number of registered nurses and healthcare support workers<sup>1</sup> who work in a particular department or team. Calculations should also distinguish the numbers of Registered Nurses and Healthcare Support Workers. It is important to distinguish between the funded establishment and number of staff 'in post' who are available to be rostered on any given day.

### 2.1. Evidence-based workforce planning

#### Staffing reviews

**When?** Boards should carry out a strategic staffing review at least annually, aligned with the operational planning process or more frequently if changes to services are

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<sup>1</sup> Some organisations refer to healthcare support workers as nursing assistants, healthcare assistants and assistant practitioners.

planned – for example, service reconfigurations associated with sustainability transformation partnership (STP) plans and UEC review.

Consider a staffing review whenever local evidence suggests patient safety may be at risk due to staffing issues flagged up by, for example, clinical incidents or complaints and available real-time data. Any review should be proportionate to the potential level of risk indicated by the data.

**What?** Transparent governance structures should enable department-to-board reporting of:

- rationale for determining staffing numbers and skill mix
- any disparity between staffing requirements and availability
- impact of workforce strategies on patient care, safety and outcomes
- effectiveness of strategies employed to improve staffing.

**How?** The decision-making process to determine safe and sustainable staffing must be clear and logical with the following key elements:

- use a 'triangulated' approach to determine what evidence and management information are used for staffing such as casemix, demand and complexity alongside professional judgement to determine the number of staff required
- ensure shift patterns/staffing resources reflect fluctuations in service demand, including seasonal variation
- use professional judgement to understand the impact of local factors
- use appropriate evidence-based tools
- benchmark with appropriately selected and comparable peers, taking account of variations in structures and processes across UEC services
- take account of national guidelines and recommendations for specific patient groups (eg children and young people), being mindful these may be based on professional consensus rather than robust evidence
- consider the professional roles and skills required to meet patient needs most appropriately
- consider how to recruit and retain, to secure workforce supply to ensure sustainability and enable succession planning.

## 2.2. Workforce planning tools

Evidence-based tools do exist to enable calculation of clinical nursing workforce requirements in EDs. But at the time of writing none has been validated across the full range of UEC services or takes account of the multidisciplinary factors previously outlined. Evidence-based tools can be useful when considered as part of the systematic approach to overall workforce planning. This resource does not endorse any particular tool for implementation.

No workforce planning tool can incorporate all relevant factors in UEC settings; therefore, cross-checking is recommended by combining workforce tool outputs with professional judgement and benchmarking of quantitative and qualitative indicators against peers, to increase confidence in and assurance of estimated staffing requirements.

Professional consensus guidance for nurse staffing in critical care could be useful for resuscitation areas, whereby level 3 patients require a nurse-to-patient ratio of 1:1 and level 2 patients a ratio of 1:2 to deliver direct care during the resuscitation phase of care (Faculty of Intensive Care Medicine and the Intensive Care Society 2015). In majors, owing to the more specialist care environment, higher staffing levels than outlined in the adult inpatient improvement resource may be required to take account of acuity, dependency, full assessment needs and patient transfer times.

Boards and staff should be mindful of the need for transparency of data and information, recognising the importance of accurate datasets to inform workforce planning decisions.

You should ask if a tool does the following when evaluating current tools or developing new tools:

Use a systematic approach

- Integrate a classification scheme for determining/capturing the care needs for individual patients
- Reflect the different needs of different patient groups, eg frail, adults, children
- Enable consistency and replicability
- Support objective decision-making

Incorporates best evidence

- Has a robust evidence base for the required nursing time, derived from data gathered in a comparable setting in the NHS
- Demonstrate that the resources recommended are sufficient to deliver care of acceptable quality
- Incorporate patient acuity and dependency

Include essential aspects of nursing resource

- Direct patient care
- Admissions and discharges
- Patient activity/throughput
- Patient care handovers
- Indirect patient care, eg communication with relatives and documentation
- Scheduled breaks
- Mentoring and supervision
- Unit management (supervisory/nurse in charge time)
- Education/training staff
- Appraisal and personal development planning
- Quality improvement, audit and research

Consider additional resource aspects

- Escort duties
- Design of unit
- Geography
- Seasonality
- Professional standards, eg revalidation

## 2.3. Allowing for uplift

Nursing establishments in UEC settings should include a realistic 'uplift' to allow for the efficient and responsible management of planned and unplanned leave and absences. Underestimation may result in an establishment that cannot meet day-to-day staffing requirements and over-reliance on unexpected and unfunded temporary staffing solutions.

It is also important to review the level of uplift at least annually as part of the overall staffing review, aligned with the operational planning process and agreed at board level.

