NICE National Institute for Health and Care Excellence

Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
1	Allocate Software plc	16	250	1.2.10	Potential confusion between establishment / baseline analysis and specific day-to-day analysis. Due to the wording of 'Stage 1: Estimate total nursing requirement to deliver patient care needs throughout a 24-hour Period' in line 250 there might be some confusion that this Stage is to determine the staffing requirements for an individual specific day (which is covered in Stage 3), when actually this is about determining the staffing needs for a baseline day (used to determine establishment and baseline staffing levels).	Thank you for your comment. The guideline has been amended to separate the process of setting the establishment and assessment on-the-day.
2	Allocate Software plc	27	469	5	Section 5 Glossary describes the use of the term 'staffing toolkit' as 'A practical resource to help calculate the staffing requirements for wards or organisations. They may be electronic or paper based.' Ultimately we believe this is describing three things not one: 1) 'Approach' or 'methodology' i.e. the heart of the guideline process covering organisational strategy, Ward level factors and approach to determining daily nursing staff requirements, monitoring and evaluating ward nursing staff establishment 2) 'Evidence based model' – these is the intelligence,	Thank you for your comment. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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					calculations and models currently referred to as 'evidence based tools' i.e. what patient classification / associated care requirements feed into the approach. 3) 'Tool' – a way to systemise the above. This could be a spreadsheet, existing software or alternative. The key thing is that it allows the methodology and model to be applied. By way of example our customers will want to use our 'tool' to apply the guideline 'Approach' by applying the endorsed 'evidence based model'. They will want to do this across multiple safe staffing guidelines 'approaches' using various endorsed 'evidence based models' (e.g. different models for different specialties) thus allowing them to use one 'tool' across the Trust. For example the following sections use the work 'tool' or 'toolkit'. In most cases they seem to describe more a 'model' as above, rather than a model-agnostic 'tool' that can automate and drive the process, and provide visibility to the necessary roles across the organisation: Line 251 - Calculate average nursing need of the ward's patients. This should be measured using a staffing toolkit	

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3	Allocate Software plc	28	501	5	The table that translates nurse:patient ratios into NHPPD requires some caution, depending on how these figures are to be used. Whilst this translation is correct in terms of hands-on nursing time, the amount of nurse hours that need to be rostered to deliver this will be different. E.g. in order to roster to a permanent 1:1 ratio you might require 25.5 Nursing Hours rostered, to cover for shift handovers, rather than 24 hours as per the table.	Thank you for your comment. The guideline has been amended in light of your comment.
4	Allocate Software plc	37	687	Appendix 1	We believe there is confusion over the word 'tool' or 'toolkit' that is used to mean slightly different things. We have already experienced this confusion and believe that if the word 'Tool' is misinterpreted this will lead to a misunderstanding of what the upcoming NICE toolkit endorsement is to cover, and potential for Trusts to stall their adoption of tools to streamline and ensure their safe staffing processes	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have amended the guideline in light of your comment to clarify that this process could be facilitated by using a NICE endorsed decision support toolkit. We have added a link to a separate webpage on the NICE website that will contain

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						information regarding the endorsement process of decision support toolkits.
5	Allocate Software plc	37	687	Appendix 1	Appendix section 1.2 - The Committee wished to acknowledge that few tools have been tested to check their validity and that robustness of the development of a tool is different to the validity of the tool in use. Tools therefore have some internal validity, but there is a need to measure the impact of using the tool. The evidence is limited on the effectiveness of the impact of tools for organisations or healthcare systems. The Committee agreed that tools should include patient input as part of the process of planning and assessment of care and feedback as part of indicators.	Thank you for your comment.
6	Allocate Software plc	60	713	Appendix 1	The Committee wished to acknowledge the need for a compromise between subjectivity of informed professional judgement compared to the objectivity of a staffing tool. They agreed there will always be a place for informed judgement to improve the accuracy of estimates and to deal with variability and problems meeting the required staffing: 713 - The Committee wished to acknowledge the need for a compromise between subjectivity of informed professional judgement compared to the objectivity of a	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					staffing tool. 722 - Many of the calculations could be supported by a NICE endorsed staffing toolkit. 727 - On the same day, the average nursing needs of the patients that were being treated on the ward was determined to be 6.08 nursing hours per patient day using a NICE endorsed staffing toolkit. We believe that there would be less confusion if the distinction between an 'evidence based model' (which is what it appears NICE will be endorsing) and a 'tool' (a software product (ranging from spreadsheets to tailored software like Allocate's 'SafeCare) that implement the desired model but aren't fixed to one - and we believe are not intended to be endorsed by NICE) would be greatly beneficial and reduce ongoing confusion.	
7	Betsi Cadwaladr University Health Board	3	1	Introduction	1. It is unclear if the documentation is intended for use in Wales, if so then reference needs to be made to Welsh Government Strategies/Standards. The Chief Nursing Officer for Wales introduced guidelines for Nurse Staffing in Acute Medical and Surgical wards in 2012. Has NICE considered these guidelines as I cannot see any reference	Thank you for your comment. We have added a link to the introduction to the guideline that will detail the applicability of this guideline across the United Kingdom.

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					to this all Wales work. 2. The flow chart on page 8 needs to make reference to acuity and dependency	
8	Betsi Cadwaladr University Health Board	8	119	1.1.2	Is this achievable in areas where there is a high number of patients sleeping out i.e. on a Gynae ward where you may have 8 medical patients, these patients need far more care	Thank you for your comment. The guideline goes into great detail to recommend that the needs of all patients are taken into account. Safe staffing needs to be about working out what number and skill level of nursing staff meets patient needs on a particular ward at a particular time.
9	Betsi Cadwaladr University Health Board	9	134	1.1.5	If we are to ensure for unplanned care then we need to consider this in the budget setting this section is unclear and open to interpretation – surely flexibility needs to be built into budget e.g. headroom	Thank you for your comment. The guideline has been amended in light of your comment where possible, including adding further detail of some of the ways in which flexibility of the nursing staff across an organisation could be achieved.
10	Betsi Cadwaladr University Health Board	9	148	1.1.7	Looking at establishments and adjusting bi annually is this realistic as recruitment takes so long	Thank you for your comment which was considered by the Safe Staffing Advisory Committee. This section of the guideline has been

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						amended.
11	Betsi Cadwaladr University Health Board	10	150	1.1.8	This is very difficult as we tend to staff our wards with the minimal standard, when workload increases due to a higher volume of patients sleeping out, patient flow is affected and then staff spend more time completing transfer and discharge paperwork	Thank you for your comment and support for this guideline.
12	Betsi Cadwaladr University Health Board	10	159	1.1.9	Placing patients in the wards that best meet their needs – in the UK we evidently need more medical beds as care in community settings is not up to standard to deal with the capacity of patients, therefore acute settings have many medical patients who get seen at the end of the medical ward rounds as they are not on the wards, acute workload and referral to treatment times are generally affected as theatre list are cancelled to accommodate excess patients	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
13	Betsi Cadwaladr University Health Board	10	176	1.2.1	Acuity and dependency models are not referenced – Wales has moved to an all wales acute medical and surgical ward tool. Scotland also uses acuity tools. Document does not really refer to this method of triangulating with other evidence	Thank you for your comment. The guideline is aimed to encompass all patient factors that are likely to influence nursing staff requirements. We have amended the guideline text to state that patient nursing needs would include both patient acuity and patient dependency.

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14	Betsi Cadwaladr University Health Board	11	190	1.2.4	As above what about acuity and dependence modelling – there are systems that capture on a daily basis or can be used to inform budget setting.	Thank you for your comment. The guideline is aimed to encompass all patient factors that are likely to influence nursing staff requirements. We have amended the guideline text to outline that patient nursing needs would include both patient acuity and patient dependency. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain all the information regarding the endorsement process of decision support toolkits.
15	Betsi Cadwaladr University Health Board	11	199	1.2.5	This is subjective – how are staff measuring what is 1:1 - are the tables on page 12 and 13 taking into account a validated acuity and dependency tool e.g. AUKUH.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this

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						guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
16	Betsi Cadwaladr University Health Board	13	205	1.2.6	Estimated patient turnover, how are we going to address these issues when we have to make so many cost savings, all wards are struggling with patient flow, unless health boards are given the funds to run hospitals and the maximum potential and not the minimum standards this is not achievable. How will this be captured?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee, however this falls outside of the parameters of the scope of this guideline.
17	Betsi Cadwaladr University Health Board	13	217	1.2.7	Staffing needs to be sufficient to enable these aspects to be completed. Nursing staff do not have protected time for supervision and mentoring. Support from AHPs etc. – what does this mean – counted in the numbers as these roles and functions are spate to nursing provision of care.	Thank you for your comment. Section 1.2 has been amended in light of your comment.
18	Betsi Cadwaladr University Health Board	15	237	1.2.9	Elements of flow chart subjective & how will it be captured – what about utilising a validated acuity tool to determine nurse staffing levels.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website

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						that will contain information regarding the endorsement process of decision support toolkits.
19	Betsi Cadwaladr University Health Board	17	290	1.2.17	What uplift is recommended – varies from 20% to 26% - this will be left open to variation in application unless recommended uplift agreed. Needs to take into account required mandatory and professional development, also take into account impact of resource implications of revalidation	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
20	Betsi Cadwaladr University Health Board	18	311	1.2.21	How is this going to be achievable? Are you going to have a pool of staff each day that are going to be disseminated to the areas that the need is greatest? The UK needs to stop staffing ward with the minimum requirement	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.

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21	Betsi Cadwaladr University Health Board	18	314	1.2.22	Agree need to keep records but how is this going to be captured, by whom – what system DATIX, e rostering system.	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.
22	Betsi Cadwaladr University Health Board	19	328	1.3	Needs to include support with nutrition, hydration	Thank you for your comment. The nursing red flags have been amended in light of your comment.
23	Betsi Cadwaladr University Health Board	19	328	1.3	Safety thermometer not used in Wales – needs to reference all wales dashboard and care metrics. HAPU – classification is different in Wales.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
24	Betsi Cadwaladr University Health Board	20	334	1.3.3	Is this realistically achievable? Health Boards are already over spent and we are only in month 3, matrons are tasked with making costs savings on a monthly basis, the NHS is greatly underfunded in the UK Agree that staffing should be set at a safe nurse to patient ratio to provide high standards of care. Where will the registered nursing staff come from? If there is a shortfall,	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee, however this falls outside of the parameters of the scope of this guideline.

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					how will care safely be provided and the gap addressed. Are the UK facing a national shortage of nurses. Need to consider other roles	
25	Betsi Cadwaladr University Health Board	General comment	General comment	general comment	1. The document is long, repetitious and is not presented in an easily readable format. In practice are front line staff going to have time to read and apply the principles. 2. The Whole document is difficult to read and identifies nurses as machinists who work in a factory of healthcare. I am shocked but not surprised that holistic nursing care is still seen / measured / valued in this way. If patient care is to be measured in minutes why are doctors not appointed in the same way it would actually be easier to measure the amount of time they spend with patients. 3. I expect most busy nurse managers would have great difficulty putting any of it into practice but perhaps that is the intention, how do we measure the time spent thinking and analysing the evidence for care provision or the worry and stress that nurses take home every day when they are not able to care for people in the way that they know they should. 4. I suggest that minimum staffing levels is a safer and appropriate way to approach this based upon the number of people /beds and number of nurses available to take care of them. Everything in this guidance is unpredictable	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. A number of revisions have now been made to the document.

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					in everyday practice and therefore unsafe. 5. Agree that budgets need sign off by designated senior nursing operational manager & director of nursing	
26	Betsi Cadwaladr University Health Board	General comment	General comment	general comment	Agree with the recommendations set out in this document as ensuring that patients have the care that they require is paramount, however as a health board we have to be realistic and ask how achievable this is with all the bed pressures that we see across the board. If we are unable to demonstrate that we comply with the standards set out in this document how is this going to affect the health board? No reference to work in Wales guidelines for nurse staffing, all wales acuity and dependency and Scottish workforce work on acuity and dependency that are much advanced. What learning can be derived from Scottish application of acuity tools Nursing staffing establishment – what about actual establishments which differs from funded?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. We have now inserted a link to a website page which will provide further information about NICE's toolkit endorsement programme.
27	BIRTHRATE PLUS Consultancy	13	221	1.2.7	Extra hours for other duties assessed by professional judgement as 5.6 hours: Our experience of working with maternity wards suggests that another way of allowing for this work and it variability is that ward leader/ co-ordinator should not be counted as extra to the staffing based on patient need during day shifts.	Thank you for your comment. The guideline does not stipulate a specific number of extra hours for this. The example previously included in Appendix 2 was meant to be an example to

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						illustrate the processes and calculations, not to recommend specific numbers.
28	BIRTHRATE PLUS Consultancy	28	506	5	Skill mix; No mention made of student nurses on ward and how they are accounted for . As RNs time is also taken in supervising /mentoring students this is a factor to be considered. Our experiences has been in UK to regards student midwives as supernumerary and that their contribution to patient care off-sets the time RNs spend in mentoring etc. In Eire a method was agreed by professional judgement to allocate a % of student time to ward roster in relation to their level of skill/experience	Thank you for your comment. The guideline has been amended in light of your comment.
29	BIRTHRATE PLUS Consultancy	72	727	Appendix 2	1620 hours per annum. Our experience suggests that this is high. There is variation in allowances across health trusts and in our work in 100 services this varied from18 - 25%.	Thank you for your comment. Appendix 2 in the draft version was clearly labelled as an example scenario and the numbers used were not intended to represent any recommended figures. The numbers used were to only illustrate the various steps of the process that were described in the recommendations section of the guideline. We have amended the

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						text in this text to further illustrate that this is an example.
30	BIRTHRATE PLUS Consultancy	General Comment	General Comment	General Comment	Very impressed comprehensive review of multiple factors affecting nursing needs	Thank you for your comment and support for this guideline.
31	Bournemouth University	3	1	Introduction	The term 'Nursing' should be distinguished between registered or qualified nursing staff and unqualified. The guidance is not as clear as it could be regarding the need for registered nurses and the link between improved/better patient outcomes.	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
32	Bournemouth University	3	16	Introduction	We recommend that the term nursing should refer to registered nurses only. There is evidence to show that if cared for by graduate registered nurses chances of survival and better outcomes of care are increased. (Aiken et al 2014 The Lancet. (online))	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
33	Bournemouth University	3	18	Introduction	Suggest a process to determine non nursing or non-direct care given by registered nurses is undertaken as registered nurses distracted by non-nursing tasks is a risk to patient safety over and above a numerical number.	Thank you for your comment. We have added detail to emphasise that nursing activity not related to direct patient care should be fully taken into account when

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						determining nursing staff requirements.
34	Bournemouth University	3	24	Introduction	As this is guidance there is a strong possibility NHS organisations, managers will use it as a maximum	Thank you for your comment.
35	Bournemouth University	7	94	1	We would suggest that further research is undertaken as in California the recommendation is 1:5 nurses to patients. The evidence to support the suggested staffing levels is not clear in the document. The recommendation should be clearer in determining the levels of acuity staffing is dependent on. To quantify nursing numbers is not sufficient on its own. Whilst this may help some areas, the focus on the target number itself may distract from further research required on local 'nuances' that impact on safe care when the ward area is on 'target' for example, a 1:8 staffing level.	Thank you for your comment. The guideline now contains completed gaps in the evidence and research recommendations sections to address these issues.
36	Bournemouth University	8	119	1.1.2	As this is guidance there is an opportunity for Managers and Boards to negotiate down the staffing required and proposed by clinical leaders, this is a very frequent occurrence in practice. Middle managers take long protracted periods of time negotiating between front line clinical leaders up to the senior executive level in order to seek agreement about funding for staffing.	Thank you for your comment. Although NICE clinical guidelines are not mandatory, the NHS is obliged to have regard to them in planning and service delivery as part of a general duty to deliver high quality care that meets patients' needs.

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37	Bournemouth University	9	136	1.1.5	Should be clearly defined as in practice staffing is taken from one area to support another, without being replaced leaving the original clinical area short of staff.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising nursing staff levels on one ward for other wards.
38	Bournemouth University	9	146	1.1.7	This should be a minimum of twice a year. Suggest quarterly.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
39	Bournemouth University	9	148	1.1.7	There is a timeliness issue as managerial processes are slow and protracted and often unresponsive when negotiating staffing levels. These need to be more efficiently conducted, in a timely way, with adequate and timely feedback to clinical leaders on decisions being made, when and how funding will be increased in budgets, or extra staff can be brought in when required.	Thank you for your comment. The guideline contains a number of recommendations that address the organisational strategy related to staff requirements.
40	Bournemouth University	13	217	1.2.7	Include supervision of transient staff for example, staff unfamiliar with the ward who are from another clinical area and agency staff. Important factors are the supervision of nursing students in practice. NHS organisations are often amalgamating wards or opening up temporary wards to cope with demand, changing nursing staffing and moving staff between during	Thank you for your comment. Section 1.2 has been amended in light of your comment.

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					these times, need to consider the time required qualified nurses require familiarise themselves with new and changed environment.	
41	Bournemouth University	14	237	1.2.9	How will the length of shifts e.g. 12 hour shifts, peaks and troughs in levels be maintained and the different grades of staff monitored against patient dependency and acuity? This is not clear and should be included.	Thank you for your comment. The guideline makes detailed recommendations to determine nursing staff requirements throughout a 24 hours period to ensure that patient needs are adequately met over 24 hours.
42	British Geriatrics Society	General comment	general comment	general comment	This consultation document is a comprehensive and detailed review of the factors influencing, and the tools in which to address, the complexity of the nursing role, and that of determining the right level and skills required ensuring patient safety. It recognises - that it is not purely about the numbers of registered nurses available on a given time, it is about the competence, skills and experience of those nurses - the evidence base that demonstrates the higher number of registered nurses available to better the patient outcome - the types of ongoing essential nursing care activities that can change nursing staffing requirements - such as	Thank you for your comment and support for this guideline.

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					supporting patients eating and drinking, fluid management, hygiene, medication administration, mouth care, pressure area care and assistance to the toilet	
43	British Geriatrics Society	General comment	general comment	general comment	The descriptor of a "Nursing Red Flag event" is in line with other NHS early warning systems requiring escalation – and as such will be a familiar process for both nurses and other members of the clinical teams.	Thank you for your comment and support for this guideline.
44	British Geriatrics Society	General comment	general comment	general comment	It acknowledges the lack of robust UK research in identifying evidence.	Thank you for your comment and support for this guideline.
45	British Geriatrics Society	General comment	general comment	general comment	The nurse-patient ratio appears to be calculated on a nurse working an 8 hour shift. It is widespread practice in the NHS that many nurses in acute areas work a 12 hour shift. This factor does not appear to be acknowledged in the draft guideline.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has been revised.
46	British Geriatrics Society	General comment	general comment	general comment	The guidance emphasises that solely providing the number of nursing staff deemed to be required does not necessarily result in improved outcomes for patients. The quality of the delivery of patient care should be additionally monitored and improved to drive improvements (page 66 – quality of evidence)	Thank you for your comment and support for this guideline.
47	British Geriatrics	General comment	general comment	general comment	The guidance is a significant step towards ensuring the best care is provided to patients.	Thank you for your comment and support for this guideline.

