**National Institute for Health and Care Excellence**

**NICE guideline: Management and organisational approaches to safe staffing**

**Scoping workshop notes**

Conway meeting room, NICE offices, 10 Spring Gardens, London

**16/04/2015 14:30 – 16:30**

Attendees included representatives from the following stakeholder organisations:

- Association of District Nurse Educators
- Blackburn with Darwen CCG
- Department of Health Workforce Capacity & Information
- East and North Hertfordshire NHS Trust
- NHS Employers
- NHS Trust Development Authority
- Nuffield Department of Population Health
- Royal College of Nursing
- Royal College of Physicians
- UNISON

Apologies from:

- Kent Community Health Trust
- Monitor

The two hour stakeholder workshop consisted of a short introduction to the Safe Staff programme and to the management and organisational approaches to safe staffing draft scope followed by a structured discussion. The discussion was designed to answer key areas of the scope and to provide opportunity for discussion on any other relevant issues.

Below is a brief summary of the issues discussed and any consensus reached:

**Q1) Are the groups to be covered in section 1.1 of the scope appropriate?**

Attendees asked for clarification of who the guidance is aimed at to help clarify if it is aimed only at executive management teams making organisation-level decisions or if it should 'filter down' to operational managers making staffing decisions that affect frontline service delivery.

The group agreed that safe staffing is ultimately the responsibility of an organisation's board and the guidance should be aimed primarily at board members and any senior management staff to whom the board has delegated responsibility.

The group also discussed if the groups listed in section 1.1 could be expanded to take account of local government organisations who may also be responsible for commissioning NHS services. For example, should elected members and cabinet members be considered responsible for the safe staffing of NHS services commissioned by local authorities?

**Q2) Are the settings to be covered in section 1.2 of the scope appropriate?**

The group discussed the staff groups covered within section 1.2. NICE clarified the draft scope is intended to include all registered and non-registered nursing and midwifery staff (including healthcare assistants and maternity support workers).

The group felt the scope should be made more explicit that this guideline would not cover safe staffing for the wider multidisciplinary team (MDT) within which nurses and midwives operate.

The group discussed if the scope should be extended to cover NHS care delivered in the following settings:

- Prisons and other custodial settings
- Schools
- Care for homeless people

A number of the attendees questioned whether it was feasible to produce guidance for such a diverse range of organisations and settings. However, the majority of the group did agree that a guideline in this area would be useful and would support the implementation of the other safe staffing guidelines.

**Q3 and 4) What are the key management and organisational issues in relation to safe nursing and midwifery staffing? Are the key areas to be included and excluded in section 1.3 of the scope appropriate?**

The group felt the areas to be included and excluded under section 1.3 were generally appropriate.

The group suggested the following for inclusion in the scope:

- Workload allocation and how is nursing work allocated to ensure safe outcomes (Examples include team nursing and task allocation)
- The term 'flexible working' should be defined. A distinction should be made between organisational staffing flexibility (i.e. an organisation's use of temporary bank & agency staff) and the flexible working application process available to individual employees.
- Temporary staffing is important and approaches for management, supervision and induction of temporary staff should be considered
- A distinction should be made clear between national and local workforce planning.
- Organisational approaches described in section 1.3 should be expanded to include development programmes

Attendees gave some examples of management/organisational approaches they were aware of:

- Keogh 'safety fellows'
- Patient safety collaboratives

The group also suggested that the following themes could be considered when developing the evidence review and guideline:

- Safety
- Empowerment
- Culture
- Leadership
- Engagement
- Involvement of service users
- Competency programmes

It was highlighted that the evidence base for a lot of leadership programmes is weak. The group suggested that the specific example of MAGNET in the draft scope should be

removed as this is an accreditation programme, not an organisational improvement programme.

The group discussed what terms like 'organisational culture' meant to them. Examples included:

- 'What happens when no one is looking'
- 'The way things are done around here'
- Norms
- Ways of working
- Regular working practices

The group also felt the guideline shouldn't prescribe a culture but rather tell organisations how to approach, assess and review their culture.

**Q5) Are the review questions in section 1.5 of the scope appropriate?**

The group felt the review questions were appropriate. The group agreed the suggested cut-off date of 1988 and the proposed country restrictions for literature searches were appropriate. There was some discussion regarding the nature of the evidence base. Attendees highlighted the importance of including evidence that demonstrates how organisational/management approaches may intervene to impact on safe staffing rather than only identifying an association between certain approaches and a range of outcomes. There is a lot of evidence showing associations between 'good' hospitals and 'good' outcomes but the literature doesn't 'tell you how to get there'.

There was discussion regarding whether literature from outside healthcare settings should be considered within the scope of the evidence review for this topic. It was suggested that management/organisational approaches from other acute safety industries (e.g. oil & gas industry, aviation) may be useful for NHS settings. However there was concern about how outcomes from the non-health literature could be linked to safe staffing for nurses and midwives and whether the findings from such studies would be transferable to NHS settings. The group therefore suggested that it would be useful to focus the evidence review on interventions which had been delivered in healthcare settings rather than include a large body of studies which had only been delivered in a non-healthcare setting.

**Q6) Are the key outcomes in section 1.6 appropriate?**

Attendees discussed if poor/unsafe care is a measurable metric.

Attendees discussed if any more 'positive' outcomes could be added to the current list in section 1.6. The group also felt that some of the safety outcomes were only really relevant for inpatient settings and suggested the list should be expanded to take account of outcomes from the other settings covered by this guideline (e.g. community settings).

The group discussed if there was an over-reliance on harm-based outcomes (e.g. serious untoward incident (SUIs)) as these events tend to be relatively rare and therefore may present difficulties when statistically analysing data. The group discussed that SUIs/never events generally tend to be multifactorial and not necessarily an outcome that can be directly linked to nurse/midwifery staffing alone.

The group suggested the following as additional outcomes to be included as examples under section 1.6:

- Length of stay
- Re-admission rates
- (Routine/regular) unpaid overtime

- Missed breaks
- Leaver rates
- Vacancy rates
- Use and spend on bank/agency staff

**Q7) Is there anything that could be removed from the guideline scope?**

The group did not suggest any areas for removal from the guideline scope.

**Q8) Are there any other issues, not previously raised, that need to be considered?**

Attendees mentioned a number of academics/organisations/data sources whose work may inform the guideline:

- Virginia Mason
- Michael West
- The Picker Institute holds staff satisfaction data and may be able to provide advice about appropriate outcomes (even if their data are not published)
- Reporting of Injuries, Disease and Dangerous Occurrences (RIDDOR)

NICE explained to attendees that a call for evidence could be issued during the course of guideline development if required.

**Q9) Do you think this scope could be changed to better promote equality of opportunity relating to age, disability, gender, gender identity, ethnicity, religion and belief, sexual orientation or socio-economic status?**

The group felt no specific changes were required although attendees made reference to a body of literature identifying better outcomes in settings where the socio-demographic profile of the nursing workforce more closely reflects the profile of the patient population it serves.

**Q10) 2 topic specialist SSAC roles were advertised as part of the first round of recruitment but only 1 of these have been filled – workforce/academic expert). What other topic specialist's roles would be useful to join the SSAC (we are looking to recruit another 4 topic specialists, 1 of which is usually a lay member)?**

The group felt it would be important to include the following roles in the committee:

- HR Director (or equivalent)
- A regulator
- Another academic/workforce expert