Elements to consider when calculating the percentage allowances for uplift include:

- **Annual leave entitlements:** Long service enhancements depend on the length of service of staff members. The entitlement of the local workforce must be calculated.
- **Sickness/absence:** Planning should be based on the organisation's target level of sickness/absence, for example 3% to 4%, and aligned with sickness improvement strategies. Long-term sickness can have a significant impact on staff availability, particularly for small teams.
- **Parenting leave:** Many organisations operate a central funding pool for parenting leave (calculated at departmental level and then managed centrally).
- **Study leave:** Allowance should be made within the establishment for both mandatory and role-specific training. Estimates for study leave may be higher for nurses working in EDs than those working in inpatient wards: emergency nurses care for patients from all four fields of practice (adult, mental health, learning disabilities and children's nursing) and need the knowledge and skills to recognise and deal with life-threatening illness and injury in all biological systems, and respond to out-of-hospital major incidents including chemical, biological and mass casualty events. In addition, the nursing of adults and

children in the UEC setting requires a more detailed understanding of safeguarding issues.

A larger study leave allowance may be needed where there are high numbers of newly qualified nurses or nurses new to the specialty and requiring essential training to be competent in emergency nursing. The [Royal College of Nursing Emergency Care Association Competency framework for emergency nurses](#) (2017) is a useful resource when assessing and planning the training requirements of the nursing team. Study leave estimates should reflect the way training is delivered (eg time required for face-to-face teaching or e-learning) and numbers of staff requiring training. See also Section 3 on Right skills.

A larger study leave allowance is also needed where the proportion of part-time staff is high.<sup>2</sup>

A review of the release of staff to allocated study leave should form part of any ongoing monitoring.

- **Quality improvement initiatives:** Many departments facilitate training and development or service improvement initiatives by creating link nurse roles. Regular time away from clinical duties to undertake the non-clinical element of these roles should be factored into the uplift.
- Local factors must be considered when calculating the percentage allowances for uplift.

As UEC teams are multiprofessional, consideration should be given to applying uplift across the whole team.

**Table 1: Indicative example of best practice in calculating how uplift may be set in EDs**

Element	Example %	Rationale
Annual leave	14.7	This is the average annual leave across the nursing workforce, in line with Agenda for Change and taking account of local patterns of length of service

<sup>2</sup> For example, if all staff are required to attend two days of mandatory training, four days will be needed if two individuals share a whole-time post

Sickness/absence	4	This is realistic for most organisations
Study leave	4.5	This includes mandatory and core/job-specific training and learning activities such as link nurse roles
Parenting leave	1	In some organisations this is managed centrally. It includes maternity, paternity and adoption leave, and is driven by local workforce demography
Other leave	0.8	This includes carers leave, compassionate leave, etc
<b>Total</b>	<b>25</b>	

## Responsiveness

*Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care. A guide for local health and social care communities* highlighted that:

“Patterns of urgent and emergency referrals and presentations, while not random, will always exhibit variation hour by hour and day by day (this is ‘normal variation’). When calculating demand, it is therefore essential to take account of the normal variation and not to plan around averages. Ignoring variation and planning to meet average demand will inevitably mean the service is under regular stress and queues will develop that may be difficult and expensive to manage”. (NHS England 2015, p11)

While staffing cannot be planned on the basis of all eventualities, some flexibility enables staff to respond to this normal level of variation. It is essential practice always to staff to meet demand in resuscitation areas; if this level of patient activity does not materialise on a particular shift, staff can be redeployed to other areas of the ED or elsewhere in the organisation.

Staffing flexibility can be supported with a range of shift patterns (including different shifts lengths) and should be included in establishment reviews as these impact on the number of staff required.

In addition to the normal variation in demand in terms of numbers of patients presenting each hour, consideration should be given to their length of stay (LoS) when calculating nursing workload. Patients waiting longer than four hours to be admitted to acute hospital beds have a disproportionate effect on nursing



dependency. The aggregate patient delay (APD) metric may be useful in identifying the additional staffing resource required to care for delays in patient admissions. For any 24-hour period, the total APD is the total time (beyond four hours) spent in ED for any and all patients awaiting admission (Royal College of Emergency Medicine 2015). This metric does not add administrative burden as it uses data that has already been collected.

For example, on a day when three patients had an ED LoS of greater than four hours (2.5 hours, 6 hours and 0.75 hours) the APD is 9.25 patient hours. To enable meaningful comparisons, improvement and monitoring, this figure should be expressed in hours per 100 patients per unit time (day/week/month).

Ultimately the goal for efficient patient care in the most appropriate care setting, through an integrated health and social care system, will impact on future workforce requirements.