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	Society					
48	British Thoracic Society	8	114	1.1	Respiratory patients requiring ventilatory support (non-invasive ventilation, tracheostomy management) are regularly cared for outside of traditional high dependency areas and on general wards. Patients with acute respiratory conditions (e.g. asthma, pneumothorax) require close observation as they can deteriorate very quickly. Measurement and documentation of the acuity of this group of high risk patients is essential and qualified staff levels should be reflected to ensure safe care and to prevent adverse incidents.	Thank you for your comment and support for this guideline. The guideline is aimed to encompass all patient factors that are likely to influence nursing staff requirements including ventilatory support and patients with acute respiratory conditions.
49	British Thoracic Society	10	158	1.1.9	Essential to have trained staff with respiratory skills and experience in caring for respiratory patients with complex needs e.g. management of tracheostomies, non-invasive ventilation, management of intercostal drains. Equally having an experienced nursing team, caring and nursing patients with disabling and distressing breathlessness, which is often deemed to be ‘basic nursing care’ is essential.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the recommendations are designed to cover patients with complex caring needs such as those related to respiratory conditions.
50	British Thoracic Society	11	187	1.2.3	Respiratory patients requiring ventilatory support (non-invasive ventilation, tracheostomy management e.g. suctioning) are regularly cared for outside of traditional high dependency areas, and on general wards. Patients with acute respiratory conditions (e.g. asthma,	Thank you for your comment. The guideline has been amended in light of your comment to include reference to this in Table 1.

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					pneumothorax) require close observation as can deteriorate very quickly. Measurement and documentation of the acuity of this group of high risk patients is essential and qualified staff levels should be reflected to ensure safe care and to prevent adverse incidents. Supporting relatives	
51	British Thoracic Society	12	202	1.2.5	Need to include ventilatory support (non-invasive ventilation, tracheostomy management e.g. suctioning) into the table to reflect the high care needs of this group of patients	Thank you for your comment. The guideline has been amended in light of your comment.
52	British Thoracic Society	18	305	1.2.19	Could include human errors e.g chest drain disconnect/ kinked resulting in tension pneumothorax, Also unexpected death, cardiac arrests Investigation of red flags	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee, however the suggested additions were felt to be too specific to recommend as nursing red flags for all acute adult inpatient wards. There is however scope for addition of more nursing red flags locally where this was felt necessary.
53	British Thoracic Society	42	698	Appendix 1	Respiratory patients deteriorate rapidly and therefore acuity of the ward can change quickly within a shift. Patients with high levels of respiratory care needs, are	Thank you for your comment. The guideline outlines the importance of regularly assessing staffing

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					often moved out of high dependency areas with little notice due to the demand on critical care beds	requirements because of changing patient needs.
54	Cambridge University Hospitals NHS Foundation Trust	9	122	1.1.2	Need to clarify: can be interpreted that the designated Board member needs to sign off the ward roster 'monthly' as they are posted monthly. Presume that it means when the budgeted shift coverage is agreed a minimum of twice yearly? Is the intention that the Chief Nurse would sign off roster as it is signposted?	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
55	Cambridge University Hospitals NHS Foundation Trust	9	133	1.1.5	There should be a reference to dying patients/end of life care (by end of life care this is 'the last year of life' which is the GMC definition 2010)	Thank you for your comment. The guideline has been amended in light of your comment where possible, including in section 1.2.
56	Cambridge University Hospitals NHS Foundation Trust	10	159	1.1.9	Placement of patients is often not ideal due to capacity demands. Patients may be moved the next day and skill mix is also not always ideal.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
57	Cambridge University Hospitals NHS	10	177	1.2.1	Communication with dying patients and their families in the last few hours/days of life (this can take a considerable time) , should be added; as should time for education.	Thank you for your comment. The guideline has been amended in light of your comment to include reference to this in Table 2.

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NICE National Institute for Health and Care Excellence

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Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
	Foundation Trust					
58	Cambridge University Hospitals NHS Foundation Trust	18	305	1.2.19	How should number of Nursing red flags be captured each day? Who would this be reported to? Shortfall of more than 8 hours – for a long day/night 1x Nurse down would be a red flag. This is too insensitive and crude. Nursing red flags should include dying patients ie last few hours/days of life	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
59	Cambridge University Hospitals NHS Foundation Trust	18	314	1.2.22	Red flag collection requires manual data collection unless an EPR system in place. Will be a bureaucratic exercise. Who will do this?	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.
60	Cambridge University Hospitals NHS Foundation Trust	20	334	1.3.3	Requirement of an evidence base for all areas eg those that require a lesser skill mix eg rehab? Is headroom/ non-patient facing time (study leave/annual leave/sickness) included?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and

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						detailed the considerations specific to developing individual recommendations in Appendix 1.
61	Cambridge University Hospitals NHS Foundation Trust	49	709	Appendix 1	This seems to be the only reference to end of life care – does it mean the last year of life? (Conversations about advance care planning can take a number of conversations and time.	Thank you for your comment. The guideline has been amended in light of your comment.
62	Cambridge University Hospitals NHS Foundation Trust	General comment	General comment	general comment	We need to make it clear that this will need to be done at key points (2 or 3 times per year) – for budgeting and planning of staff. Of course needs 'checking' periodically but needs advanced planning unless pools of staff are free in hospitals or easy access to bank/agency budgets.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has now been revised in light of your comment where possible.
63	Care Quality Commission	General comment	General comment	general comment	I think it's right to use a formula for assessing the needs of those requiring care and then matching the staff to meet those needs. This is preferable to a simple ratio of staff to patients which potentially endangers the flexibility which senior nurses use to move staff around. Fixing a ratio could lead to telling CQC when the magic number is breached, when in fact the staff levels are safe. There may also be times when the ratio is met but owing to high numbers of patients with complex needs, more staff are	Thank you for your comment and support for this guideline.

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					needed.	
64	Cerner Corporation	7	94	1	We agree with this recommendation. Nurse patient ratios should not be mandated due to the variability in acuity and dependence from patient to patient.	Thank you for your comment and support for this guideline.
65	Cerner Corporation	9	135	1.1.5	This could be more precise by referencing the variability in acuity or intensity within individual patients and therefore demand on nursing time during a stay, or within populations in a ward.	Thank you for your comment. The guideline has been amended in light of your comment.
66	Cerner Corporation	9	145	1.1.7	Patients have individual as opposed to average care needs. Monitoring and reviewing the staff establishments of individual wards "at least twice a year" lacks precision and is continuation of the status quo. There is an opportunity for the NHS to raise the bar. Consistent with the understanding that staffing does matter on every shift, there should be an expectation of understanding the acuity driven work load on every shift. Increasingly in other countries, and in the NHS, clinical documentation (tasks and assessments) from the electronic health record can be used to calculate individual care needs in a real time or near real time basis. These guidelines should move the NHS trusts toward better understanding of the variability in	Thank you for your comment. The guideline has been amended in light of your comment where possible.

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					acuity or intensity and the resulting demand on nursing time.	
67	Cerner Corporation	11	191	1.2.4	Professional judgment can be complemented by objective and reliable measures of acuity, intensity and nursing workload using the analysis of clinical documentation from the electronic health record.	Thank you for your comment.
68	Cerner Corporation	13	203	1.2.5	The listing of nursing care activities is heavy on activities of daily living and physiologic needs, and should be expanded to include behavioural health, perceived health – such as pain scales, and family interaction.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
69	Cerner Corporation	14	226	1.2.7	Plus support for junior medical staff	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
70	Cerner Corporation	14	239	1.2.9	Please specify qualified and/or non qualified staff	Thank you for your comment. Section 1.3 has been amended in light of your comment.
71	Cerner Corporation	15	248	1.2.9	Section 1 – Please specify qualified and/or non qualified staff	Thank you for your comment. Section 1.3 has been amended in light of your comment.

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72	Cerner Corporation	15	248	1.2.9	Section 2 - Does skill mix mean the education level, experience and competencies of the individual nurse?	Thank you for your comment. Section 1.3 has been amended in light of your comment. In addition there is an existing definition of skill mix in the glossary section.
73	Cerner Corporation	16	261	1.2.12	Agree that occupancy is a poor measure of nursing workload. Real time census used for a real time determination of needs is more precise than bed utilization.	Thank you for your comment and support for this guideline.
74	Cerner Corporation	18	305	1.2.19	The final bullet point (shortfall of 8 hours or 25%) seems too liberal when we know that staffing impacts patient morbidity and mortality. A shortfall of 8 hours is the point at which preventable patient harm has been linked to staffing. Guidance for the NHS should be tighter. If I am a patient on the ward, I am not OK with 24% short, and particularly if the target is calculated using the needs of average patients. Guidance should err on the side of patient and nurse safety and restrict these limits.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
75	Cerner Corporation	25	457	3	Peggy Jenkins work on costing of the nursing care of individuals by electronically matching the patient to the nurse in an integrated electronic patient record provides a foundation for understanding the patient level cost data.	Thank you for your comment. We shared this reference with our costing team who are undertaking the costing analysis which will

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					Jenkins, P., Welton, J. (2014) Measuring direct nursing cost per patient in the acute care setting. The Journal of Nursing Administration, 44(5), 257-262.	accompany the guideline.
76	Cerner Corporation	25	460	3	Suggested research questions: How do we link productivity measures to patient outcomes? What is the variability of patient acuity and nursing needs within and between patients on a ward? How do other countries measure acuity? What care model, or proportion of RNs, produces the best outcomes for a specific diagnosis or ward? How can we match the skill set of the individual nurse to the needs of the individual patient? What do other health roles contribute to patient outcomes and better utilisation of the workforce for direct care? What is the impact of technology on nursing staffing requirement? How does the 'future hospital' design and shift toward single rooms, affect quality of care and nurse workforce requirement?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
77	Cerner Corporation	71	726	Appendix 2	The entire document is thoughtful and aspirational to better care up to this point. The example of calculating patient care needs should be more specific to individual	Thank you for your comment and support for this guideline.

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					patient needs. Measures of individual acuity should be assessed throughout the day and as patient's condition and interventions change. In the not too distant future technology enabled acuity algorithms (which already exist) will continuously calculate by extrapolation of data acquired either automatically or as part of the normal care workflow to assess the risk and change in acuity and demand on nursing time. Measures of real time census and acknowledgement of the work and time associated with admissions, transfers and discharges would be preferable to average bed utilisation. The model would be stronger if there was acknowledgement of the team, for example, the different contributions of nurse and nurse assistant roles.	

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78	Chartered Society of Physiotherapy (CSP)	3	1	Introduction	The introduction identifies the immediate starting-point for the guideline's development; i.e. the Francis and follow-on reports. In doing this, it refers to the DH/NHS England request 'to develop evidence-based guidelines on safe and effective staffing'. However, the explanation then shifts to a specific focus on nursing staff levels, without an explanation as to the rationale for this. We understand this shift to be based on nurse staffing levels being perceived to be relatively straightforward to address, particularly within a hospital ward setting, and being of particular importance for ensuring that patients receive a baseline level of personal and compassionate care within this setting. It would be helpful for the rationale for the guideline's focus - whether it is as above or other reasons - to be made explicit in the guideline. The text should also acknowledge the many other members of multi-disciplinary team who together contribute to ensuring that patient care is safe, effective, timely and compassionate. We make this point in relation to our other comments in relation to lines 9 and 226-227.	Thank you for your comment. We have now added more detail from the scope document of the guideline to the introduction section to clarify what this guideline focuses on.

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79	Chartered Society of Physiotherapy (CSP)	3	9	Introduction	It is not clear whether the opening reference to the 2013 NQB report is an implicit endorsement of this publication and, more specifically, how the guideline picks up on particular expectations set out in the 2013 report. In particular, the NQB report explicitly acknowledges the role played by the multi-disciplinary team in ensuring good quality patient care. This is missing from the guideline (see also our comment in relation to lines 226-227). The NQB report also stresses the links between commissioning processes and ensuring sufficient, sustainable staffing levels for delivering good-quality care to patients, and the importance of factoring staffing levels requirements into future workforce planning processes. Neither of these issues is sufficiently acknowledged in the draft guideline. In light of the above points, it is not clear how the NICE guideline forms a progression from the NQB report. The acknowledgement of the lack of evidence to support the guideline (as expressed in Appendix 1) should be more overtly highlighted as a reason why such a progression from the NQB report's expectations cannot easily or robustly be made.	Thank you for your comment. We have reworded the introduction section to include a subsection to related documents and to explain that these documents should be read alongside this guideline.

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80	Chartered Society of Physiotherapy (CSP)	4	43	Introduction	It is not clear whether the planned endorsement process will only apply to toolkits relating to nursing staff requirements, or whether the scheme/endorsement mark, will have intended currency for tools developed for the wider workforce. It will be helpful for the planned parameters of the scheme to be clarified.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
81	Chartered Society of Physiotherapy (CSP)	6	63	Introduction	It is not clear from the explanation provided how far the draft guideline is evidence-based and how far it is simply based on the committee members' 'experience and expertise' and the level of agreement or consensus achieved on specific recommendation areas. It would be very helpful for the text of the guideline to include a summary appraisal of the data sources on which the committee has been able to draw, including the perceived robustness of these sources and the value of their transference and application to different settings. While Appendix 1 provides an outline review of available evidence that has underpinned the guideline's development, this clearly gives a negative impression of the sufficiency, specificity and quality of the evidence base. It seems essential that this is more overtly	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and have added more detail to the considerations specific to developing individual recommendations in Appendix 1.

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					acknowledged within and across the text of the guideline. We return to this point in our comments below on Appendix 1.	
82	Chartered Society of Physiotherapy (CSP)	7	94	1	It is not clear from the text whether the statement that there 'is no single staff to patient ratio that can be applied across the wide range of wards' is intended to convey a broad point, or whether it relates specifically to 'adult inpatient wards in acute hospitals'. It is also not clear whether the guideline is endorsing a 1:8 nurse to patient ratio. We return to this point again in relation to lines 496-505 below and the glossary definition of 'Nursing hours per patient day'.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
83	Chartered Society of Physiotherapy (CSP)	8	107	1.1 Organisational Strategy	Whilst this section is clearly focused at organisational level, it would be valuable to note the elements within that are absolutely unique to the acute inpatient ward and those which are directly transferable to other settings.	Thank you for your comment. The recommendations have been developed after consideration of a systematic evidence review of the literature that focused on the particular scope of this guideline. We agree that there will be much from this first guideline that can be applied in other healthcare settings. It would make sense for all healthcare professionals to look at this first guideline for adult

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						inpatient wards in acute hospitals and see how they can apply the recommendations as soon as possible.
84	Chartered Society of Physiotherapy (CSP)	8	110	1.1 Organisational Strategy	Our comment immediately above in relation to lines 94-98 also applies to this section.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
85	Chartered Society of Physiotherapy (CSP)	9	130	1.1.3	We do not consider it sufficient to state, 'be aware that improved patient outcomes are associated with a higher proportion of registered nurses in the nursing staff establishment', without providing more detail of the evidence and specifically which patient outcomes. Such a level of statement should be more clearly supported and the specific patient outcomes itemised, particularly given that Appendix 1 explicitly highlights the lack of evidence relating to nurse staffing levels and patient outcomes (see also our comment on lines 404-410).	Thank you for your comment. The guideline has been amended in light of your comment where possible, however the detailed evidence that the recommendations have been developed from remain in Appendix 1 in order to limit the length of the recommendations section of the guideline.
86	Chartered Society of Physiotherapy (CSP)	10	164	1.1.10	We strongly support the assertion of the importance of nursing staff having 'appropriate experience and training' to appraise nursing requirements.	Thank you for your comment and support for this guideline.

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87	Chartered Society of Physiotherapy (CSP)	10	174	1.2	As outlined in our first main general comment, we are concerned that undertaking all components of the recommendations will require considerable time to complete. Acknowledging the limited strength of evidence available and the time required, we would question whether it is reasonable and useful to complete for every shift.	Thank you for your comment. The guideline has been amended where possible and indicates where components of the recommendations could be facilitated by a NICE endorsed decision support toolkit. We hope this would reduce the time taken to undertake some of the recommendations of this guideline.
88	Chartered Society of Physiotherapy (CSP)	10	179	1.2.1	The requirement to use a 'staffing toolkit' features without adequate explanation or reference to examples for clarity. Given the statements in Appendix 1 about the lack of evidence of the value of such tools, it would be helpful for the text to provide greater explanation of the kinds of issues that should be considered in selecting a toolkit (which we would then expect to feature strongly in the planned NICE endorsement criteria).	Thank you for your comment. The guideline has been amended in light of your comment. In addition we have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
89	Chartered Society of Physiotherapy	11	188	1.2.3	It appears that 'estimate' and 'calculate' are used synonymously in relation to 'total nursing requirement'. This affects the guideline's clarity, particularly for those	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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	(CSP)				required to implement its recommendations.	
90	Chartered Society of Physiotherapy (CSP)	12	202	1.2.5	It is not clear either how the tasks listed in Table 1 represent 'a holistic assessment of patients' nursing needs', or practically how these factors should be used within professional judgement. The requirement to outline additional factors to be considered highlights the limitation of table 1 to facilitate a genuinely holistic consideration of needs. The recommendation and list also fail to acknowledge the contributions of other members of the multi-disciplinary team to ensuring that patient needs are met safely, effectively and in a timely manner. As examples, this relates particularly to reference to 'care planning' and 'mobilisation'. Without due acknowledgement that others actively contribute to patient care in these areas, and have a significant impact on patients' quality and outcomes of care, the table presents a partial presentation of factors that need to be considered.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used.
91	Chartered Society of Physiotherapy (CSP)	13	214	1.2.7	It is not clear how the 'staff factors' are included in the proposed calibration to determine staff to patient ratios; see also our comment on lines 496-505 in the glossary regarding the definitions of 'Nursing hours per patient day'.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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92	Chartered Society of Physiotherapy (CSP)	14	226	1.2.7	We challenge the appropriateness of the statement to the effect that 'Support from non-nursing staff such as allied health professionals and administrative staff' should be factored into determining nursing staff requirements. This implies that these staff groups' role is simply to support the activity of nursing staff. It fails to reflect a focus on meeting the needs of patients and achieving quality outcomes and experience for patients.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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93	Chartered Society of Physiotherapy (CSP)	15	248	1.2.9	While the chart summarises key input and demand factors and issues relating to determining nursing staff requirements, it does not reflect outcome-related issues for patients. Key areas captured in the summary are explained in the analysis of gaps in the evidence (in Appendix 1) as not being linked to positive benefits for patients. It would be valuable for a more thorough explanation of the summary content's limitations to be explained in the text of the guideline. The description of the first step of stage one requires additional content to make clear the requirement to implement tables 1 and 2 as well as a staffing tool kit. The information in lines 251-154 should be mirrored in the summary diagram for greater clarity. A new element of 'diversity of clinical specialities' features in this summary. However, it is absent from the accompanying text. The requirement for nursing staff to have 'appropriate experience and training' as we highlight in relation to lines 164 and 165 cannot be underestimated. At this point in the guidelines. it appears that a greater emphasis on education and support to deliver this process is necessary.	Thank you for your comment. We have amended these parts of the guideline to clarify these issues. The final sub-section of the recommendations section of this guideline is dedicated to monitoring and evaluation of outcomes.

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Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
94	Chartered Society of Physiotherapy (CSP)	17	283	1.2.15	As indicated in earlier comments, it seems unhelpful that broad reference is made to 'improved patient outcomes' being 'associated with a higher proportion of registered nurses' without being more specific about the evidence for this, or its limitations. It would also be helpful to highlight the importance of non-registered nursing staff having good access to learning and development opportunities and to structured appraisal schemes. Again, while there may not be evidence that positively affirms the link between patients receiving safe, good-quality, compassionate care and support workers' access to education, obviously this has a been strong focus of the post-Francis agenda, including the development and planned implementation of the fundamentals of care certificate.	Thank you for your comment. The guideline has been amended so that section 1.3 now contains more detailed recommendations on determining skill mix.
95	Chartered Society of Physiotherapy (CSP)	18	305	1.2.19	It is helpful that the guideline identifies the significance of red flags. However, it would be useful for the text to acknowledge the part played by others in identifying and addressing patient needs that require urgent attention and action. Although repeated attention is drawn to 'nursing red flags', it is not apparent how the elements have been identified as	Thank you for your comment. We have amended these parts of the guideline to clarify this issue. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and

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					suitable, or what evidence exists to support their combined use (see also our comment on line 708). It is also unclear whether these are commonly understood and used in practice.	detailed the considerations specific to developing individual recommendations in Appendix 1.
96	Chartered Society of Physiotherapy (CSP)	18	306	1.2.20	It should be acknowledged that staff, other than those within the nursing (and patients, relatives and carers), could report nursing red flag events. This seems important for recognising the shared responsibility held for ensuring safe, compassionate care for patients and as a key action within addressing the recommendations of the Francis report.	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation in the organisational strategy section to address this issue.
97	Chartered Society of Physiotherapy (CSP)	19	321	1.3.1	In keeping with our previous comments, it is essential that patients' nursing needs are not considered in isolation from the contributions that other staff groups make to ensuring safe, high-quality patient care and outcomes.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment in the introduction and recommendations sections.
98	Chartered Society of Physiotherapy (CSP)	19	328	1.3	The boxed information relation to 'safe nursing indicators' and 'Safety outcomes' all relate to negative indications of patient care and negatives impacts on how nursing staff are enabled to work. It seems important that this is made explicit, since they relate to occurrences to be considered within the monitoring and evaluation of a ward's nursing	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					staff establishment that would denote that stages 1 and 2 of the guideline's implementation had not worked effectively.	
99	Chartered Society of Physiotherapy (CSP)	20	336	1.3.3	This recommendation seems to indicate that the guideline endorses the nurse to patient ratio of 1:8. As indicated in our comments elsewhere (see our comments about lines 496-505), this is not explicit elsewhere in the main body of the guideline text.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
100	Chartered Society of Physiotherapy (CSP)	23	404	3	As indicated in our earlier comments (see in relation to lines 130 and 248), it seems important that the acknowledgement that there is not currently evidence available to demonstrate positive links between nurse staffing levels and patient outcomes is made more overt within the guideline text.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. There is substantial evidence that does support a positive association between numbers of nursing staff and a range of patient outcomes.
101	Chartered Society of	23	414	3	It would be helpful for the recommendations to highlight the issue of 'missed care'. While it is indicated here that	Thank you for your comment. A number of the individual red flags

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	Physiotherapy (CSP)				data could usefully be captured on this, this does not come through as a guideline recommendation (please also see our comments on lines 492 and 495).	have been derived from missed care items.
102	Chartered Society of Physiotherapy (CSP)	23	419	3	This provides a sizeable list (albeit useful for this) of the areas and issues for which there is a lack of good-quality research. This raises questions about the basis on which the guideline has been developed.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1.
103	Chartered Society of Physiotherapy (CSP)	24	430	3	We would make the same comment as above about the statement that there is a lack of research that assesses the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix.	Thank you for your comment. This point has been included as a recommendation for research.
104	Chartered Society of Physiotherapy (CSP)	24	435	3	We would make the same comment as above about the statement that there is a lack of research that assesses the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix, but in relation to management structures and organisational cultures	Thank you for your comment. This point has been included as a recommendation for research.
105	Chartered Society of	24	440	3	We would make the same comment as above about the statement that there is a lack of research that assesses	Thank you for your comment. This point has been included as a

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	Physiotherapy (CSP)				the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix, but in relation to organisational policies and procedures	recommendation for research.
106	Chartered Society of Physiotherapy (CSP)	24	445	3	We would make the same comment as above about the statement that there is a lack of research that assesses the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix, but in relation to economic studies relating to staffing requirements and skill mix	Thank you for your comment. This point has been included as a recommendation for research.
107	Chartered Society of Physiotherapy (CSP)	24	449	3	We would make the same comment as above about the statement that there is a lack of research that assesses the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix, but in relation to economic evidence and ward environment	Thank you for your comment. This point has been included as a recommendation for research.
108	Chartered Society of Physiotherapy (CSP)	25	454	3	We would make the same comment as above about the statement that there is a lack of research that assesses the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix, but in relation to the economic analysis of patient costing and outcomes data at a ward level.	Thank you for your comment. This point has been included as a recommendation for research.
109	Chartered Society of Physiotherapy (CSP)	27	478	5	It is not clear how this definition of 'Effective nursing care' is applied within the guideline, as highlighted in our comments on lines 6,7 and 49 (as examples). The definition includes 'good outcomes'. However, we wish to	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. They felt that there was significant

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					reiterate an insufficient focus on assessment and monitoring of patient outcomes.	focus already on monitoring and evaluation of patient outcomes, however, the introduction section and the beginning of the recommendations section has been amended to further emphasise the importance of this.
110	Chartered Society of Physiotherapy (CSP)	27	492	5	Again, it is not sufficiently clear how 'Missed care' is applied within the guideline (see also our comment on line 414). We would expect this crucial aspect of ensuring that patients receive timely, responsive, good-quality and compassionate care – and avoiding the inverse of this – as needing to feature more strongly in the recommendations, in line with the origins of the guideline's production (i.e. the Francis report).	Thank you for your comment. A number of the individual red flags have been derived from missed care items.
111	Chartered Society of Physiotherapy (CSP)	28	496	5	We consider that the explanation given of 'Nursing hours per patient day' both implies that NICE is recommending a particular nurse to patient ratio (with 1:8 drawn out as the developed example and representing the minimum ratio highlighted in the supplied table) and wholly ignores the time that any health care staff need to spend each working day in activities that do not involve direct contact with patients (with these kinds of elements acknowledged in our comments on lines 283-286). The glossary explanation	Thank you for your comment. The guideline has been amended in light of your comment.

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					therefore seems misleading in indicating that a nurse working an 8-hour shift 'can contribute 8 hours of nursing care that day', and could therefore deliver one hour of care to 8 patients during that shift. This also seems in tension with the explanation given of 'Total nursing requirement' in lines 543-548 of the glossary.	
112	Chartered Society of Physiotherapy (CSP)	28	511	5	As indicated in relation to line 305, it seems unhelpful to make the inference that nursing red flags may trigger only the need for 'additional nursing staff to be allocated to the ward'. As indicated in relation to lines 306-310, it is important that wider consideration is given to how patient safety, quality of care and outcomes can best be assured. The appropriate response might be a review of the staffing levels and skill mix across the multi-disciplinary team to ensure the management and delivery of care is in patients' best interests.	Thank you for your comment. The guideline has been amended in light of your comment.
113	Chartered Society of Physiotherapy (CSP)	28	521	5	We question the assertion that 'nursing intensity' is interchangeable with 'patient acuity'. While the definition indicates that this is 'sometimes' the case, it seems unhelpful to suggest that such a usage is helpful. Again, it risks not focusing on the needs of patients and creating too narrow a focus on nurse staffing issues.	Thank you for your comment. The guideline has been amended in light of your comment.
114	Chartered Society of	28	525	5	We question the explanation that 'patient dependency' can simply be measured by the amount of 'nursing care'	Thank you for your comment, which was considered by the Safe

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	Physiotherapy (CSP)				required by a patient. It needs to be considered from a broader patient and professional role perspective. As an example, physiotherapy staff can be key to ensuring that patients receive effective and timely mobilisation, often in ways that can expedite their recovery, reduce their stay in hospital and have long-term benefits for their rehabilitation, re-ablement and independent functioning.	Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
115	Chartered Society of Physiotherapy (CSP)	28	529	5	We would expect the issue of patient turnover to feature more strongly in the guideline recommendations.	Thank you for your comment. Patient turnover was identified as a key determinant of nursing staff requirements and features in the existing guideline as a ward factor to be considered when determining nursing staff requirements
116	Chartered Society of Physiotherapy (CSP)	28	537	5	It is not clear how this definition of 'Safe nursing care' is applied within the guideline, as highlighted in our comments on lines 6,7 and 49 (as examples).	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
117	Chartered Society of Physiotherapy	28	543	5	The explanation of 'Total nursing requirement' appears to indicate that activities other than those relating to the direct care of patients are factored into how nursing staffing	Thank you for your comment. The guideline has been amended in light of your comment.

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	(CSP)				levels should be calculated. However, by referring to the definition of 'Nursing hours per patient day' this appears to be contradicted elsewhere in the Glossary (please see our response to lines 496-505).	
118	Chartered Society of Physiotherapy (CSP)	35	672	8	The absence of the tools that have reportedly been developed to help organisations to implement this guideline is considered to impact on clarity of the overall guideline.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have amended the guideline in light of your comment to clarify that this process could be facilitated by using a NICE endorsed decision support toolkit. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
119	Chartered Society of Physiotherapy	49	708	Appendix 1	As stated regarding line 179, as the evidence is reported to lack studies 'on the effectiveness of the impact of tools for organisations or healthcare systems', further	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The

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	(CSP)				justification for the tools' inclusion in the recommendations would be of value.	guideline has been amended in light of your comment, where possible.
120	Chartered Society of Physiotherapy (CSP)	49	708	Appendix 1	With regard to the description of nursing red flag events, we have been unable to locate the associated evidence or discussion within the appendix (see also our comment on line 305).	Thank you for your comment. The guideline has been amended in light of your comment.
121	Chartered Society of Physiotherapy (CSP)	49	709	Appendix 1	Further to our comments on lines 321-328 and 511-514, we remain disappointed about the lack of acknowledgement about the contribution and impact of other members of the multi-professional team on the quality of patient experience and outcomes, and the need to consider this in appraising the required nurse staffing establishment.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. However, the focus of this guideline was the nursing team.
122	Chartered Society of Physiotherapy (CSP)	67	717	Appendix 1	Linked to our comment about line 9, the discussion regarding the 1:8 nurse to patient ratio in this section does not clarify why this reference is included, especially as the key element in this paragraph is a repetition of the SSAC opinion and guide for nursing staff to be determined by individual wards. The rationale to include this becomes more unclear in the 'other considerations' section, where a dated data set from the 1990s is cited.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1.

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						This has been further added to following your comment.
123	Chartered Society of Physiotherapy (CSP)	General comment	General comment	general comment	We have concerns that the draft guideline is partial in its treatment of the subject matter. It makes limited reference to the quality of patient care and the focus needing to be on patient outcomes and benefit. We would wholly support such a focus. However, the substance of the guideline relates almost exclusively to input issues. The guideline's further, particular focus on tasks to be performed by nursing staff narrows its coverage further, with its paying very little attention to the value, impact and outcome of these activities for patients. The current challenge of being able to link staffing levels with patient outcomes is highlighted in the summary of gaps in the evidence as presented in Appendix 1. However, these limitations are not made sufficiently explicit in the text of the guideline itself. The guideline is ambiguous in its consideration of staffing. It quickly shifts from a broad reference to staffing levels to a specific reference to nurse staffing levels. However, the text does not make explicit that this is the case.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. A number of the sections of the guideline, such as the introduction section, have been amended to address the comments raised.

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124	Chartered Society of Physiotherapy (CSP)	General comment	General comment	general comment	The guideline is ambiguous in its consideration of staffing. It quickly shifts from a broad reference to staffing levels to a specific reference to nurse staffing levels. However, the text does not make explicit that this is the case. Overall, the guideline fails to acknowledge the significance of the contribution of multi-disciplinary teams to the quality of care received by patients. With the narrow focus on nursing staff and the tasks performed by them, it misses key aspects of quality of patient care and experience. Examples of this are highlighted with reference to specific lines below. In addition, the guideline fails to acknowledge that staffing levels are only one element in seeking to assure that patient care is of a consistently good quality and is delivered with compassion. We would expect the document to reflect more overtly the following kinds of contributing factors: • Service delivery models • Caseload management and risk stratification approaches • Clinical care environment and available equipment • Skill mix configuration, review and role development • Clinical leadership and peer review • Team-working • Standards/guideline implementation • Service integration • Achieving sustainable services and the best-quality patient	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. We recognise that these are all important factors, some of which are addressed by the guideline (such as skills mix and clinical case environment). However, other areas are not within the scope of this guideline programme, such as service delivery, and may be covered in other NICE guideline programmes in the future.

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					experience/outcome (including approaches to care that can minimise hospital stays and re-admissions and enhance care transfer) • Service evaluation and re-design • Learning and development opportunities • Supported staff engagement in service improvement/re-design • Quality employment.	
125	Chartered Society of Physiotherapy (CSP)	General comment	General comment	general comment	We are also concerned about the practical application of the guideline and the time-consuming exercise of implementing its stages and individual recommendations. The administration attached to the guideline's use and the evaluation and review of this would take nursing time away from direct patient care in ways that would be counter-productive to its intended purpose. The value of investing in the depth of activity outlined is unclear, especially given the absence of strong evidence of any positive correlation between the substance of the guideline's recommendations, quality patient care, and this specific professional group. There is also no comment from the expert contributors on the value of compliance with the recommended process. Although a process summary has been included (line 248) the length of the guideline, its numerous components and interactions, and its current structure mean that it is challenging to précis the guideline's general approach, or the	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. They were cognisant of the data collection burden and have tried to limit this where possible, but felt strongly that it was important to recommend monitoring and evaluation of nursing red flags and safe nursing indicators. NICE is considering if additional resources may be developed to help facilitate data collection.

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					key outcomes to be monitored. A more practically-focused overview would be of value. Given that this is the first of a planned series of NICE guidelines on nursing staff requirements in different healthcare settings, we would urge that the broad issues that we raise in our response (and which we would expect other respondents to raise) are considered and addressed before the broader programme of activity is progressed.	
126	Chartered Society of Physiotherapy (CSP)	General comment	General comment	general comment	We have concerns that terminology is used loosely and inter-changeably across the document, without due explanation as to why different terms are used, clarity about whether this is intentional, and what the use of different terminology at specific points is intended to denote. While 'safe' is used in the title, both 'safe' and 'safe and effective' are used within the text of the document. The glossary provides broad definitions of 'safe nursing care' and 'effective nursing care', but it is not clear how these transpose to specific usage within the guideline text.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. We have also reviewed the guideline again to ensure consistent use of terms where appropriate.
127	Chronic Pain Policy Coalition	18	306	1.2.20	We support the reporting of red flag events by a wide range of people including family members and carers but this needs to be supported by education and information so family and carers are able to recognise and report a red	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation

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					flag event.	in the organisational strategy section to address this issue.
128	Chronic Pain Policy Coalition	18	311	1.2.21	Responses to red flags events need to reflect the needs of patients .If the red flag incident is pain related then we would suggest that the response takes into account the need for good long term management of pain. Education of nurses and trainee doctors as to how to manage escalating pain is necessary, plus provision of an in-patient pain service is wards are not able to manage the patients pain	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
129	Chronic Pain Policy Coalition	19	328	1.3	We are encouraged that “adequacy of provided pain relief” will be a safer nursing indicator; we would suggest that this is changed to the “adequacy of provided pain management” as for some patient’s relief may not be possible. Pain relief suggests medication	Thank you for your comment. The guideline has been amended in light of your comment.
130	Chronic Pain Policy Coalition	19	328	1.3	We are very pleased to see pain included as part of the nursing red flags as a fundamental care need. Pain should initially be assessed by an intensity scale (Verbal Rating or Numerical Rating Scale. The impact that pain has on functioning should also be assessed using the Brief Pain Inventory and should reflect pain on movement (deep breathing and coughing) and not at rest. Pain in hospital patients is extremely common. It can occur post-operatively on surgical wards, it can be as a	Thank you for your comment and support.

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					result of trauma and be seen on orthopaedic wards and it can occur as a result of the illness which has brought the patient into hospital, such as myocardial infarction, osteoporotic collapse, cancer, pancreatitis etc. It can also be co-morbid with the admitting condition. Some evidence has shown that inadequate management of acute pain can lead to chronic pain and it should be remembered that surgery can lead to neuropathic pain conditions.	
131	Chronic Pain Policy Coalition	45	702	Appendix 1	Economic considerations Evidence would suggest that adequate control of pain on acute wards and on discharge will prevent chronic pain developing later at greater cost	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
132	City Hospitals Sunderland	9	122	1.1.2	We agree that staffing establishments should be signed off by the matron/ward manager and chief nurse when the establishment is set however it is not realistic for the chief nurse to sign off rosters, this is the responsibility of ward managers.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
133	City Hospitals Sunderland	9	147	1.1.7	We agree that monitoring and review of staffing establishments should occur at least twice each year and these procedures should include monitoring of nurse sensitive indicators (NSI). We do not agree with the NSI detailed in Box 2, using the results of the national in	Thank you for your comment. The guideline has been amended in light of your comment where possible.