## 2.4. Professional judgement for specific local needs

Staffing decisions based solely on professional judgement (the expert opinion of clinical staff) are subjective and may not be transparent; however, professional judgement is an essential element of staffing decisions. In exercising professional judgement, nurses should adhere to the Nursing & Midwifery Council (NMC) Code<sup>3</sup> and *NMC briefing: Appropriate staffing in health and care settings*.

Professional judgement should consider:

- **Departmental facilities/layout:** These can affect the nursing capacity needed to deliver efficient patient care. Factors to consider include:
  - visibility of patients by nursing staff; ‘remote’ areas such as a clinical decision unit may require extra staff
  - proximity of ward areas and other relevant departments, eg imaging facilities (also see escort duties below)

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<sup>3</sup> Each clinical profession is governed by its own professional code.

- separate streaming facilities, eg majors, minors, children's, resus, ambulatory care and emergency care, may facilitate better patient care but require additional staffing
- ward areas such as clinical decision units are often staffed by the ED establishment; nursing workload in such settings is calculated differently from in the ED.
- **Internal and external escort duties:** The staffing impact of clinical escort duties, eg to specialist services in other trusts, should be considered. If this is not included in the decision support tool output, but is considered a significant local factor affecting the numbers and skill mix of staff available for clinical care, a local data collection and analysis exercise may be useful in determining a percentage to be added to the establishment to take account of staff who are out of the department on escort duties.  
Consideration should be given to the staffing in other departments (eg radiology), the competencies staff require to undertake escort duties, and maximising the use of telephone handovers where feasible.
- **Multiprofessional working:** The presence or absence of other healthcare professionals and administrative support staff may impact on nurses' workload at particular times of the day. Consider whether specific AHP expertise would more appropriately meet the needs of patient groups at particular times of the day (see, for example, [Royal College of Occupational Therapists 'Urgent Care: The Value of Occupational Therapy' 2015](#)). See also Section 3.2 on Skill mix.
- **Shift patterns:** The type of shift pattern (long day versus short day) may affect the overall establishment required to ensure shift-to-shift staffing levels. Consider staggering start and finish times which have been mapped to patterns of patient attendance.
- **Local infrastructure:** On-site specialist expertise and treatment pathways can impact on staffing requirements in UEC settings. For example, the design of the stroke pathway may mean a patient bypasses the ED to have direct access to specialist expertise in the local stroke unit. Staffing plans should be reviewed to reflect changes in patient pathways.

Where it is difficult to construct a strong evidence base, it is important to apply professional judgement to staffing requirements. As some decision support tools may already cover the elements that need to be considered, care must be taken to avoid duplication. For this reason a triangulated approach is advocated; using a decision support tool, where available, in conjunction with clinical quality indicators and professional judgement/scrutiny.

## **2.5. Benchmarking/peer review**

Peer comparisons can provide data for further inquiry. While you should exercise caution, comparing staffing with peers can act as a 'sense check', particularly on assumptions and professional judgements. Benchmarking can stimulate sharing of best practice, but it is imperative to compare like with like. As mentioned earlier, national UEC designation work is underway and once new service configurations are implemented you will be able to benchmark using nationally agreed quality, activity, workforce and financial metrics.

The Model Hospital<sup>4</sup> is a new digital information service provided by NHS Improvement where NHS trusts are able to explore their comparative productivity, quality and responsiveness.

Collecting data on care hours per patient day (CHPPD) has been mandatory for inpatient areas since April 2016. Along with workforce, quality and financial data, it is part of the [Model Hospital's nursing and midwifery dashboard](#) (Department of Health 2016). We expect this will eventually include a measurement for the multiprofessional workforce in clinical teams, including for ED, as Getting it Right First Time (GIRFT) defines what good looks like at a clinical specialty/service level.

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<sup>4</sup> <https://model.nhs.uk/> Access is currently provided to NHS provider trusts only.