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					patient survey as the baseline is not sensitive of timely enough. We suggest the metrics should be linked to the Open and Honest metrics which are already displayed at ward level.	
134	City Hospitals Sunderland	10	150	1.1.8	Suggest this should refer to hours of nursing available on a shift by shift basis as required by Hard Truths and will reflect the national UNIFY return.	Thank you for your comment. The guideline has been amended in light of your comment.
135	City Hospitals Sunderland	10	176	1.2.1	We welcome NICE endorsement of staffing toolkits. In the absence of NICE endorsement there should be no expectation to use such tools.	Thank you for your comment. The guideline has been amended in light of your comment. In addition we have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
136	City Hospitals Sunderland	11	183	1.2.2	Will the guidance provide any methodology for using "professional judgement"	Thank you for your comment. The recommendations in section 1.2 detail information that can be used to assist professional judgement.
137	City Hospitals	11	199	1.2.5	1:1 should be reworded to "enhanced care", as 1:1 implies one nurse to one patient at all times, when in fact when	Thank you for your comment. We have amended these parts of the

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	Sunderland				required in managing some patients e.g dementia care, when the patient is sleeping the level of care can be reduced.	guideline to clarify this issue.
138	City Hospitals Sunderland	12	202	1.2.5	It is unclear how Table 1 and Table 2 should be used.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used.
139	City Hospitals Sunderland	14	228	1.2.8	We are pleased to note the inclusion of maternity leave in the required uplift, which is not currently included in most uplifts Can NICE specify the "uplift" percentage	Thank you for your comment and support for this guideline. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.

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NICE National Institute for Health and Care Excellence

Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
140	City Hospitals Sunderland	17	278	1.2.15	It is interesting to note the comment re higher proportion of registered nurses, this needs to be included with caution, as some areas may have a high level of RNs and an equal number of HCAs, therefore appearing to have a diluted skill mix, when in fact they have an enhanced level of HCA staff to provide quality care.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
141	City Hospitals Sunderland	17	280	1.2.15	Will the guidance include any indicative skill mix.	Thank you for your comment. The guideline has been amended so that section 1.3 now contains more detailed recommendations on determining skill mix.
142	City Hospitals Sunderland	18	305	1.3	We like the "red flag" concept however the red flags detailed in box 1 require more detail to ensure a consistent approach nationally. Red flags should be things that are easy to measure and that the system does not create additional bureaucracy. It is important that reporting mechanisms do not detract from existing reporting such as incident reporting.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue and to add further detail to the suggested reporting of these nursing red flags.
143	City Hospitals Sunderland	18	311	1.2.21	Whilst we agree in principle that a red flag may be related to staffing levels this will not always be the case. Urgent need for additional nursing to be allocated to the ward may not be possible and using the red flags in this way could be manipulated.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.

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144	City Hospitals Sunderland	19	328	1.3	Measuring missed breaks and additional hours would require mechanisms to measure	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2.
145	City Hospitals Sunderland	19	328	1.3	Can we have a definition of planned and required	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2.
146	City Hospitals Sunderland	20	334	1.3.3	What about night time ?	Thank you for your comment and support for this guideline. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this

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						area based on the available evidence and their expertise. However there is a nursing red flag that has been developed to help ensure safety throughout a 24-hour period.
147	City Hospitals Sunderland	28	496	5	Nursing hours per patient per day - the document explains how this can be linked to the nurse to patient ratio however does not detail any method to calculate actual patient requirements.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have amended the guideline in light of your comment to clarify that this process could be facilitated by using a NICE endorsed decision support toolkit. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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148	Coloplast Ltd	9	125	1.1.3	Although Coloplast agrees that there should be capacity to deal with planned variations, we believe that consideration needs to be given to where that capacity is drawn from. We understand that there have been cases where stoma care clinical nurse specialists have been asked to cover general ward duty on a regular basis, such as for one day a week, in order to make up for the shortfall in staffing numbers. This takes time away from the duties which the stoma nurse has been employed to do. Given the pressure which is already being placed on specialist nurses, it is detrimental both to nurses and patients to expect them to take time away from their main job to cover for shortages elsewhere; it will lead to nurses being able to provide less specialised care to the patients who need it.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising nursing staff levels on one ward for other wards.
149	Coloplast Ltd	9	138	1.1.5	Coloplast very much agrees that flexibility in ward nursing staffing should not compromise safe nursing in other wards. Patients who require specialist stoma care must not suffer because their nurse has been assigned to work on a general ward to make up for staff shortages.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising nursing staff levels on one ward for other wards.
150	Coloplast Ltd	10	161	1.1.9	Coloplast believes that it should be made clear that when placing patients in wards where their clinical needs can be best met, the specialist nurses looking after these patients should not be made to cover the shortfall of other wards.	Thank you for your comment. The guideline covers the ward nursing staff establishment, so unless specialist nurses are funded by a

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					By making specialist nurses cover for other nurses, we believe patient safety is at risk. Specialist nurses have a unique knowledge of their area and are responsible for accurately teaching inpatients how to manage their condition. For example, stoma care nurses will teach the stoma care skills to patients. If a specialist is not there to accurately teach patients the necessary skills for the management of their condition, discharge of the patient can be delayed, or worse, the patient could be readmitted due to a lack of understanding about how to manage their condition.	particular ward, they would not be included in that ward's establishment.
151	Coloplast Ltd	13	214	1.2.7	We would like to highlight that low staffing levels are detrimental to the ability of specialist nurses to provide supervision and mentoring to other nursing staff. Given the relatively low number of stoma care nurses proportional to the general need, such training is vital.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
152	Coloplast Ltd	18	305	1.2.19	Box 1 states that regular checks on patients need to be undertaken to ensure their care needs are met. Whilst the draft document recognises to the need for frequent toilet trips to accommodate a patient’s personal needs, we believe that a reference should be added to highlight that patients with bladder and/or bowel problems, who utilize stoma/catheter bags, should have their stoma/catheter bags emptied on a frequent basis, or as soon as the need	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee, however the suggested additions were felt to be too specific to recommend as nursing red flags for all acute adult inpatient wards. There is however scope for

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					arises.	addition of more nursing red flags locally where this was felt necessary.
153	Coloplast Ltd	19	321	1.3.1	(Box 2: safe nursing indicators – nursing staff establishment) Coloplast would like to point out that although we fully agree that high levels of temporary nursing staff are not acceptable, we do not want to see clinical nurse specialists make up the shortfall on the ward should there be a reduction in the number of temporary nursing staff. We believe that a reduction in number of temporary nursing staff should be met by an increase in permanent nursing staff of an equivalent level of expertise.	Thank you for your comment and support for this guideline.
154	Coloplast Ltd	37	695	Appendix 1	Whilst the Committee's evidence review may not have found any significant association between low staffing and catheter associated UTI, Coloplast would like to emphasise that stoma care is distinct from urology and poses different challenges and different risks. Studies which are applicable to urology cannot be directly applicable to stoma care as they are fundamentally different.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
155	Department of Health	3	27	Introduction	It is recognised that the definition of "nursing" is provided in line 519 page 29 and includes registered nurses and healthcare assistants, it would be helpful to clarify this definition earlier on so that it is clear from the outset that	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the

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					nursing staff is not just nurses	introduction and the recommendations section to clarify what we mean by this term.
156	Department of Health	4	32	Introduction	The guidelines would also be of interest to regulators, could NICE consider including these?	Thank you for your comment. The guideline has been amended in light of your comment.
157	Department of Health	7	94	1	We agree with the emphasis on following professional judgement when setting/determining staff establishment rather than hard and fast ratios and guidelines. And we agree with the view that there is no single staff to patient ratio that can be applied across the wider range of wards to meet the nursing care needs of patients.	Thank you for your comment and support for this guideline.
158	Department of Health	7	100	1	Might it be useful to remind readers that this also includes weekends?	Thank you for your comment. Recommendation 1.1.1 has been amended in light of your comment to emphasise that patients should receive the nursing care they need regardless of the day of the week or time.
159	Department of Health	9	130	1.1.4	Second sentence needs clarification. How does this relate to line 404 which says there is a lack of high quality evidence on skill mix?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing

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						the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1.
160	Department of Health	10	163	1.1.10	The recent Cavendish Review into healthcare assistants and support workers in the NHS and social care settings, highlighted that levels of care could be improved if employers were more ambitious in how they recruit and train their support workforce. Ward sisters should be empowered by Nursing Directors and their Boards, to take ownership of the recruitment of their support worker and actively 'own' each support worker and in some cases their domestic staff also, schooling them from the very start of their employment in the values of the organisation, patient care and safety. The introduction of the Care Certificate, which is currently being piloted and due to be introduced in March 2015 is designed to aid this process.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
161	Department of Health	10	166	1.1.11	As a point for further consideration, Cavendish also highlights that it would be beneficial to the way services are delivered if staff from different professional groups undertake certain aspects of their training together. This will enable staffing groups to more efficiently interact with one another and to understand their respective roles and responsibilities better. It would also allow for managers to	Thank you for your comment, which was considered by the Committee. This section of the guideline has been amended where possible given the parameters of the scope of this guideline.

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					understand If teams are innovative about the way they communicate and understand one another, rather than working and training in silos, then a strong team environment is established where staff can set their own standard of what is acceptable and be comfortably able to challenge colleagues who fall below that standard.	
162	Department of Health	12	202	1.2.5	There are specific references to nursing staff, this may need clarification –other areas don't refer to type of staff.	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
163	Department of Health	13	220	1.2.7	Managing the nursing team and the ward, are these one and the same, for example, might this be better shown as two indents, one managing the staff and a separate one for managing the ward.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
164	Department of Health	16	249	1.2.10	It is helpful to have a clear process laid out for setting nursing staffing requirements and helpful to tabulate the kind of factors that need to be taken into account when assessing staffing requirements including distinguishing between ongoing and one-off factors affecting nursing care	Thank you for your comment and support for this guideline.

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					needs. Helpful to see suggestion of expressing calculation of average patient nursing needs in terms of nursing hours per patient day. This potentially allows productivity and direct patient contact to be taken into account rather than a single ratio of staff to patient.	
165	Department of Health	19	324	1.3.1	NICE has recommended “consider” continuous data collection of the safe nursing indicators, we would recommend that this is could be reworded as “undertake” and this would be more in line with NQB guidance that requires 6monthly in-depth reviews of staffing and monthly reporting to Board.	Thank you for your comment. The guideline has been amended in light of your comment.
166	Department of Health	20	335	1.3.3	Ref to registered nurses Careful handling is needed to be exercised when finalising the guidance on the messaging in relation to the suggestion of the need to consider increasing ward establishment in the light of red flag events etc. This should be linked to the need to establish off setting benefits and savings from increased staffing levels	Thank you for your comment. The recommendations have been amended to clarify this issue that there may be other influences on safe nursing indicators other that the ward nursing establishment size.
167	Department of Health	21	385	2	There is a need to consider or at least make reference to any offsetting benefits and savings from increasing staffing. These might come for example, from reductions in agency staff, a reduced level of patient re admissions or reduced length of stay.	Thank you for your comment. The guideline has been amended in light of your comment.
168	Department	27	486	5	Should read healthcare assistant not healthcare.	Thank you for your comment. The

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	of Health					guideline has been amended in light of your comment.
169	Department of Health	27	487	5	Definition of HCA, this is very similar to that on the NHS Careers website. Neither the NHS occupational code manual or the Cavendish report provide a succinct definition but Cavendish does specifically use the term unregistered.	Thank you for your comment. The guideline has been amended in light of your comment.
170	Department of Health	37	695	Appendix 1	To be sustainable, safe staffing must be delivered within budgets. Within a fixed budget funding envelope, increased staffing levels will put pressure on pay and other areas of spend. There is a danger that the guidance will affect behaviour locally as already there is anecdotal evidence pointing to trusts increasing staffing numbers. The economic case needs to emphasise the offsetting benefits – see ref 385 above.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This Appendix to the main guideline is designed to contain more detail on the how the evidence considered (including economic evidence relates to costs and benefits) was used in the development of the recommendations for those who wish to refer to it.
171	Department of Health	50	708	1.2	other considerations: First sentence could benefit from rewording, i.e. when required safe staffing levels are not met.	Thank you for your comment. The guideline has been amended in light of your comment.
172	Department of Health	51	709	Appendix 1	Moving away from using acuity and dependency. We support the proposed change although suggest the word	Thank you for your comment and support for this guideline.

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					need should be needs	
173	Department of Health	70	718	Appendix 2	Ref to registered nurses Careful handling is needed to be exercised when finalising the guidance on the messaging in relation to the suggestion of the need to consider increasing ward establishment in the light of red flag events etc. This should be linked to the need to establish off setting benefits and savings from increased staffing levels	Thank you for your comment. The guideline has been amended in light of your comment.
174	Department of Health	71	719	Appendix 2	Seems a logical bottom up approach and the worked example is fairly instructive and helpful. This also needs to be worked through for other shift patterns. 12 hours shifts are common.	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in section 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments

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175	Department of Health	83	891	Appendix 3	On the temporary nursing: the numerator and denominator seem reasonably defined from a recording perspective – i.e. the definitions appear to be fairly clear and unambiguous. The measure assumes no differentiation between temporary registered nurses and temporary assistants. Presumably this has been considered and thought to be appropriate. However, it may be helpful to consider this as the outcome measure refers to expenditure. In some cases, for example, where a trust foresees future constraints on its pay budget, it might be financially beneficial to use more expensive temporary staff in the short term rather than committing to unsustainable permanent staff.	Thank you for your comment. The guideline has been amended in light of your comment.
176	East Kent Hospitals University NHS Foundation Trust	11	183	1.2.2	The flexibility suggested can not be entirely achieved by ‘standing staff down’ or filling gaps with temporary staff at short notice. It may therefore be useful to highlight that risk reduction by moving staff to areas of greater need should be employed.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising nursing staff on one ward for other wards.

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177	East Kent Hospitals University NHS Foundation Trust	11	190	1.2.4	Assessment of the nursing care activities in table 1 and 2 can not easily be used to assess acuity & dependency and over complicate the process. It would be better to include here the use of the SNCT / Shelford as a universally used, validated and user friendly tool.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
178	East Kent Hospitals University NHS Foundation Trust	11	201	1.2.5	1:1 nursing requirement is included in the SNCT so it is unnecessary to identify separately here.	Thank you for your comment. This NICE guideline is not intended to be used in conjunction with a single specific decision support toolkit; therefore the Safe Staffing Advisory Committee felt it was important to detail all the factors that are relevant to determining nursing staff requirements. There is a separate endorsement process for decision support toolkits and we have added a link in the

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						introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
179	East Kent Hospitals University NHS Foundation Trust	14	228	1.2.8	This section could better summarise the requirement for an on cost allowance to cover annual leave, professional development and sickness absence. This is generally 22%	The example previously included in Appendix 2 was meant to be an example to illustrate the processes and calculations, not to recommend specific numbers.
180	East Kent Hospitals University NHS Foundation Trust	17	297	1.2.18	The calculation of actual total nursing requirement in nursing hours per patient day will require a robust toolkit that is consistently applied but the NICE guidance does not provide further detail on what this looks like. The proposal that NICE will endorse any toolkit that meets the NICE endorsement criteria will unfortunately lead to inconsistency and commercial opportunity which may be unhelpful. NICE should be consider the inclusion of a toolkit within this guidance.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that contains information regarding the endorsement process of decision support toolkits.

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181	East Kent Hospitals University NHS Foundation Trust	28	501	5	Nursing hours per patient day should make it clear that these are total nursing hours (registered nurse and support worker) as the guidance appears to suggest that these are registered nurse hours only.	Thank you for your comment. The guideline has been amended in light of your comment.
182	East Kent Hospitals University NHS Foundation Trust	General comment	General comment	general comment	Comprehensive and a good starting point from which to build. Perhaps the document could be more succinct as it is repetitious. It introduces a new method of evaluating safer staffing that requires calculation of hours of nursing required each day. Would it not be appropriate to use what is already tried and tested - There is little mention of triangulation of evidence based tools e.g Professional judgement, SNCT, Hurst workforce planning tool. There is also little reference to the Safer Staffing Alliance 'never more than 8' which has some value also. The inclusion of red flags is useful, particularly medication delays for pain relief and delays in completion of vital signs recording. The recognition of the need for workforce design and how we take into account the needs of patients needs to be included – more likely that therapists will be included as part of ward establishments so the blend of staffing levels and skill-mix may need to change over-time. Also there is	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have made a number of amendments to help reduce the repetition. The final guideline also includes reference to delegation of tasks where appropriate.

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					no recognition of the associate practitioner level contribution to the team which again is a missed opportunity in releasing RN time effectively to lead and co-ordinate assessment and plan of care, as well as being involved in direct care of patients. The Associate Practitioner band 4 role in providing expertise in care delivery for specific pathways and how this may reduce the reported skill mix but actually enrich the skills available to the patient should be recognised in this guidance.	
183	East Surrey CCG	9	134	1.1.5	Unplanned variations – for example busy theatre days may require more escort nurses.	Thank you for your comment. This section of the guideline has now been amended.
184	East Surrey CCG	13	221	1.2.7	Also professional supervision time for student nurses. Time to support first year evaluation.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
185	East Surrey CCG	19	319	1.3	Provider Boards to agree dedicated time to monitor/assess staffing levels. Stronger alignment for those given time to study/carrying out research, to ensure research projects aligned to these guidelines to encourage a return on investment for study.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.

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186	East Surrey CCG	20	328	1.3.1	Use of Bank staff – some substantive staff increase their hours by working bank shifts which may be in more than one hospital – potential for burn out/fatigue. Bank or temporary staff may require extra support which needs to be factored in. Bank staff/temporary staff may be used predominantly on night shifts, patients may deteriorate/crucial time.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
187	East Surrey CCG	74	728	Appendix 3	Suggested additional questions for the patient questionnaire – time consuming jobs that may be delayed due to short staffing situations: 'I got my medicine on time' 'My dressings were changed when needed'	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
188	East Sussex Healthcare NHS Trust	13	204	1.2.5	Table 2, admission assessment should be in the third column – Significant care needs. If done correctly an initial assessment with risk assessments is likely to take longer than 30 minutes if done correctly.	Thank you for your comment. The guideline has been amended in light of your comment.
189	East Sussex Healthcare NHS Trust	13	205	1.2.6	I would name this ward/environmental factors e.g in extreme temperatures patients may need extra time spent on assisting with fluid intake	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee, however they decided to retain the existing terminology.

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190	East Sussex Healthcare NHS Trust	15	248	1.2.9	NHHPD is one tool but the SNCT also fulfils a similar function. The guidance seems to promote use of NHHPD rather than recommending as one of a number of recommended tools	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). We have amended these parts of the

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						guideline to clarify this issue.
191	East Sussex Healthcare NHS Trust	16	255	1.2.11	In reality nursing hours will be complicated and time consuming to calculate without suitable and accessible tools	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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192	East Sussex Healthcare NHS Trust	17	290	1.2.17	There are wide variations in uplift across and within organisations. Current mandated and essential requirements exceed most uplifts and it would be beneficial to at least have a national range. There are no acute sites that will require staff with less than 6 days education a year to meet requirements.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
193	East Sussex Healthcare NHS Trust	18	305	1.2.19	Delay in providing pain relief - would like to see set at 15 mins – 30 mins is too long or is this based on evidence?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
194	East Sussex Healthcare NHS Trust	General comment	General comment	general comment	Overall, the guidance is self explanatory, Professional judgement is essential to support any formulae.. The challenge will be to encourage staff to use the formula as evidence that they have considered staffing levels on every shift and if lacking what actions they took to ensure a safe high quality service was given to patients.	Thank you for your comment and support for this guideline.

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195	East Sussex Healthcare NHS Trust	General comment	General comment	general comment	The evidence regarding non clinical time for Ward Sisters/matrons needs to be updated , at least 50% is the minimum	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The need to take into account of clinical time by wards sisters etc is also now covered in the recommendations.
196	Foundation Trust Network	10	171	1.2	Data burden • The IT systems are not in place to manage this data collection so the initial collections will be labour intensive. • In addition, some members have flagged that uploading the data twice, both to their trust website and the NHS choices website is proving to be somewhat burdensome. It would be helpful if we could minimise such duplication.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. They were cognisant of the data collection burden and have tried to limit this where possible, but felt strongly that it was important to recommend monitoring and evaluation of nursing red flags and safe nursing indicators.

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197	Foundation Trust Network	10	171	1.2	Data definitions • Members have, of course, reported that they require additional information than that reported – including for instance, intelligence on the quality, skills and capacity of individual members of staff on each ward, and balance of bank and agency staff, to establishment. • The request to provide the data in hours, not shifts, with different definitions of what counts as 'day' and 'night' to the shifts that actually operate in the trust mean that the gathering of the data is a hugely onerous exercise and will require significant changes to how electronic rostering is set up. • Prior to the announcement of the UNIFY system approach, all the guidance was suggesting reviewing staffing based on shifts. The conversion to hours has a lot of implications: i. Shift times and shift overlap. There is therefore potential for misinterpretation of the data as a result of working a combination of short and long days on any ward. For example, if a short shift is 7.5 hours and long day is the combination of two early shifts, then the public will expect for the ward to be covered for 15 hours. However, if the ward is being covered by someone on a long day, the individual will only be working 11.5 hours as the overlap	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2. The UNIFY system is separate to this guideline and further information regarding this has been issued by the relevant organisations.

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					time between the early shift and the late shift will not be required but the patient needs will still be met. ii. Measuring fill rates for total monthly hours may hide or mask daily variations. iii. Shift times and temporary staff use - it is best practice to reduce the amount of time temporary staff are required per shift, that is, there is no need for bank or agency staff to work a full 7.5 hour shift as they are not required for the overlap period. iv. Reporting timeframe - The timeframe is a calendar month, but rosters are planned and managed on a four weekly period. This means instead of having 12 rosters in a year, most Trusts roster over 13 periods to cover the full year.	
198	Foundation Trust Network	18	318	1.3.3	• The RAG rating system is unclear e.g. one could achieve 1:8 and produce a better rag rating by setting lower planned figures. The RAG will not necessarily reflect quality of care or the relevant aspects of staffing provision. Individual hospitals set their planned staffing levels and the report will compare actual against this figure. A similar ward with similar patients in another Trust may set higher or lower planned levels, but have the same number on duty - what assurance does this provide the patients and public?	Thank you for your comment. The existing safe nursing indicators suggest data collection for planned, available and required nursing staff to address this very potential issue if only the planned and available nursing staff data is collected. This NICE guideline also does not suggest a RAG system.

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					• Patient acuity/levels of dependency isn't factored into the proposed RAG rated template and there are situations when patient acuity is so low that it is safe to redeploy staff from one unit to assist another unit where the acuity is higher than planned.	
199	Gloucestershire Hospitals NHS Foundation Trust	3	13	Introduction	When will the NICE approved staffing tools be announced and will this include the Keith Hurst database?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
200	Gloucestershire Hospitals NHS Foundation Trust	3	22	Introduction	Our trust feels that Maternity staffing should be included in the recommendations.	Thank you for your comment. The second safe staffing guideline will focus on midwifery staffing in maternity settings. There is further information on the NICE website about the other topic areas that NICE have been asked to produce safe staffing guidelines on to date.
201	Gloucestershire Hospitals	7	94	1	Ratios are not an effective way to set staffing. Rather, staffing should be set on a shift-by-shift patient	Thank you for your comment and support for this guideline.

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	NHS Foundation Trust				dependency (or average assessment of that).	
202	Gloucestershire Hospitals NHS Foundation Trust	7	101	1	Monitoring and cross comparisons against a range of data sources is a huge task in itself. The guidance makes reference to 'recommendations for monitoring whether or not the calculated staffing requirements are being met', but does not recommend any tools.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
203	Gloucestershire Hospitals NHS Foundation Trust	8	115	1.1.1	How can we develop assurance mechanisms to ensure nursing staff establishments are sufficient to provide safe care if organisations are all using different tools.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits. An endorsed decision support toolkit would be expected to be used together with following the recommendations of this guideline to ensure safe nursing care.

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Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
204	Gloucestershire Hospitals NHS Foundation Trust	8	119	1.1.2	'Agree the required ward or departmental establishments and ensure they are signed off…….' Whilst we already do this as an organisation – is this the correct way forward in light of the Mid Staffs enquiry. Just because we have signed off establishments doesn't mean that they are adequate. Who and what are we benchmarking against?	Thank you for your comment. The guideline has been amended in light of your comment.
205	Gloucestershire Hospitals NHS Foundation Trust	9	130	1.1.4	'Be aware that improved patient outcomes are associated with a higher proportion of registered nurses in the nursing staff establishment'. We acknowledge this fact however we also need to factor in the substantial contribution from other members of the healthcare team such as Health Care Assistants, doctors and Allied Health Professionals in care provision and monitoring	Thank you for your comment. The guideline has been amended in light of your comment where possible.
206	Gloucestershire Hospitals NHS Foundation Trust	9	140	1.1.6	'Consider approaches to support flexibility, such as adapting nursing shifts, skill mix, location and contractual arrangements, and implement them if appropriate'. How do we do this without a nationally recognised tool?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
207	Gloucestershire Hospitals NHS	10	176	1.2.1	'Use a systematic approach that takes into account the patient, ward and staffing factors to determine total nursing requirement.	Thank you for your comment. We have added a link in the introduction section of this

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Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

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	Foundation Trust				Again – how do we do this without a nationally recognised/approved tool?	guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
208	Gloucestershire Hospitals NHS Foundation Trust	11	181	1.2.1	'When staffing toolkits have been endorsed by NICE, these should be used'. Following the directive from the National Quality Board, considerable work has already been undertaken over the last few months in readiness for reporting staffing establishments both monthly and six monthly to Trust Boards and to the public. This has involved extensive input from a number of different teams and information sources. It would appear that this substantial quantity of work would need to be undertaken again when NICE announce which particular toolkits they endorse.	Thank you for your comment. This NICE guideline continues on from the NQB guidance and makes evidence based recommendations to ensure safe staffing for nursing in adult inpatient wards. There may be some additional work required in order to meet the new recommendations as is the case with all new guidelines.
209	Gloucestershire Hospitals NHS Foundation Trust	13	206	1.2.6	'Take into account the following ward factors when determining nursing staffing requirements – ward layout and size'. What tool does NICE suggest to factor in ward layout and size?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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210	Gloucestershire Hospitals NHS Foundation Trust	14	230	1.2.8	'Planned absence/unplanned absence (uplift)' – Could NICE recommend a national Overhead factor? Is it 19%, 22% or 30%?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
211	Gloucestershire Hospitals NHS Foundation Trust	16	255	1.2.11	'Consider expressing average patient's nursing needs in nursing hours per patient day'. Nationally this is usually expressed in FTE (full time equivalent) – not hours. 'Determine the nursing staff requirements in terms of whole time equivalents….' There is huge potential for confusion here if benchmarks and comparisons are being assessed and expressed in different terms (nursing hours v WTE).	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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212	Gloucestershire Hospitals NHS Foundation Trust	17	290	1.2.17	'Add an allowance (uplift) for planned and unplanned absence to the estimate of total nursing requirement'. What allowance (uplift) does NICE recommend as this could have considerable impact in practice?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
213	Gloucestershire Hospitals NHS Foundation Trust	19	328	1.3	How can the development of pressure ulcers be used to state the adequacy of care over a single shift when it can take days for a pressure ulcer to develop?	Thank you for your comment. The safe nursing indicators are intended to be used to assess the adequacy of the number of available nursing staff over a period of time, whilst the nursing red flags are intended to assess the adequacy of the number of available nursing staff in real-

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						time.
214	Gloucestershire Hospitals NHS Foundation Trust	19	328	1.3	'Missed breaks: record the proportion of breaks expected for nursing staff working on inpatient hospital wards that were unable to be taken. 'Nursing overtime: record the proportion of nursing staff on inpatient hospital wards working extra hours (both paid and unpaid)' How does NICE suggest this data should be reported?	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2.
215	Gloucestershire Hospitals NHS Foundation Trust	General comment	General comment	general comment	How does NICE suggest the triangulation of data of: Staffing Patient satisfaction Nurse Satisfaction Patient Adverse Incidents To be reported on a shift-by-shift basis without taking nursing hours away from patient care? It would have been really helpful if NICE could have evidenced the available software systems to help collate this data.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. They were cognisant of the data collection burden and have tried to limit this where possible, but felt strongly that it was important to recommend monitoring and evaluation of nursing red flags and safe nursing indicators. NICE is considering if additional resources may be developed to help facilitate data collection.
216	GMB	8	107	1.1	The NICE document appears to be aimed at the NHS hierarchy structures such as the board, senior management and commissioners. GMB has some	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					concern with this approach as the hierarchy structures don't necessary fully appreciate the demands on frontline clinical staff.	
217	GMB	8	114	1.1	GMB is of the view that there needs to be stronger engagement between the managements structures and with front line clinical staff. The input of front line staff in specific wards/depts remains essential. It is the front line staff who have developed a strong knowledge and skills on the needs of patients. Who in the main understand the complexity, requirements of their depts/wards and have the staff knowledge needed for the day to day running of wards/depts and are equipped to inform the process on how numbers are defined. Current parameters set out by NICE in this consultation document will not meet the needs of wards/depts so we ask that front line staff inputs are seriously considered in how numbers are to be defined.	Thank you for your comment. The guideline has been amended in light of your comment to clarify who each of the recommendations are aimed at. This includes stating that there needs to be involvement of and input from front line staff.
218	GMB	9	144	1.1.7	We also have some concern of the setting of guidelines that may lead trusts to only undertake a 6 monthly review. We feel that is less than sufficient as there is no real mechanism set out to encourage early intervention. Demands on NHS services have massively increased. Where once peak time cycles could be mapped and considered over the course of the NHS year this is now not the case. If there are peak periods in a trust there is a	Thank you for your comment. The guideline has been amended in light of your comment where possible.

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					potential that these times could get understaffed if the review is undertaken at the wrong time of the year.	
219	GMB	11	187	1.2.3	There is a surge in unpredictability in patients results in much greater requirements. Withdrawing patients and intoxicated patients have not been included within this document, however the numbers of these types of patients is ever increasing. Complex admissions, and complex patients will require far more staff time than straight forward admission of patients yet this has not been considered in this consultation but all have knock on effects on defining numbers and skills mix needs at any given time. It is well recorded that tired, overworked staff results in unhappy staff which impacts on patient care. Consistency is something all patients require and consistency is what staff can also benefit from. Patients who are able to relate to the same members of staff are able to develop a rapport and everyone benefits from this and this is best for patient care, quality and outcomes.	Thank you for your comment. The guideline has been amended in light of your comment to include reference to this in Table 1.
220	GMB	13	205	1.2.6	The layout of wards makes a dramatic difference to the numbers of staff required and it is a fact that the introduction of single sex requirements have further exasperate and increased these requirements. With layouts of hospitals taking a uniform approach to wards and departments, the increase of staff requirements for	Thank you for your comment and support for this guideline. The guideline is aimed to encompass all the factors that are likely to influence nursing staff requirements and therefore ward

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					these areas will be the same throughout.	layout has been included amongst these. The Safe Staffing Advisory Committee felt there was still significant variation in the existing size and layout of wards to warrant retaining this.
221	GMB	17	280	1.2.15	We have some concerns with the potential of movement of staff which we feel could be detrimental to patient care as some areas have specialist trained staff in an area outside of their expertise. Essentially there could be staff who do not have a base; bank staff; zero-hour contracts, this cannot be a benefit to patient requirements or ward productivity. Wards and departments have a tendency to follow the same routine, which means the highest requirement for staff will be at the same time in each area. This could mean there is little scope for movement simply because it could be detrimental.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising staff nursing on one ward for other wards.
222	GMB	17	301	1.2.19	It's common practice that Red flag events have to be acted upon by the nurse in charge, management team or hospital-based patient support. The response to demand levels has to be prompt. The GMB is of the view that front line NHS staff should be consulted and in many cases the nurse in charge is often best equipped to act upon red flag events. Currently it appear from within the consultation that	Thank you for your comment. We have amended these parts of the guideline to clarify this front line staff should be involved in these processes.

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					this looks unlikely as the nurse in charge will not have much input into defining the numbers. We feel this will up have a negative impact and is likely to increase not reduce the red flag events in the first place.	
223	GMB	18	314	1.2.22	In order to avoid red flag events and to ensure the trust meet the requirements of this document there will be a tendency to document retrospective numbers, rather than pre numbers or actual numbers and this does cause us much concern. If the criteria set out to define numbers is applied retrospectively improvements are unlikely. We need a strong criteria that is flexible to respond to the needs of defining numbers as demand increases.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
224	GMB	19	318	1.3	Whilst the NICE document has highlighted some important considerations on how numbers could be defined it has fallen short by pinpointing a minimum requirement of staff numbers. GMB remains of the view that a broad criteria that triggers a review for safe staffing levels is essential if we are to adequately respond to the needs of patients. Without a strong focus of safe staffing levels the needs of patients and the reduction of incidents are unlikely to be fully met.	Thank you for your comment and support for this guideline. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was

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						possible to make any more specific recommendations in this area based on the available evidence and their expertise. However the detailed processes that are recommended including the reporting of nursing red flags and safe nursing indicators are to ensure safe staffing for nursing in adult inpatient wards in acute hospitals.
225	GMB	28	518	5	The NICE consultation document refers to nursing staff as registered nurses and healthcare assistants, yet highlight the importance of patients receiving care from the appropriately trained and professional staff. There could be a danger that the points in the NICE consultation with regards to better trained healthcare assistants will promote a move to the use of healthcare assistants instead of trained staff as this would be financially beneficial for the trust. Healthcare assistants and trained professionals have their own respective roles with regards to patient care and interventions. Ensuring there is a balanced mix of staff is imperative.	Thank you for your comment. Section 1.3 has been amended in light of your comment. In addition the existing definition of skill mix in the glossary section has been amended.

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226	Guy's & St Thomas' NHS Foundation Trust	9	121	1.1.2	...."final sign off by the designated board member (Such as chief nurse or equivalent)" Is this to be interpreted that every roster is to have Chief Nurse sign off before publishing? Or is this meaning that a workforce review of nursing establishments is signed off when set/reviewed every 6 months? This is not clear from the text as reads every roster needs Chief Nurse Sign-off, which is not realistic, this would be in practice delegated in most organisations to a Matron or equivalent level once a roster is produced by a ward sister level.	Thank you for your comment. Please see response to comment number 582 as this appears to be a duplicated comment.
227	Guy's & St Thomas' NHS Foundation Trust	11	202	1.2.5	Chart/guidance needs refining with more explicit guidance over time of additional activities. Time ranges are to vague and needs to be more specific i.e. more than 30 minutes per activity, what is the range? Needs to be a researched validated tool for this section.	Thank you for your comment. Please see response to comment number 590 as this appears to be a duplicated comment.
228	Guy's & St Thomas' NHS Foundation Trust	13	211	1.2.6	Can there be more specific guidelines around the impact of ward layout and size on workforce requirements. XX XX has done some work around this area.	Thank you for your comment. Please see response to comment number 592 as this appears to be a duplicated comment.
229	Guy's & St Thomas' NHS Foundation	15	248	1.2.9	For this to be a tool that staff use for workforce planning there needs to be an electronic tool to support this process to aid the calculation of a nursing workforce. The process of determining nursing staff requirements was tested in its	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision

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	Trust				basic form by some of our Matrons. Feedback was that is a useful tool but results seem to significantly inflate a recommended establishment by over 4wte + to ward establishments that are professionally judged to be already above the national average. It is felt results produced from this tool will significantly challenge more disadvantaged organisations.	support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
230	Guy's & St Thomas' NHS Foundation Trust	17	295	1.2.18	Red Flags: This was felt to be an advantage in empowering ward staff/patients to raise a staffing concern with some structure. However there are a number of areas set out that would trigger a red flag. Although this is welcomed there needs to be in place a governance structure which supports this across any organisation as raising a red flag is only one part of the process, the response what action was taken is the most important. This could become a significant burden; it may be best replaced by the nurse in charge asking themselves one question…. 'do I have enough staff with the right skills to care for the patients I am responsible for today?.. yes or No, if the answer is No then this escalates a red flag and triggers a Trust escalation. This would cover any of the elements you have set out rather than raising several red flags for different reasons. We are trialling a new red flag	Thank you for your comment. Please see response to comment number 608 as this appears to be a duplicated comment.