## 3. Right skills

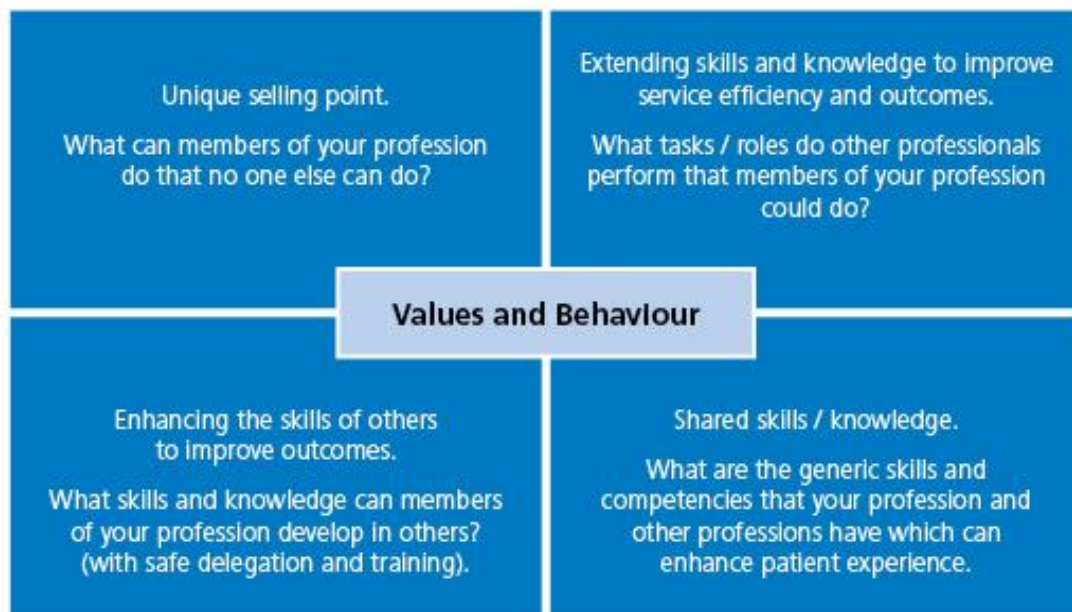
You need to consider the skill mix for delivering safe, efficient and effective services. Clinical leaders should use the workforce's knowledge, skills and competencies to the full, developing and introducing new roles as need or skill gaps are identified.

### 3.1. Role of nursing in the multiprofessional team

Nurses have a key role in planning and delivering care to patients and their families. There are increasing opportunities for nurses in different roles in UEC settings. Registered nurses now include emergency care practitioners, ACPs (Royal College of Emergency Medicine 2015), matrons, nurse consultants and practice development facilitators. Some of these are part of the nursing team while others alleviate shortages in other professions, particularly medicine. Some ACPs in UEC departments may have roles that medical staff have traditionally performed. They should be considered part of the medical establishment, but their professional accountability and revalidation remain with nursing.

UEC nurses work with a range of health and social care professionals. To use the workforce efficiently and effectively, identify the skills needed for the care required, and deploy the right skill mix of staff accordingly. It is important to seek appropriate clinical or qualified health professional input when making decisions on staff deployment. Carefully consider the multiprofessional team's attributes when making such decisions: for example, using ACPs or occupational therapists at the 'front door' may add to the holistic nature of a patient's assessment and experience, or that health and social care professionals supervision requirements may differ from those of clinicians. Take account of the factors in Figure 2 when determining who is best placed to safely meet patients' current and future care needs (NHS England 2017).

**Figure 2: Who is best placed to safely meet future patient needs?**



Source: NHS England (2017)

For more on accountability and delegation, see [An RCN guide to accountability and delegation in the workplace for the nursing team](#).

A recent evidence review of skill mix and roles in UEC settings (Dall’Ora et al 2016) identified new roles. But these roles often lack definition in terms of training, scope of practice and standardisation. Therefore, consideration should be given to the training, skills and experience of post-holders. Evidence showed emergency nurse practitioners<sup>5</sup> have a positive impact in terms of patient satisfaction, quality of care and waiting times. In urgent care settings, the evidence indicated that emergency care practitioners (ECPs)<sup>6</sup> provide care equivalent to or better than that provided by practitioners in traditional roles. ECPs in urgent care settings were less likely to discharge and more likely to make referrals to hospitals/EDs than physicians. Evidence indicates that walk-in centres, generally staffed by non-medical practitioners, provide acceptable care; the economic and overall service impact as well as the quality of evidence were unknown (Dall’Ora et al 2016).

<sup>5</sup> A registered nurse who has undertaken specific additional training to assess, diagnose and prescribe treatment for patients who present with minor injuries and/or illness.

<sup>6</sup> ACPs with a specialist focus on emergency care.

## 3.2. Skill mix

Nursing teams include registered nurses (RNs), healthcare support workers (HCSWs) and assistant practitioners (APs). Some nursing teams also include ward clerks, housekeepers and play workers. The appropriate mix of registered nurses and support staff should be determined locally, informed by decision support tools, evidence reviews and professional judgement.

In the future you should consider the impact of the nursing associate role in UEC departments.

When comparing the nursing skill mix between UEC departments in different organisations, it is imperative to compare like with like. Caution should be given to comparing skill mixes that include a substantial contribution from new roles such as APs, ACPs and associate nurses; these are likely to be used differently by different employers and have variable skills and experience.