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					escalation system and would be happy to share the results and learning from this. Line 311-313 could be elaborated by stating additional staff could be use of temporary staffing, support from senior departmental nursing management or reallocation of nursing staffing from an alternative area.	
231	Guy's & St Thomas' NHS Foundation Trust	General comment	General comment	general comment	Positive feedback: Overall the guidance gives readers a common national language re: nursing workforce. Bed utilisation as a marker rather than occupancy supports high turnover units where previous tools have missed this workforce pressure. In addition the recognition of the extra time required to meet supporting students and other training and supervision time is welcomed. To improve: as a Trust we have used the SNCT everyday for the last 3 years, this has allowed us to make objective decisions about the acuity and dependency and how our workforce should be profiled. This guide would be strengthened significantly if it could include a tool like the SNCT. We tested out the model using the SNCT and converting the acuity levels into NHPBD. The staffs feedback was that as it stands without something like the SNCT the process was very time consuming and also led to different results dependent on who did the exercise. Therefore as it stands	Thank you for your comment and support for this guideline.

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					it is open misinterpretation. There is no doubt that we need a national tool that supports setting staffing levels based on the profile of your patients and that there is a need for professional judgement. For this to work it needs to be much more focussed, less ambiguous and have a tool that is easy to use by the frontline staff.	
232	Health Education East Midlands	10	159	1.1.9	There is no account for health education / health promotion opportunities (PHE: make every contact count) Specialist nurses undertaking advanced roles (some covering Medical tasks) should not be counted in the RN ward numbers	Thank you for your comment. The role of nursing staff in health education is included in table 2 under the section "patient and relative education". The guideline covers the ward nursing staff establishment, so unless specialist nurses are funded by a particular ward, they would not be included in that ward's establishment.
233	Health Education East Midlands	10	164	1.1.10	Consideration for the nursing staff having students / learners to supervise and assess, including competencies & behaviours whilst on clinical placement does not appear to have been considered.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
234	Health Education East	14	228	1.2.8	No consideration for the level of competence for the nurse appears too considered. I.e. is the nurse that is on preceptorship considered the same as a nurse who's been	Thank you for your comment. Section 1.3 has been amended in light of your comment.

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	Midlands				in that same ward / department for 10 years and has a vast amount of skills and experience?	
235	Health Education East Midlands	17	278	1.2.15	healthcare assistant are included in the nursing staff establishment and as there is no regulatory framework for HCAs it would seem difficult to measure the skills level and potential quality of care accurately between individuals and/or wards	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
236	Health Education England	3	1	Introductio n	NHS England work on 12 hour shifts is an 'initial scoping exercise'	Thank you for your comment.
237	Health Education England	3	16	Introductio n	? word missing after nursing should this read 'nursing staff' or 'nursing team'	Thank you for your comment. The guideline has been amended in light of your comment.
238	Health Education England	3	21	Introductio n	It might be helpful to also highlight that the guideline does not apply to inpatient wards in community hospitals	Thank you for your comment. We have now added some more detail from the scope document to the introduction section of the guideline to clarify what this guideline focuses on.
239	Health Education England	4	41	Introductio n	If the final document is available prior to publication in the guideline the link to this should be included	Thank you for your comment. The guideline has been amended in light of your comment.
240	Health Education	4	43	Introductio n	Suggest use of term 'staffing toolkit' which is in line with term in glossary	Thank you for your comment, the Safe Staffing Advisory Committee

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	England					have discussed the terminology and wish to use decision support toolkits
241	Health Education England	4	46	Introduction	Should it be mentioned that the staffing toolkits will be subject to review in line with future guideline updates?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
242	Health Education England	5	48	1	NHS constitution also includes staff rights and NHS pledges to staff	Thank you for your comment. This section is specifically related to patient-centred care so references to other parts of the NHS constitution are not mentioned here.
243	Health Education England	6	64	Introduction	Add details of which committee	Thank you for your comment. The guideline has been amended in light of your comment.
244	Health Education England	7	94	1	Given the media coverage of the draft guideline specifically focused on ratios. Can this section be strengthened / expanded to reinforce the fact that there is no single ratio which can be applied to all in-patients in	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					acute hospitals. The NQB guidance clearly highlights that other factors are also important for example staff experience, capability and leadership.	
245	Health Education England	7	102	1	Suggest use of term 'nurse staffing' instead of 'nursing staff' this would apply throughout the guideline	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
246	Health Education England	8	106	1	Suggest splitting patient, ward and nurse staffing factors into 3 separate bullets as they are separate issues	Thank you for your comment. The guideline has been amended in light of your comment.
247	Health Education England	8	106	1	Suggest including additional text or additional box to emphasise the need to monitor staff in post against the agreed nurse staffing establishment	Thank you for your comment. The safe nursing indicators have been amended in light of your comment.
248	Health Education England	8	106	1.3	This section highlights the importance of setting the right nurse staffing establishment however it is also vital that the establishment is recruited to with substantive staff otherwise there will be a deficit of staff 'in post' (an issue identified in the Keogh review) with the potential for shifts left uncovered or an over reliance on temporary staffing.	Thank you for your comment. The safe nursing indicators have been amended in light of your comment.

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249	Health Education England	8	119	1.1.2	Suggest changing 'signed off'' on line 120 to 'developed with and agreed by' Suggest changing 'ward leader' to 'ward manager' in line 121 Suggest changing last sentence (line 122-124) 'At a minimum, this should be done when the ward establishment and budget are set and reviewed on a regular basis' or 'At a minimum, this should be done when the ward establishment and budget are set and reviewed on a regular basis, in line with the National Quality Board guidance'.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
250	Health Education England	9	125	1.1.3	Suggest being more explicit about the need to include capacity to deal with planned (annual leave, maternity leave and study leave) and unplanned absences (sick leave and other leave for example carers leave or compassionate leave) as well as variations in clinical activity. Suggest splitting these two points into two separate sentences.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
251	Health Education England	9	143	1.1.7	This is in line with the expectations outlined in the National Quality Board Guidance.	Thank you for your comment and support for this guideline.

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252	Health Education England	9	143	1.1.7	There is a step missing between monitoring and reviewing nurse staffing establishments and having procedures in place to identify differences between staff available and the staff required. The missing step is the need for organisations to recruit to the agreed funded nurse staffing establishment. (This links with the comments under diagram box one and ensure capacity 114-131 above)	Thank you for your comment. The recruitment of nursing staff and workforce planning are outside of the scope of this guideline.
253	Health Education England	10	150	1.1.8	This is in line with the expectations outlined in the National Quality Board Guidance	Thank you for your comment and support for this guideline.
254	Health Education England	10	153	1.1.8	Suggest changing wording to ‘throughout a 24-hour period , 7 days per week’	Thank you for your comment. The guideline has been amended in light of your comment.
255	Health Education England	10	158	1.1.9	No account is taken of the health education / health promotion role and related activity of nursing staff	Thank you for your comment. The role of nursing staff in health education is included in table 2 under the section "patient and relative education".
256	Health Education England	10	163	1.1.10	Suggest adding bullets which covers the following: Nursing staff having education and training in: • the use of staffing toolkits • implementation of this guideline • effective rostering	Thank you for your comment. The guideline has been amended in light of your comment where possible.

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257	Health Education England	10	169	1.1.12	Suggest specific reference to escalation policies	Thank you for your comment. The guideline has been amended in light of your comment where possible.
258	Health Education England	10	175	1.2	This section advocates the use of a staffing toolkit that is endorsed by NICE then later in the guidance one particular methodology / staffing toolkit is featured – Nursing Hours per Patient Day. How can other staffing toolkits be equitably assessed against guidance which advocates one particular toolkit yet excludes others for example a patient acuity / dependency approach?	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is

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						interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
259	Health Education England	11	187	1.2.3	Suggest making reference to the point that: it is desirable patients are cared for within the relevant clinical specialty	Thank you for your comment. This important point is covered in the existing recommendation under the section of "focus on patient care".
260	Health Education England	13	203	1.2.5	Admission row – add complex admission assessment under significant column	Thank you for your comment. The guideline has been amended in light of your comment.
261	Health Education England	13	214	1.2.7	Split bullet 3 into 2: • Professional supervision / preceptorship of nursing staff • Mentorship of students Add bullets • Communications with other members of the multi-professional team • Undertaking quality of care audits and training needs analysis • Staff related activities including setting objectives, appraisal and personal development planning	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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262	Health Education England	14	228	1.2.8	Suggest removing brackets in lines 234-235. 'Allowance for these types of planned and unplanned absence is commonly referred to as uplift or headroom'.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
263	Health Education England	14	228	1.2.8	Planned absence includes provision for mandatory training as well as continuing professional development	Thank you for your comment. The guideline has been amended in light of your comment.
264	Health Education England	14	239	1.2.9	What is the methodology for estimating the total nursing requirement? How will this be applied consistently?	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
265	Health Education England	15	248	1.2.9	This section advocates the use of a staffing toolkit that is endorsed by NICE then later in the guidance one particular methodology / staffing toolkit is featured – Nursing Hours per Patient Day. How can other staffing toolkits be equitably assessed against guidance which advocates one particular toolkit yet excludes others for example a patient	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to

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					acuity / dependency approach?	advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
266	Health Education England	15	248	1.2.9	This section is very confusing and it is not clear how this would be used alongside an endorsed staffing toolkit. Is the intention that the staffing toolkits which are endorsed will address all these factors? How would this be used in the absence of a staffing toolkit? There is a risk that a	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could

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					significant amount of effort could be expended by nursing staff in organisations estimating the number of nursing hours per patient day which would result in a high level of subjectivity and variability in relation to interpretation of this guideline. What is the evidence base for the selection of Nursing Hours for Patient Day and the numbers included – this is not explicit in the guidance. It is not clear if it is intended that this process is followed to set an establishment or to identify staffing needs on a real time / day to day basis. This clarification is essential as you would include an allowance for planned / unplanned absence when setting nursing establishments but not on a shift by shift basis. This section needs to be reviewed and rewritten, if it is intended that this will be real time process then are elements which will need to be developed based on historical data and factored into the calculations for example %headroom / uplift; time spent on non direct patient care etc. HEE recommends that this section is converted into a list	facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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					of factors that relevant staffing toolkits will be endorsed against. This would include a series of steps which should be taken account of when setting a nursing establishment (as outlined in the NQB guidance).	
267	Health Education England	16	250	1.2.10	It would be unreasonable to expect nursing staff in local organisations to estimate nursing hours per patient day for the caseload of patients on any given shift. A staffing toolkit should be used for this purpose for example the nurses would record the categorisation of each patient in the form of a patient acuity / dependency score or similar categorisation and the tool used would then estimate the nursing requirements for that group of patients based on a database of information relevant to the care needs of these patients. It would also be unreasonable to expect nursing staff in local organisations to be estimating the additional ward and staff factors on a daily basis. This would need to be estimated from recording and analysis of baseline data ensuring a consistent approach is used across organisations. Some of the information detailed is not real time for example you cannot say what the bed utilisation will be for that day. It can only be used retrospectively.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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268	Health Education England	16	271	1.2.14	An uplift for planned and unplanned leave should be included in this calculation.	Thank you for your comment. Uplift for planned and unplanned leave is already included in this section.
269	Health Education England	17	278	1.2.15	The title of this section is confusing it relates to staff establishment and shift allocation yet actions are as follows: 1.2.15 relates to allocation of the staffing resources available on a shift by shift basis 1.2.16 relates to planning a roster Suggest title of this section is amended to effective use of available resources. Suggest 1.2.17 is amended to reflect the need to plan annual leave and study leave so that there is a consistent allocation across all duty rosters ensuring that there are not too many staff off at any one time. Suggest there is reference made to the accountabilities of Registered Nurses when care is delegated to health care support workers The level of competence of the Registered Nurse does not appear to have been considered	Thank you for your comment. The guideline has been amended to separate the process of setting the establishment and assessment on-the-day.

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270	Health Education England	17	290	1.2.17	1.2.17 As mentioned above the allowance for planned and unplanned leave would not be added at this stage,	Thank you for your comment. The guideline has been amended so that section 1.3 now contains more detailed recommendations on determining skill mix.
271	Health Education England	17	295	1.2.18	1.2.19 and 1.2.21 Although there is support for monitoring red flag events the predictability of these may not be known at the start of the shift and when they do begin to arise it could be difficult to access more staff part way through a shift as no area has a surplus of nursing staff and additional staff require to be booked in advance. The only one that will be clear at the start of the shift is the shortfall in presence of staff, all the others can only be recorded as they occur throughout the shift. The red flags could be used retrospectively to demonstrate that the adequacy of the establishment agreed for that clinical area linked to monitoring of the actual staff available on each shift (1.2.22)	Thank you for your comment. We have amended these parts of the guideline to clarify these issues.
272	Health Education England	19	328	1.3	Staff reported missed breaks needs further consideration. How will this be recorded and reported? One missed 10 minute tea break on a short shift is different to all breaks being missed on a 12 hour shift. Similarly how will the nursing overtime be recorded? Who	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2. Verification of this data and remuneration for

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					will verify this? Will staff be paid for this? The section re the recording planned and available nursing staff should be aligned to the requirements of NHS England which have been published since this consultation was issued. Bank and agency staffing are generally referred to as temporary staffing. Those on short term contracts are more akin to substantive staff as they tend to have better induction, training and more familiarity with organisation. Other staffing indicators could be ability for staff to complete mandatory and other training, appraisal rates for nursing staff and satisfaction rates for nursing staff.	overtime will be down to local discretion. The Safe Staffing Advisory Committee were keen to recommend data collection for the planned, available and required nursing staff as the required number of nursing staff is more important than the planned number.
273	Health Education England	20	329	1.3.2	The establishment review should use a staffing toolkit as endorsed by NICE.	Thank you for your comment which is in line with the intentions of the guideline recommendations.
274	Health Education England	20	334	1.3.3	Cognisance should be taken of the fact that the establishment may be set at the appropriate level however this level of staffing may not be delivered due to vacancies or absence. Similarly where the staffing levels are met on a shift by shift basis the quality of care could be influenced	Thank you for your comment which is in line with the intentions of the guideline recommendations and is the basis for including the range of safe nursing indicators

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					by the number of staff who are substantive and the number who are temporary staff (particularly agency) and the levels of experience of the staff.	that have been recommended, in particular those on the ward nursing staff establishment.
275	Health Education England	21	340	2	Should the NQB guidance be included as there was a presentation on this at the first meeting of the advisory group?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
276	Health Education England	23	422	3	Point b) suggest this relates to available Registered Nurses as c) covers healthcare assistants Point c) suggest this is expanded to look at the impact of different levels of healthcare assistant for example Assistant / Associate Practitioners	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible
277	Health Education England	25	459	3.1	Suggestions for future research questions include: • Nurse staffing levels and the quality of patient care / experience / outcomes for patients in the UK • Nurse staffing skill mix and the quality of patient care / experience / outcomes for patients in the UK • Recommendations of different staffing methodologies / toolkits • Nurse staffing levels and staff outcomes in the UK • Impact of different levels of HCA for example Assistant / Associate Practitioners and Healthcare Support Workers • Impact of shift patterns on quality of patient care / staff	Thank you for your comment. The guideline has been amended in light of your comment.

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					outcomes • Impact of supervisory status of the lead sister / charge nurse on patient care / staff outcomes	
278	Health Education England	27	470	5	It might be helpful to also highlight that the guideline does not apply to inpatient wards in community hospitals	Thank you for your comment. The guideline has been amended in light of your comment.
279	Health Education England	27	470	5	Can it be assumed by default that all other wards across all other specialties are included? This needs to be more explicit.	Thank you for your comment. The guideline has been amended in light of your comment.
280	Health Education England	27	478	5	Suggest patient safety and quality of care are included in this definition	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
281	Health Education England	27	492	5	Suggest title is amended to reflect care which is delayed, sub-optimal or inappropriately delegated. Suggest missed, incomplete and inappropriate care	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
282	Health Education England	28	496	5	This section is totally inaccurate as it does not reflect the non-direct patient care activity including meal breaks, handover, ward rounds, communications with team and family, preceptorship, mentorship of students etc	Thank you for your comment. The guideline has been amended in light of your comment.

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283	Health Education England	28	506	5	Nursing skill mix is usually presented as a %ratio for example 70:30 / 65:35	Thank you for your comment. Section 1.3 has been amended in light of your comment. In addition the existing definition of skill mix in the glossary section has been amended.
284	Health Education England	28	515	5	Suggest use of term nurse staffing establishment throughout document instead of nursing staff establishment	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. In order to be consistent with other terminology used in the guideline the term ward nursing staff establishment has been retained to indicate that this includes both registered nurses and healthcare assistants.
285	Health Education England	28	540	5	Will the staffing toolkit by retrospective, real time or prospective?	Thank you for your comment. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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286	Health Education England	28	543	5	The definition needs to be more explicit regarding the elements of non-direct patient care for example handover reports, ward rounds, communications with team and family, discharge planning and audits etc. Staff factors include education and training, preceptorship, mentorship of students, rostering, appraisals, personal development planning and undertaking training needs analysis. Total nursing requirement is not usually expressed in nursing hours per day – it is commonly referred to as a whole or full time equivalent.	Thank you for your comment. The guideline has been amended in light of your comment.
287	Health Education England	35	673	8	What is the process for approving these tools? Will this be presented to the advisory committee? Will this be consulted on prior to final approval? What are the timeframes for this? What professional expertise will be included in this process?	Thank you for your comment. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
288	Health Education England	37	688	Appendix 1	This section is repetitive, confusing and too lengthy. It is difficult to follow and will not be accessed by frontline staff in this format. Is there a simpler way of presenting this information? Mention could be made of the impact of staff satisfaction on patient outcomes	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. However, please note that this is an Appendix to the

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						main guideline and is designed to contain more detail on the how the evidence considered was used in the development of the recommendations for those who wish to refer to it.
289	Health Education England	37	695	Appendix 1	This statement is unclear as the process is measuring nursing workload based on patient care needs and some organisations already have robust systems in place to deliver this currently so in these organisations there may not be cost implications to meet nursing care requirements	Thank you for your comment. The guideline has been amended in light of your comment.
290	Health Education England	40	697	Appendix 1	Other considerations box – suggest amending patient needs to patient care needs (row 7)	Thank you for your comment. The guideline has been amended in light of your comment.
291	Health Education England	42	698	Appendix 1	It should be acknowledged that where there is inadequate or insufficient capacity there will be an increased reliance on temporary staffing which can have implications on cost and quality of care.	Thank you for your comment. The guideline has been amended in light of your comment.
292	Health Education England	44	701	Appendix 1	Suggest reference is made to the NQB staffing guidance in this section	Thank you for your comment. The guideline has been amended in light of your comment.
293	Health Education England	46	704	Appendix 1	Suggest education and training should be extended to include effective use of resources / rostering / use of nurse staffing toolkits / implementation of guidance	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The

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						guideline has been amended in light of your comment, where possible.
294	Health Education England	48	705	Appendix 1	Other considerations section – this could be reworded to highlight the importance of organisational culture on quality of care and one example of good practice from another healthcare system is magnet accreditation. Is magnet accreditation transferable to UK / NHS context?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
295	Health Education England	51	709	Appendix 1	NQB guidance refers to professional scrutiny rather than professional judgement- suggest making link here	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
296	Health Education England	51	709	Appendix 1	Other considerations – is mortality not directly linked to numbers of Registered Nurses? Text currently reads ‘mortality increases when required or the set staffing level is no met for particular shifts’ Tools & professional judgement are used to determine the required nursing establishment but then this establishment needs to be approved by the Trust Board (or equivalent) and recruited to. Funded establishments could be fine but	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					care is compromised where the establishment is not recruited to	
297	Health Education England	53	710	Appendix 1	Other considerations section. Third para suggest making it explicit that age relates to patient's age	Thank you for your comment. The guideline has been amended in light of your comment.
298	Health Education England	55	711	Appendix 1	Other considerations section p54/55. Suggest incorporating the term day attender or ward attender into the second para. Third para – change term 'single beds' to 'single rooms'. Make reference to ease of observation by nursing staff.	Thank you for your comment. The guideline has been amended in light of your comment.
299	Health Education England	56	711	Appendix 1	Economic considerations – last sentence is not aligned with staff factors rather it relates to ward environment / layout	Thank you for your comment. The guideline has been amended in light of your comment.
300	Health Education England	55	711	Appendix 1	Quality of evidence section – not clear how this relates to planned and unplanned leave	Thank you for your comment. The guideline has been amended in light of your comment.
301	Health Education England	58	712	Appendix 1	Suggest splitting professional supervision of nursing staff from mentoring of student nurses (two distinct activities) Other activities include audit work, education and training delivery to staff and patients and attendance at education and training	Thank you for your comment. The guideline has been amended in light of your comment.
302	Health Education	58	712	Appendix 1	Para 2 re on-going training and education dislike term 'personal training' this is mandatory training or professional	Thank you for your comment. The guideline has been amended in

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	England				training to deliver safe and effective, evidence based care or to expand professional practice to benefit patient care	light of your comment.
303	Health Education England	60	713	Appendix 1	Is it expected that this process will be followed on a real time basis by ward staff, if so this is unrealistic. This is what a staffing toolkit would be used to deliver. The suggested process would result in wide variability as the estimations would be interpreted differently by frontline staff who lack the expertise to undertake this complex assessment.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
304	Health Education England	61	714	Appendix 1	1.2.15 mention should be made of appropriate delegation as opposed to allocation.	Thank you for your comment. The guideline has been amended in light of your comment.

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305	Health Education England	70	718	Appendix 1	Despite the caveats around the wording of this section the focus on 1:8 in the draft guidance has already been misinterpreted by the media and some members of the nursing profession. HEE do not support the concept of a uniform nurse to patient ratio particularly as the main evidence base for this is one UK study relating to mortality in surgical wards – can this finding be applied more widely to other in-patient wards as is being proposed in the guidance? This study uses data from the late 1990s (over a decade ago) and both nursing and clinical practice has changed significantly during this period. HEE believe that nurse staffing levels should be calculated based on patient care needs using an evidence based staff tool as outlined in the NQB staffing guidance. The expectations in the NQB guidance are being successfully applied to a range of clinical in-patient wards in acute hospitals, however there is a risk that the focus on a ratio in the NICE guidance could have an adverse impact on this work as organisations may focus on this single ratio instead of using an evidence based tool (staffing toolkit) which could result in inadequate nurse staffing to meet individual patient care needs. Additionally the focus on a single ratio is inflexible and does not take account of	Thank you for your comment and support for this guideline. We have made amendments to help clarify this issue.

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					fluctuations in clinical activity or patient acuity, dependency or throughput. Furthermore the focus on a simple ratio does not take account of other factors which are of critical importance to patient care for example the skills and expertise of Registered Nurses and support staff; the familiarity with the ward or organisation (substantive or bank staff will be more familiar with this than agency staff); the education and training received and the nursing leadership at ward and organisational level. HEE request that this section be reconsidered as there is a high risk that if this is included it will be the main area of focus for healthcare organisation which could be detrimental.	
306	Health Education England	70	718	Appendix 1	P70 para 2 indicates why it is not helpful to focus on a 'one number / ratio fits all approach'. The approach should be to focus on the specific individualised care needs of a caseload of patients. Para 3 – what other studies are being referred to?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. This has been further added to following your comment.

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307	Health Education England	71	719	Appendix 2	As outlined previously it is not clear why the NHPPD toolkit approach has been included in the guidance. Why was this chosen over an acuity or dependency approach for example? What was the decision making process?	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in section 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio

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						or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
308	Health Education England	71	720	Appendix 2	Complex process, difficult to understand and follow. How would staffing toolkits be assessed against this process? It favours the NHPPD approach over other methods. It is not clear how the calculations have been derived for the NHPPD. What is the source / evidence base?	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in section 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments. Nursing hours per

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						patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.

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309	Health Education England	71	727	Appendix 2	What is the evidence base for the 5.32 hours per patient day estimation? What is the evidence base for the additional workload of 5.6 nursing hours per day estimation? Do frontline nurses understand this process or have the knowledge and skills to apply it accurately and consistently particularly in a real time context? Based on feedback from Dr Keith Hurst the Safer Nursing Care Tool multipliers when converted to NHPPD showed that: Level 0 patients (least dependent) need 4.68 hours Level 1a - 6.47 Hours Level 1b - 8.05 Hours Level 2 -9.21 Hours Level 3 – 27.95 Hours The use of 5.32 NHPPD is therefore of concern and unworkable.	Thank you for your comment. Appendix 2 in the draft version was clearly labelled as an example scenario and the numbers used were not intended to represent any recommended figures. The numbers used were to only illustrate the various steps of the process that were described in the recommendations section of the guideline. We have amended the text in this text to further illustrate that this is an example.

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310	Health Education England	General comment	General comment	general comment	Health Education England (HEE) supports the principle of greater transparency in relation to nurse staffing levels and a focus on the explicit calculation of nurse staffing levels based on individual patient care needs. HEE understands the need for the document to be formal and evidence based but the current guidance it is not in a format which is 'user friendly' for frontline staff. Overall the views of HEE are that the guidance is difficult to follow, confusing and too lengthy. What education and training will be available to support implementation of the guideline in acute hospitals? Part way through the guidance a staffing methodology (Nursing Hours per Patient Day) is used and it is not clear why this is included in the guidance; how the exemplar NHPPD hours were derived and how this would be used in practice alongside other NICE endorsed tools. The NHPPD calculations in the guidance do not correspond with the calculations used in the Safer Nursing Care tool for example. HEE recommends that reference to NHPPD is excluded from the guidance and that this methodology is	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. Nursing hours per patient day is also used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to

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					then assessed against the guidance as a staffing toolkit which can be endorsed by NICE as appropriate. This would be a fairer process which would enable all staffing toolkits to be reviewed on an equitable process basis. The reference to 1:8 (although only in appendices) is likely to dominate the interpretation of the guideline.	patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
311	Healthwatch Dudley (HWD)	9	133	1.1.5	The focus appears to be on numbers of nursing staff with little attention paid to skills and competency level. Moving nurses around wards is common practice to keep the numbers ‘up’, we receive concerns from nurses who say they do not have the experience to safely manage patients when they are moved into unfamiliar wards at short notice. The length of time a nurse has been qualified should be considered, as junior staff nurses are been relied upon to act into more senior roles when staff levels are low.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
312	Healthwatch Dudley (HWD)	11	188	1.2.3	Nursing skills should match patient requirement	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
313	Healthwatch Dudley (HWD)	11	194	1.2.4	And skills and competency in dealing with certain conditions, including…	Thank you for your comment.

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314	Healthwatch Dudley (HWD)	13	216	1.2.7	Efficiency of nursing staff available.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
315	Healthwatch Dudley (HWD)	14	244	1.2.9	In terms of numbers and experience of the team	Thank you for your comment. The guideline has been amended in light of your comment.
316	Healthwatch Dudley (HWD)	18	305	1.2.19	Ability to respond to nurse call button within couple of minutes in order to acknowledge the urgency of patient request.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
317	Healthwatch Dudley (HWD)	20	333	1.3.2	And the experience of newly qualified staff	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
318	Hearing Link	11	197	1.2.4	The holistic assessment of patient need should include assessment for hearing loss.	Thank you for your comment. We feel that hearing loss assessment is encompassed within Table 1 in the row that discusses communication
319	Hearing Link	11	199	1.2.5	Communications support should be considered for patients with hearing loss.	Thank you for your comment. We feel that hearing loss assessment

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						is encompassed within Table 1 in the row that discusses communication
320	Hearing Link	12	202	1.2.5	Really encouraging to see the needs of patients with sensory loss recognised.	Thank you for your comment and support for this guideline.
321	Hearing Link	13	203	1.2.5	No mention of sensory loss support here	Thank you for your comment. We feel that hearing loss assessment is encompassed within Table 1 in the row that discusses communication
322	Hearing Link	13	219	1.2.7	Consideration of support for relatives and carers that might have hearing loss.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. Tables 1 and 2 cover communication and carer support.
323	Hearing Link	General comment	General comment	general comment	General comments: We recommend that deaf awareness training is readily available for all staff, including nursing staff and that regular updates are given.	Thank you for your comment and support for this guideline.

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324	Hinchingbrooke Health Care NHS Trust	8	114	1.1.1	Ensure Capacity: Assurance mechanisms are definitely required for nursing establishments. What also needs to be considered is the impact of staff turnover, ward/unit speciality and the acknowledgement that as patients get older they will require an increase in nursing care as well as seasonal variations and ensure that environmental considerations are taken into account. There should also be some thought as to the effectiveness of escalation bed opening and safety of patients.	Thank you for your comment and support for this guideline. The guideline is aimed to encompass all the factors that are likely to influence nursing staff requirements. This includes patient and staff factors.
325	Hinchingbrooke Health Care NHS Trust	9	130	1.1.4	The evidence is clear and valid regarding the association between registered staff numbers and better patient outcomes. It is essential that this is explored fully and ratio of registered staff to unregistered staff fully explored. In order to continue to provide the best experience and outcomes for patients as well as ensuring career pathways for health care staff it is vital that the evidence is recognised.	Thank you for your comment. The guideline has been amended in light of your comment where possible, however the Safe Staffing Advisory Committee felt it was not appropriate to recommend a ratio of registered nurses to healthcare assistants. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations

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						specific to developing individual recommendations in Appendix 1.
326	Hinchingbrooke Health Care NHS Trust	9	133	1.1.5	Support Flexibility: This is an essential area to promote and it may be an area where further work can be done to ensure efficiency and effective care in a sustainable, planned manner. The gap in research evidence is noted and it may well be a suitable area for future project/research.	Thank you for your comment and support for this guideline.
327	Hinchingbrooke Health Care NHS Trust	9	143	1.1.7	Monitor adequacy of nursing staff establishment: Support this recommendation and again note lack of research on this topic. Monitoring and reviewing in a formal manner along with procedural review would enhance the stability of the workforce and perhaps also retention of staff.	Thank you for your comment and support for this guideline.
328	Hinchingbrooke Health Care NHS Trust	10	158	1.1.9	Focus on patient care Although no formal research, reports identify this as an area for implementation. The expertise of nurses in their speciality as well as the contribution of Specialist Nurses to practice is something that should be acknowledged and recognised as an essential factor in patient outcomes	Thank you for your comment. The guideline has been amended in light of your comment.

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329	Hinchingbrooke Health Care NHS Trust	10	163	1.1.10	Promote staff training and education: Ward management is an essential skill for ensuring patient safety and the value of this can sometimes become lost in the leadership agenda . In order to be able to manage the staffing and skill mix on the clinical area senior staff require experience and coaching as well as gaining knowledge.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
330	Hinchingbrooke Health Care NHS Trust	10	166	1.1.11	Involvement of staff in quality assurance process enhances ownership of quality and safety issues, however, these need to be meaningful to the area and realistic with achievable outcomes. This should also be underpinned by sound principles	Thank you for your comment. The guideline has been amended in light of your comment where possible.
331	Hinchingbrooke Health Care NHS Trust	10	171	1.2	Ward Level factors and approach to determine daily nursing requirements: A staffing tool kit that has been consulted on and developed in partnership with all stakeholders and endorsed by NICE would provide assurance, consistency and validity to the process of using clinical and professional judgement of staff requirements.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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332	Hinchingbrooke Health Care NHS Trust	11	187	1.2.3	Patient Factors: Clarity is required regarding acuity and dependency of patients as the terms can be confusing and may be used interchangeably. Patient focused care, with the patient at the heart of planning care and care pathways is absolutely essential along with the involvement of the whole healthcare team	Thank you for your comment. The guideline is aimed to encompass all patient factors that are likely to influence nursing staff requirements. We have amended the guideline text to state that patient nursing needs would include both patient acuity and patient dependency as we agree the terms acuity and dependency may be confusing.
333	Hinchingbrooke Health Care NHS Trust	13	205	1.2.6	Ward Factors: These recommendations highlight the importance of nursing workload in relation to ward layout and patient turnover. We feel that this is an important issue that will need to be addressed now and in the future as healthcare commissioning and delivery evolves.	Thank you for your comment and support for this guideline.
334	Hinchingbrooke Health Care NHS Trust	13	214	1.2.7	Nursing Staff Factors: Recognition of the value of the role of mentors and the supervision of staff, whether in learning, coaching or support on the ward is important. These recommendations add strength to supporting staff in practice. It would be valuable to undertake a project/study around the commitment required for supporting staff.	Thank you for your comment and support for this guideline.

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335	Hinchingbrooke Health Care NHS Trust	14	236	1.2.9	Process for setting ward nursing staff requirements: These recommendations get to the heart of the issue around nursing staff ward requirements. It is noted that the distinction between bed occupancy and bed numbers is highlighted in this recommendation. It is important that establishing staffing requirements takes account of the whole range of factors that may affect staffing numbers. It is recognised that professional judgement is also essential component of critical analysis. Monitoring process measures is essential for patient safety i.e. reducing medication errors	Thank you for your comment and support for this guideline.
336	Hinchingbrooke Health Care NHS Trust	19	318	1.3	Monitor and evaluate ward nursing staff establishment: Monitoring and evaluating nursing practice against nursing indicators and taking into consideration nurse/patient ratio is again an area that is vital to ensuring patient safety and improving patient experience. It is important to ensure the process takes account of the patient acuity and dependency as well as patient numbers when determining nurse/patient ratio.	Thank you for your comment. This if fully in line with the recommendations of this guideline to ensure patient needs are fully accounted for when determining nursing staff requirements.
337	Hywel Dda University Health Board	9	130	1.1.4	Welcoming to note that improved outcomes are associated with a higher proportion of registered nurses in the nursing staff establishment, the evidence is clear and although this is not a surprise to Nurses is to some of our other colleagues.	Thank you for your comment and support for this guideline.

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338	Hywel Dda University Health Board	13	203	1.2.5	We particularly like the tables on page 12 & 13 these are similar to the methodology used in Birth Rate Plus but with a nursing focus. I do however think that the additional patient factors outlined in 1.2.4 should be incorporated into the tables or they may be omitted	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The section regarding patient factors has been amended; however, the Safe Staffing Advisory Committee felt that retaining these factors outside of the tables would make them more visible.
339	Hywel Dda University Health Board	15	248	1.2.9	We welcome this calculation and this could well support us to scope out what is potentially required in terms of staffing levels and time required although it does not suggest the skill mix apart from a 60:40 ratio of registered and unregistered. The formula suggested by NICE also recognises that time is needed to assess the patients thoroughly and to document all the needs adequately. By allowing this time then I believe we will have more robust understanding of the individuals needs and tailor their care to meet that element.	Thank you for your comment and support for this guideline. Please note that the guideline does not stipulate a specific skill mix ratio. The example previously included in Appendix 2 was meant to be an example to illustrate the processes and calculations, not to recommend specific numbers.
340	Hywel Dda University Health Board	28	525	5	The guidance mentions patient dependency but it may be more helpful to utilise the term complex as 'dependent' may be misleading, implying that a person requires a lot of input. However many patients who are totally dependent are stable and predictable whereas the term 'complex'	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where

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					indicates that the level of need is not predictable, where one condition interacts with another and may require intensive support and management.	possible.
341	Hywel Dda University Health Board	General comment	General comment	general comment	Please find very general comments below on the consultation of staffing levels in the acute sector from NICE. We welcome this document as it emphasises the importance and positive impact that nurses have on patient care and outcomes. We particularly like the concept of the nurse manager having the autonomy to flex the staffing levels up and down on a needs basis. The document also highlights and recognises the importance of using professional judgement in order to meet the needs of the acute wards. Most staffing levels have been based on historical figures and yet the patient profile of today's population has significantly changed with an ageing population along with increased frailty, co-morbidities and dementia. Just looking at the concept of dementia means that increased time is required to successfully meet this client groups needs due to the levels of cognitive impairment. NICE clearly recognises this and suggests additional time is built into the toolkits to address this. With approx 60% of our patient	Thank you for your comment and support for this guideline.

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					population are elderly occupying the beds and this therefore means there must be a significant level of people with dementia in our hospitals, all requiring additional time to meet their needs.	
342	Hywel Dda University Health Board	General comment	General comment	general comment	We value the autonomy given back to the ward sisters to flex up and down depending on need although we would need to manage this with prospective off duties and e rostering. However, this gives us scope to address the contracted hours with the additional hours being met by our in house bank which we could budget into the system in advance and only utilise it as required. Finally we welcome this as it returns the autonomy to the nursing profession and nurse managers who have the professional judgement to understand the needs and requirements of their wards. They are the ones who know their staffs' skills and competencies and so can then roster the appropriate people on any shift.	Thank you for your comment and support for this guideline.
343	Kettering General Hospital NHS Foundation Trust	General comment	General comment	general comment	This is very comprehensive. My only comment would be in association with consistent delivery across the whole healthcare economy and how Trusts will be measured. There is also something regarding the wider workforce - AHPs, Medics for example...why the focus on just nursing when other professions have an impact on patient	Thank you for your comment and support for this guideline. We have now amended the introduction section to explain that we were asked to focus on nursing staff.