EDs may need access to specific specialist registered nursing expertise: for example, mental health nurses (Department of Health 2014), learning disability nurses or children's nurses (Royal College of Paediatrics and Child Health 2012, NHS England 2015).

Specialist skills are integral to the UEC workforce, and clinical educator roles can help ensure clinical staff are competent. Some organisations operate a 'link nurse' model, with nurses assuming a lead role for a particular area of practice: for example, dementia, tissue viability, falls or safeguarding. It is important that these members of staff have the education, training and dedicated time to function safely and effectively in these roles.

UEC staff safety is paramount: consider the level of cover that security staff provide. The nature of their support should be based on an assessment of the needs of people who feel under threat. Close working relationships with local police are also crucial to safe working environments for clinical staff.

### 3.3. Staff training, development and education

The lead nurse for the care setting is accountable for staff having the training and development to function effectively. In addition, a named practice education lead should be responsible for assessing individual team members' training requirements and developing a plan to meet them using available resources. It is essential the practice education lead has protected time for this.

Education and training needs can be met in various ways: for example, through local skills training, e-learning, seminars, shadowing, clinical placement exchanges and rotation programmes. Bespoke education programmes for staff working at various levels in UEC settings are available at higher education institutes. The comprehensive [Royal College of Nursing Emergency Care Association Competency framework for emergency nurses](#) will help with planning education and training requirements. The 'silver book' details the skills and competencies for delivering safe and effective care for older people in emergency care (British Geriatrics Society 2012).

For the care of children, guidance indicates that:

“in units which accept children there should be a paediatric registered nurse/allied health professional available for paediatric major trauma 24/7 who has successfully attained the paediatric competency and educational standard of level 2 (as described in the National Major Trauma Nursing Group guidance). All nursing/AHP staff caring for trauma patients should have attained the competency and educational standard of level 1. In centres that accept paediatric major trauma, this should include the paediatric trauma competencies (as described in the National Major Trauma Nursing Group guidance)” (NHS England 2016, T16-2b-103, p18).

In addition:

“it is the responsibility of individuals, the emergency care settings team, and the employing organisation to ensure any child or young person is reliably cared for

by staff with the necessary competencies, at any time” (Royal College of Paediatrics and Child Health 2012, p20).

Registered professionals require periodic revalidation. Although individual nurses are responsible for ensuring they revalidate, many organisations have adopted a partnership approach.

### 3.4. Leadership

The lead nurse is critically important to safe and effective UEC, and is responsible for ensuring staffing meets locally agreed levels. The lead nurse is also responsible for setting the culture of compassionate care and teamworking.

The time spent on supervision by the lead nurse should be determined locally, with an appropriate impact assessment, analysis and review. When undertaking local assessments, remember the [Mid Staffordshire Inquiry Report's](#) recommendation 195 (p106) that ward nurse managers should operate in a supervisory capacity to ensure they have time to lead on quality, people management and operational delivery.

The research the Royal College of Nursing (RCN) has published in its report *Stepping in, stepping out, stepping up* (2015) which can help your decision-making on the supervisory aspect of the lead nurse role.

In line with this, it is important to have an experienced sister/charge nurse on duty 24/7 with appropriate skills to oversee care delivery, including level 2 competencies (RCN Emergency Care Association Competency Framework 2017).

For major trauma centres, guidance states:

“there should be a nurse/allied health professional of band 7 or above available for major trauma 24/7 who has successfully attained the adult competency and educational standard of level 2 (as described in the National Major Trauma Nursing Group guidance)” (NHS England 2016, T16-2b-103, p18).



Organisations are responsible for ensuring that lead nurses are prepared for this role and given ongoing support – for example, leadership development, mentorship or coaching.

### 3.5. Recruitment and retention

Recruitment and retention strategies at organisation and department level are vital as part of a sustainable workforce plan. The lead nurse can identify or anticipate problems with recruitment and retention by monitoring, managing and planning for:

- vacancy rates
- sickness/absence
- turnover
- the team's age profile
- outcomes from retention/exit interviews.

Staff should be recruited using a competency and values-based selection process aligned with the NHS Constitution and local policy.

Department and organisational leaders need to boost retention across generations by understanding what motivates people to stay in their jobs. See [Mind the gap](#) (Health Education England 2015).

Strategies to improve retention can prove cost-effective because experienced staff stay in post, avoiding agency and recruitment costs. Evidence from acute care suggests leadership and adequate resources strongly influence turnover intention (Hayes et al 2012). A proactive approach to managing predictable staff turnover – using strategies such as prompt recruitment and responsibly managed over-recruitment – will minimise the time posts remain vacant between post-holders. Think about role sustainability and longevity, given the challenging nature and intensity of UEC work. In emergency medicine, portfolio careers have become popular. This can equally apply to emergency nurses and AHPs in UEC. Portfolio careers can take many paths but typically include spending part of the week in a different specialty or role. Examples include ED nurses working part of the week as

resuscitation training officers, clinical educators or research nurses. In recent years formal clinical/academic pathways have been developed (AUKUH 2016).

There are many possible combinations and the benefits of portfolio careers include: developing a broader knowledge and skill base; expanding professional networks; and preventing 'burnout' by introducing variety and changing the pace and intensity of work. However, portfolio careers are not without their challenges: time management and realistic role expectations are important considerations. Providing part-time opportunities in other areas/roles can aid recruitment and retention, and reduce the loss of highly skilled nurses and AHPs from UEC. University Hospital Southampton NHS Foundation Trust and Faculty of Health Sciences, University of Southampton has published a case study titled 'Shift work in hospitals: what are the effects on patient and employee outcomes? (2017)'.

Further resources available to organisations seeking to explore factors important in attracting new staff and retaining existing staff are available from NHS Improvement and NHS Employers:

- [www.improvement.nhs.uk/resources/improving-staff-retention](http://www.improvement.nhs.uk/resources/improving-staff-retention)
- [www.nhsemployers.org/your-workforce/retain-and-improve](http://www.nhsemployers.org/your-workforce/retain-and-improve)

## 4. Right place, right time

Staff should be deployed in ways that ensure patients receive the right care, first time, in the right setting, in a sustainable way. This will include effective management and rostering, with clear escalation policies if concerns arise.

### 4.1. Productive working

Routinely review work processes<sup>7</sup> at organisation and department level to reduce unwarranted variation, improve patient flow and increase productive direct patient care time. Increasing productivity in healthcare is often based on lean methodologies that eliminate waste and promote activities that ‘add value’ – for example, the Virginia Mason Production System (NHS Improvement and Virginia Mason Institute).<sup>8</sup>

Productive working in UEC can be supported by:

- managing the patient’s care experience effectively through the department, recognising this is inextricably linked to the effective functioning of the wider organisation and beyond
- efficient layout of the department (Department of Health 2013)
- co-location of services, minimising transfer times
- shared multiprofessional documentation to avoid duplicating information
- using technology appropriately.

Pressures across the health and social care system can have an adverse impact on the flow of patients through UEC settings. A whole-system approach across health and social care is needed to ensure resources are used to best effect, including admission avoidance, effective discharge planning and robust escalation plans. There is a direct relationship between time spent in the ED and mortality for both admitted and non-admitted patients. This increased mortality is seen in the month

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<sup>7</sup> Annually or more frequently where there have been changes to services.

<sup>8</sup> Five NHS trusts are part of a five-year partnership with Virginia Mason Institute to develop a ‘lean’ culture of continuous improvement that puts patients first.

<https://improvement.nhs.uk/resources/virginia-mason-institute>

after attending the ED (Richardson 2006, Guttman et al 2011, Plunkett et al 2011, Hong et al 2013).

## 4.2. Efficient deployment and flexibility

Factors to consider when rostering clinical staff include:

- in-charge capability/competence
- skill/band mix
- paediatric or mental health experience
- profile of patient activity
- local events that may increase activity
- seasonal demand.

The [Carter report](#) (2016) recommends using electronic rostering systems for effective staff utilisation.

Best practice guidance for effective e-rostering is available from [NHS Employers](#) and the Carter report.

### Flexible working

Flexible working in UEC is essential to meet patient care needs. Flexible working options suit many nurses and are important for retaining them. The benefits of flexible working include recruiting and retaining the best staff, and reducing absenteeism and work-related stress (Royal College of Nursing [Flexible working advice guide](#)).

Examples of flexible working practices include:

- part-time working
- flexitime
- compressed hours
- annualised hours
- job sharing
- term-time contracts
- self-rostering

- range of shift patterns
- flexible retirement schemes.

Follow [NHS Employers' guidance](#) when developing opportunities for flexible working. Plan shifts with [best practice principles](#) in mind. The RCN (2012) has published guidance on the occupational health and safety of shift work. Many trusts vary the length of shifts to accommodate patient need and staff preferences, and because reduced handover periods may be more efficient. But longer shifts may be less efficient. Managers planning rosters should organise shift patterns to reduce cumulative fatigue and maximise recovery time (Dall'Ora and Griffiths 2016). This is important as fatigue can lead to errors as well as lost efficiency. The RCN (2012) has published [guidance on the occupational health and safety of shift work](#). NHS England has published additional research on [12-hour shift patterns among registered nurses and healthcare support workers](#).

Using twilight shifts in UEC may enable you to align the workforce more closely with patient demand.

### **Staff deployment**

UEC establishments need capacity to respond to peaks in patient demand or unanticipated staffing shortages. Capacity can be increased with overtime, temporary staffing and dedicated 'float pools' of staff to be deployed where demand is greatest. Float staff may be deployed in a 'home' ward or department, and redeployed when required. There is no clear evidence on the relative effectiveness of different staffing policies. Policies that lead to frequent deployment of agency staff are likely to incur significant expense.

### **Rest breaks**

Local policies for managing rest periods must meet working-time regulations. Staff should take breaks during the shift rather than at the beginning or end of a shift. This reduces risks of fatigue and errors while safeguarding staff health and wellbeing. It is

important to remember that adequate rest and refreshment facilities should be provided and time to get to them should be allowed.

### **4.3. Minimising agency staffing**

#### **Flexible use of establishment**

Temporary staff are a valued part of the workforce and, when correctly trained and inducted into an organisation, can be a useful contingency for filling anticipated and unanticipated staff shortages. However, they should be recruited from in-house staffing banks. Only if this is impossible should you approach a framework agency (NHS Improvement 2015, updated 2017). Reliance on high levels of agency staff is unlikely to be effective or sustainable.

#### **Escalation processes**

Despite best planning, patient care demands will exceed planned staffing levels at times. Organisations should have a protocol for frontline staff to escalate concerns about the safety and effectiveness of care to a senior level.

## 5. Measure and improve

Trusts should collect departmental and organisation-level metrics to monitor the impact of staffing levels on patient care and outcomes, on the use of resources and on staff themselves. The aim is to continuously improve patient outcomes and use of resources in a culture of engagement and learning.

Evidence-informed metrics for UEC may focus on:

- patient outcomes (eg falls in the UEC department; pressure ulcers, healthcare-acquired infections or Serious Incidents where local investigation suggests these arose from care given in the UEC department)
- patient and staff experience (eg Friends and Family Test and complaints)
- staffing data (eg appraisal; retention; vacancy; sickness/absence)
- process measures (eg time to initial assessment; time to decision within the ED; time to specialist assessment – for example, timeliness of comprehensive geriatric assessment for frail older patients or patients on an admitted pathway; timeliness of constructing a definitive case management plan; time to treatment; time to analgesia; time left without being seen; four-hour standard; total time spent in the ED; unplanned re-attendance/re-admission rates; sepsis bundle; hand hygiene; documentation standards)
- training and education (eg mandatory training, clinical training).

These metrics should be reviewed as measures of improvement to inform safe and sustainable staffing decisions. But be careful when focusing on timeliness of assessments and treatments for particular patient groups that this does not delay care or result in unintended consequences for other patient groups.

### 5.1. Measure patient outcomes, people productivity and sustainability

Trusts should have a local quality dashboard for safe and sustainable staffing that includes department-level data to support decision-making and inform assurance. This should be reviewed monthly and take account of the budgeted establishment

and expenditure to date, including temporary staffing. It is essential to interpret metrics at department level. Learning lessons to improve the quality and safety of patient care is a prime function of the dashboard review. It is also important to understand metrics on a pathway basis, where harm can occur at different stages. For example, patient safety thermometer data on pressure ulcers and infections cannot always be easily attributed to one professional group's actions or omissions. Monitoring a range of information is critical to creating a feedback loop that helps you understand whether staffing is effectively meeting patient care needs. This monitoring enables continuous improvement not only in outcomes, but in using limited resources more effectively.

Interpreting any metrics at departmental level can be challenging. Staffing data can usually be directly linked to a ward or department, and processes (such as rounding, taking observations or administering medication) can also be effectively monitored by ward or department. However, patient pathways will typically include more than one ward or department, and it is often not possible to link outcomes directly to a single ward or department.

It is important to identify aspects of quality that are linked to safe staffing in UEC. In their evidence review of nurse staffing in Type 1 EDs (consultant-led, 24-hour EDs with resuscitation facilities), Recí-Saucedo et al (2015) identified several outcomes that may be associated with nurse staffing levels. It appears that nurse staffing levels in EDs are associated with patients leaving before being seen, care time and patient satisfaction – lower staffing being associated with worse outcomes. There was no strong evidence that nurse staffing levels affect waiting times, medication errors or ambulance diversions.

Recí-Saucedo et al (2015) also identified organisation-level factors from the literature. Longer lengths of stay in EDs were associated with increased hospital occupancy and additional admissions from EDs to the wards and critical care units. Increased medical and nurse staffing and bed capacity in a hospital were associated with a reduction in waiting time.

*Leading change, adding value: a framework for nursing, midwifery and care staff* (NHS England 2016) was co-produced and endorsed system-wide. It can help



achieve the ‘triple aim’ of better outcomes, better patient and staff experience, and better use of resources. It can also empower local leaders to improve quality in their own areas. Commitment 9 is to “have the right staff in the right places and at the right time”. Commitment 6 states “better staff health and wellbeing are associated with improved outcomes and experience for patients”.

## 5.2. Report, investigate and act on incidents

Trusts should follow best practice guidance when investigating patient safety incidents, including [root cause analysis](#) for [Serious Incidents](#)<sup>9</sup>.

As part of this systematic approach, organisations should consider staff capacity and capability, and act on any issues and contributing factors they identify.

Trusts should consider reports of incidents, where a patient was or could have been harmed,<sup>10</sup> as part of the risk management of patient safety incidents. They must review incidents alongside other data sources, including local quality improvement data (eg for omitted medication),<sup>11</sup> clinical audits<sup>12</sup> or locally agreed monitoring information, such as delays or omissions of planned care.

Trusts should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff lead to, or seems highly likely to have led to, a patient being harmed. Professional judgements must be made about patient need and staff resources, including skills, to meet that need. You should consider these locally reported incidents as patient safety incidents rather than solely staff safety incidents, and routinely upload them to the National Reporting and Learning System.

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<sup>9</sup> <https://improvement.nhs.uk/resources/serious-incident-framework/>

<sup>10</sup> <https://www.england.nhs.uk/patientsafety/report-patient-safety/>

<sup>11</sup> [https://www.safetythermometer.nhs.uk/index.php?option=com\\_content&view=article&id=3&Itemid=10](https://www.safetythermometer.nhs.uk/index.php?option=com_content&view=article&id=3&Itemid=10)

<sup>12</sup> <http://www.hqip.org.uk/national-programmes/>

Staff in all care settings should be aware they have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider they may be at risk (NMC 2013, updated 2015). Policies should [support staff who raise concerns](#) as and when they arise.

### 5.3. Patient, carer and staff feedback

The views of patients, carers and staff can give vital insights into staffing capacity, capability and morale – for example, through national and local surveys, patient or staff stories, complaints and compliments. You should consider findings from incident and Serious Incident investigations alongside the suggested list of quality indicators (in Section 5), so you can rapidly identify and act on the nature and causes of any issues. Some national and local surveys include questions with direct or indirect bearing on staffing (for example, asking patients if they think there were enough staff to meet their needs, and whether they had to wait for call bells to be answered, etc), but wider feedback on the overall experience of receiving or delivering care is also likely to be affected by staffing.

The Health and Safety Executive [management standards indicator tool](#)<sup>13</sup> may help in assessing and managing work-related stress.

Organisations need to take note of feedback from regulators, arm's length bodies and patient organisations, and agree, through their governance processes, their formal action in response.

Feedback may arise from:

- Care Quality Commission inspections
- Health Education England quality visits<sup>14</sup>
- NHS Improvement diagnostic reviews
- clinical commissioning group reviews
- Royal College of Emergency Medicine inspections
- Healthwatch ED visits

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<sup>13</sup> <http://www.hse.gov.uk/stress/standards/downloads.htm>

<sup>14</sup> HEE quality framework

[https://hee.nhs.uk/sites/default/files/documents/HEE\\_J000584\\_QualityFramework\\_FINAL\\_WEB.pdf](https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf)

- Emergency Care Improvement Programme acute walkthroughs and whole-system enquiries.

## **Culture**

Do not underestimate the importance of the organisation's and the department's culture. Consideration of and a strategic approach to culture will help staff to continually improve and redesign services, and to reduce factors associated with low morale such as increased sickness absence and bullying.

The NHS staff survey provides feedback to organisations on the morale and wellbeing of staff, and can be used to highlight areas of good practice and areas for development. Boards and the wider leadership in organisations have a fundamental part to play in creating a culture in which safe, high quality care can flourish, and should seek to continuously strive to bring about improvement and spread best practice.

NHS Improvement has co-designed a [culture and leadership programme](#) in partnership with The King's Fund. It utilises staff survey data to help organisations take a strategic approach to the ongoing development of their organisational cultures. The programme provides practical support to help trusts diagnose their cultural issues, develop collective leadership strategies to address them and implement any necessary changes.

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## 8. Stakeholder list

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Sir Robert Francis QC		
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