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					outcome and experience	
344	Lewisham and Greenwich Healthcare NHS Trust	6	79	Introduction	These sections around evidence strengths and "strength" of recommendation are useful. Helpful to highlight these more clearly perhaps in the form of a Box and repeating this in the Glossary	Thank you for your comment. The guideline has been amended in light of your comment.
345	Lewisham and Greenwich Healthcare NHS Trust	7	94	1	No set ratio was expected and welcomed	Thank you for your comment and support for this guideline.
346	Lewisham and Greenwich Healthcare NHS Trust	7	105	1	The recognition and splitting of Recommendations into Organisational Strategy Ward Level Factors and Monitoring and Evaluation of Ward Nursing Establishment is helpful and the sub categories are clearly followed through	Thank you for your comment and support for this guideline.
347	Lewisham and Greenwich Healthcare NHS Trust	11	183	1.2.2	Professional Judgement recognition welcome with some parameters for making that judgement. Not clear how Table 1 contributes-very specific and would be cumbersome in practice. Simple Acuity and Dependency Tool could/should pick up this element. Risk of layering advice over advice. NICE Endorsed Toolkits should address specifics and provide that level of description-risk	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have amended the recommendation which describes how Tables 1 and 2 could be used.

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					that will be seen as THE way to undertake Establishment and Skill Mix Review	
348	Lewisham and Greenwich Healthcare NHS Trust	11	199	1.2.5	Acknowledgement of Specials helpful	Thank you for your comment and support for this guideline.
349	Lewisham and Greenwich Healthcare NHS Trust	14	237	1.2.9	This section like above seems to suggest this is THE way of approaching it. Doesn't seem to have a resemblance to any currently available tool but has aspects of a range of tools. This level of specific information would be contained in a NICE endorsed tool not as example in guidance. Perhaps a summary focus on what the characteristics of a toolkit should consist of would be helpful in the guidance. Concept of bed utilisation as opposed to occupancy helpful as it will account for aspects of flow.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
350	Lewisham and Greenwich Healthcare NHS Trust	18	306	1.3	Red Flags will be helpful to inform escalation frameworks that will in turn inform ESMR's. Not sure how some of this would be captured or validated at a practical level though	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red

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						flag events.
351	Lewisham and Greenwich Healthcare NHS Trust	19	318	1.3	Use of NSI alongside ESMR's expected and may give an indication of sufficiency or insufficiency of staffing but would only signal the need for further analysis to establish this. Some suggested indicators include number of missed breaks and this would require more data collection at ward level.	Thank you for your comment. The safe nursing indicators were developed following a systematic literature review of the best available evidence. Those that are included are based on the expert view of the Safe Staffing Advisory Committee to be the most sensitive to the number of available nursing staff.
352	Lewisham and Greenwich Healthcare NHS Trust	23	404	3	Limitations to evidence base articulated and this may have a bearing on what tools/resources a Trust deploy. It appears from the evidence base that there is little or no evidence that assesses effectiveness of using defined approaches or toolkits. On that basis Trusts will go to what familiar, what they have used in past and what they have some expertise in running.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline recommends that a NICE endorsed decision support tool should be used when available. We have added links to a separate webpage on the NICE website that will contain all the information regarding the endorsement process of decision

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						support toolkits
353	Lewisham and Greenwich Healthcare NHS Trust	71	720	Appendix 2	Terminology being used in the example will be unfamiliar to staff. Nursing Hours per Patient Day. In addition this needs to be calculated on a ward by ward basis by examining/observing activity over an extended time period. Existing tools such a Hurst or SNCT include either an assumed A and D or a worked out from actual patient WTE. This is more intuitive and less time consuming and something staff may be more familiar with.	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in section 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments
354	Lewisham and Greenwich Healthcare NHS Trust	74	729	Appendix 3	Safer Nursing Indicators are expected and could be incorporated into Patient Experience FFT collections; use of existing data collections is helpful. Some aspects would require collection of new data and not sure evidence base for them is clear-Missed Breaks-also a significant challenge to gather and sustain. Suspect trusts will focus on those determined to be clearly NSI and those collect already	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
355	Lewisham and	82	865	Appendix 3	Partly collectable through NHS Choices but the Planned vs Required more complex and would require assessment of	Thank you for your comment, which was considered by the Safe

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	Greenwich Healthcare NHS Trust				A and D-practicalities have to be considered here in how that was gathered if it was going to be selected as a Safe Care Indicator.	Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
356	Marie Curie Cancer Care	3	24	Introduction	It is important to note that this guideline also applies to organisations such as Marie Curie. At present our hospices provide services on behalf of the NHS, with the NHS providing partial funding and Marie Curie covering the rest. There is also no mention of the four main regulators and the potential impact either of them or on them. Given their focus on patient safety, it is important that their views on this are made explicitly in the final version of the guideline.	Thank you for your comment. We have now added some more detail from the scope document to the introduction section of the guideline to clarify what this guideline focuses on.
357	Marie Curie Cancer Care	8	106	1	In the box entitled “Safe staffing for nursing in adult inpatient wards in acute setting”, we believe that ‘focus on patient care’ should sit at the top of the list of priorities to reflect its importance. We also believe that additional priorities should be inserted on promoting a culture of learning and development and one also of continuous professional development. For the box entitled “Ward level factors and approach to determining daily nursing staff requirements”, it is important to note that staff will need training on how to be ward leaders. In general with this box, we are concerned that the requirements need to	Thank you for your comment. The guideline has been amended in light of your comment and recommendation 1.1.1 is the recommendation "focus on patient care".

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					be strengthened in order to ensure patient safety.	
358	Marie Curie Cancer Care	11	198	1.2.3	We would like to see an explanation of why end of life care is considered a need to increase staffing requirements and what specific work would be needed for an end of life care setting. We feel this section generally needs to be expanded	Thank you for your comment. The guideline has been amended in light of your comment to include reference to this in Table 2.
359	Marie Curie Cancer Care	13	203	1.2.5	We would like to highlight that the vast majority of the entries in this table could be applicable for a hospice inpatient setting.	Thank you for your comment. There will be much from this first guideline that can be applied in other healthcare settings. Healthcare professionals are encouraged to look at this first guideline for adult inpatient wards in acute hospitals and see how they can apply the recommendations to their own setting.
360	Marie Curie Cancer Care	13	203	1.2.5	We believe that some of the entries identified in this table are not one-off incidents and with an end of life care setting, there could be multiple incidents just for one patient.	Thank you for your comment. The guideline has been amended in light of your comment to include reference to this in Table 2.
361	Marie Curie Cancer Care	15	248	1.2.9	For the box entitled “Additional workload in nursing hours per day”, we would like to see end of life care specifically	Thank you for your comment, which was considered by the Safe

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					highlighted as one of the diversity of clinical specialities cared for by the nursing team. For the box entitled "Determine required ward nursing staff establishment and shift allocation", we would suggest adding that uplift is often more commonly known as 'headroom' within certain organisations to ensure clarity.	Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
362	Marie Curie Cancer Care	35	660	8	We believe it is important to note that NICE are also taking into account the views of voluntary sector organisations that provide NHS services, either under contract or through a more informal arrangement. This position, as held by Marie Curie and others, puts us in a very different position to other organisations and we would like to see greater consultation and appreciation of the specific position charities like us hold so that guidelines can be developed with our input and advice and understand the situations under which we operate.	Thank you for your comment and support for this guideline.
363	Marie Curie Cancer Care	40	697	Appendix 1	In terms of the economic analysis listed where an a plausible incremental cost effective ratio of approximately £1400 per fall avoided is identified, we would be very interested to see this analysis as it could be extremely helpful when we are looking at developing our current and potential services if we would be able to use these figures to support our case.	Thank you for your comment. The economic analysis is available to view from the safe staffing webpages of the NICE website.
364	Marie Curie	General	General	general	Marie Curie Cancer Care welcomes the opportunity to	Thank you for your comment and

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	Cancer Care	comment	comment	comment	contribute to this consultation and would be happy to provide further evidence and support for the development of this guideline	support for this guideline.
365	Marie Curie Cancer Care	General comment	General comment	general comment	Whilst this scope is about safe staffing levels in adult inpatient wards in an acute setting, it also has relevance to Marie Curie Cancer Care, as we also provide services on behalf of the NHS and we do some of this in a ward setting. It is important to be aware of organisations such as us that provide NHS services, but are organisations outside of the NHS, including charities.	Thank you for your comment and support for this guideline. We have amended the introduction section in light of your comments.
366	Marie Curie Cancer Care	General comment	General comment	general comment	This guideline is extremely helpful, but it is important that it is reinforced with the appropriate support, particularly as part of nurses' training and for those taking on the role of professional judgement or for tasks such as the calculation of nursing hours. It would be useful if this guideline included recommendations of appropriate training courses and programmes to attend. It is also worth highlighting that while the toolkits mentioned in this guideline should be developed and produced as an immediate priority.	Thank you for your comment and support for this guideline. NICE is considering if additional resources may be developed to help facilitate the implementation of the guideline.
367	Mid Cheshire Hospitals NHS Foundation Trust	3	29	Introductio n	A descriptor/clarification of what is meant by professional judgement should be included in the guidance. Without this, there is too much subjectivity and vagueness which could lead to disparity when agreeing safe staffing levels. Although some clarity is provided in paragraph 1.2.2 this is	Thank you for your comment. We have added detail to clarify this in light of you comment.

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					not enough. There also needs to be guidance as to whose professional judgement is to be used.	
368	Mid Cheshire Hospitals NHS Foundation Trust	14	230	1.2.8	More detail should be provided in relation to a reasonable uplift and how this should be calculated. This is an essential component of calculating safe staffing levels. On page 72, an uplift of 20.4% is cited whereas the Safer Nursing Care Tool uses 22% uplift. Further guidance on this matter would ensure all wards and organisations are working to the same criteria.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
369	Mid Cheshire Hospitals NHS Foundation Trust	18	305	1.2.19	How has the conclusion been reached that 8 hours shortfall or 25% is the trigger for a red flag – this needs to be clarified in the guidelines?	Thank you for your comment. We have amended these parts of the guideline to clarify this issue. We have outlined how the best available evidence has been considered by the Safe Staffing

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						Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1.

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370	NHS Employers	3	1	Introduction	It is helpful to see articulated what is in and out of scope within this guideline outlined in the introduction. The reference about the need for professional judgement is critical. From our engagement with employers in recent weeks we have found that there is a lot of confusion about the work NICE is doing and the requests from NHS England to submit staffing level data. We would suggest this is strengthened to ensure the message is clear. We are concerned that without explicit reference in the introduction to the importance of overarching organisational and managerial factors as well as the importance of multi-disciplinary teams when looking at safe staffing, we miss the opportunity to set the right tone for the remainder of the document and the subsequent specific guidelines that are planned. An unintended consequence of this is a focus on purely numbers of single staff group. Employers recognise that numbers are important but we need to ensure that we do not. We would encourage NICE to include detail on the importance of organisational factors, behaviour, the importance of effective multi-disciplinary working and employee new	Thank you for your comment. We have now added more detail from the scope document of the guideline to the introduction section to clarify what this guideline focuses on. We have also added further detail in the introduction and the beginning of the recommendations section to emphasise the importance of organisational and managerial factors that are required to support safe staffing.

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					engagement when looking at safe staffing. The evidence around employee engagement and its impact on NHS performance is widely available and NHS Employers has a role to support employers with the implementation of policy and in the interests of making the guideline as useful as it can be to achieve the overall objective of the work, we would be happy to discuss and work on this further with you.	
371	NHS Employers	8	107	1.1	Following on from the introduction it would be helpful to re-iterate the importance of staff experience and employee engagement as part of the organisational strategy to reviewing safe staffing and the relevance of effective multi-disciplinary team working by including it in this section of the guideline.	Thank you for your comment. The guideline has been amended in light of your comment with the addition to the existing sub-section of recommendations "promote staff training and education".
372	NHS Employers	23	399	3	The lack of available evidence and data to support the development of this guideline is concerning. As a result of this exercise we would be happy to facilitate a discussion with employers about what would be most useful to commission as a priority to support this work going forward. The lack of financial impact, economic data and evidence is a concern to the NHS Employers organisation. The level of work that has gone into reviewing the potential	Thank you for your comment. Parallel to the development of the guideline, NICE will also be publishing a costing statement which will address the issues of financial impact that have been mentioned in your comment. The recommendations for research have been written to encourage

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					economic benefits from reviewing staffing levels is impressive. We would like to see a similar detailed exercise looking at what the impact on the whole system is likely to be by introducing this guideline. We believe that when the guideline is published it will be adopted by NHS England and CQC with immediate effect, and therefore it is important to understand as a minimum what the workforce gap is, the average cost per NHS trust and the administration for collating the relevant returns. From early discussion with employers, the latter appears to be proving extensive in these early stages. We know from other work that we have done with employers that there are gaps in the nursing workforce that you can see in the survey published in the link below. We are not suggesting that cost should prohibit moving forward with improvement, but with so many gaps in the evidence the committee have been able to review we are concerned that there isn't a financial impact assessment that has been undertaken that looks at system impacts now and for the future, that we can expect to see from implementing the guideline. http://www.nhsemployers.org/case-studies-and-	more research in this important area.

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					resources/2014/05/nhs-qualified-nurse-supply-and-demand-survey	
373	NHS England	4	43	Introduction	Suggest using the phrase “staffing toolkit” to be consistent with the rest of the document.	Thank you for your comment, the Safe Staffing Advisory Committee have discussed the terminology and wish to use decision support toolkits
374	NHS England	4	44	Introduction	Suggest replacing “nursing staff” with “nurse staffing” – repeated through the document.	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
375	NHS England	4	50	Patient centred care	Suggest including the word “inpatient” here (and other references through the document) to be consistent with line 19.	Thank you for your comment. The guideline has been amended in light of your comment.
376	NHS England	6	64	Evidence to recommendations	Should the name of the committee be listed in full?	Thank you for your comment. The guideline has been amended in light of your comment.
377	NHS England	7	94		There appears to be a conflict between the statement included here and the references further in the document (para 1.3.3) that refers to “considering increasing	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					establishments…whether registered nurses are caring for more than 8 patients....”.	
378	NHS England	7	106		Suggest including “and actual nurse staffing” at the end of the sentence in the bottom box of the diagram. At present, the diagram highlights the importance of establishments but does not capture the importance of the actual number of staff that are available to deliver care.	Thank you for your comment. The safe nursing indicators have been amended in light of your comment.
379	NHS England	8	115	1.1.1	Although there is reference later in the document (1.1.8), it may be helpful to indicate that organisations should be developing mechanisms for ensuring that the actual number of staff for wards or departments is sufficient as well as the establishments. Capacity relates to both establishments and actual staffing levels.	Thank you for your comment. The guideline provides a number of recommendations to collect data on the actual number of nursing staff available to ensure safe care.
380	NHS England	8	121	1.1.2	Suggest replacing “final sign off” with “agreed by” the chief nurse. Suggest replacing line 124 with “at regular intervals in line with the NQB guidance”.	Thank you for your comment. The guideline has been amended in light of your comment.
381	NHS England	10	164	1.1.10	Although technically outside scope, should this paragraph also include reference to experience and training in rostering. Also suggest considering changing the word “estimate” to determine” given that the guidance sets out to provide a basis upon which establishments should be determined.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
382	NHS England	10	167	1.1.11	Suggest changing “outcomes” to indicators”	Thank you for your comment. The guideline has been amended in

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						light of your comment.
383	NHS England	10	170	1.1.12	Suggest making specific reference to escalation procedures and policies.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
384	NHS England	11	180	1.2.1	The paragraph references the use of a staffing toolkit that is agreed “locally”. It would be helpful to define locally and if it is intended that local means organisation it may be helpful to reference to the staffing toolkit in section 1.1.1.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
385	NHS England	11	181	1.2.1	This guidance suggests that that staffing toolkits endorsed by NICE should be used (when available). Further on in the document (248-249), nursing hours per patient day is advocated. NHS England colleagues that have contributed to this feedback have raised concerns that the guide appears to be contradictory in relation to its recommendations, i.e. on the one hand NICE endorsed staffing toolkits are recommended and on the other, a specific methodology is recommended.	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are

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						present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
386	NHS England	11	187	1.2.3	The evidence to recommendations table that supports this section makes reference to the fact that age is a significant independent factor in determining staffing levels and it is not mentioned in the body of the text. It is not clear how this section links to the previous section that sets out the requirement to use a staffing toolkit, some of which include approaches to assessing patients care needs. It is not clear whether there is specific evidence that underpins the content of table 1, or if it is intended simply to be a prompt to support professional judgement. If it is the latter, its qualitative style may make it difficult for staff to consider its relationship to the staffing toolkit, workload assessment and deployment of staff.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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387	NHS England	14	239	1.2.9	It is not clear how staff will be expected to estimate the nursing requirement. What methodology should be applied and colleagues have raised concerns that the guidance is suggesting an estimation rather than an endorsed toolkit.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
388	NHS England	15	248	1.2.9	It is not clear how the flowchart relates to the use of a staffing toolkit. Is it intended that the diagram represents the process that a staffing toolkit would follow? If not, how does the process add to requirement to use a staffing toolkit? It is not clear if the process is designed to set an establishment or to be used to identify nurse staffing requirements on a shift by shift by shift basis. Suggest that the flowchart is converted into a set of principles or elements that an endorsed staffing toolkit might be expected to include.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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389	NHS England	15	251	1.2.10	The use of a staffing toolkit is recommended again in this section. See comments above regarding the link between the staffing toolkit and methodology suggested in 248-249.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
390	NHS England	15	255	1.2.11	This section returns to the use of nursing hours per patient day – again, it is not clear how this relates to the staffing toolkit. The section therefore only applies if nursing hours per patient day is being used as the principle methodology. It is not clear why nursing hours per patient day has been selected for inclusion in the guidance – the calculations in the guidance do not correspond with those in the safer nursing care tool for example.	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to

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						patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding. The guideline has also been revised to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits
391	NHS England	15	276	1.2.14	There does not appear to be a methodology for calculating the additional workload from other ward and staff factors so it is unclear how these can be added into an overall nursing requirement calculation.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that will contain all the information regarding the endorsement

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						process of decision support toolkits.
392	NHS England	16	280	1.2.15	This section appears to be more about effective use of resources/rostering rather than determining the required ward nursing establishment. Suggest including some reference to the principles of good rostering practice such as planning annual and study leave etc. The section does not appear to include a process for determining the actual establishment, which is a separate process to allocating/rostering resource.	Thank you for your comment. The guideline has been amended to separate the process of setting the establishment and assessment on-the-day.
393	NHS England	16	301	1.2.19	Comment on 'red flags' The principle of 'red flags' that may indicate nurse staffing levels are becoming unsafe is supported, and agree real-time information that may indicate nurse staffing levels have become inadequate in the here-and-now is needed. However, we have significant concerns about the 'red flag' content as currently written. The reasons for this are explained below, and provide an alternative way of presenting this part of the guidance as Annex 1, if the legitimacy of our concerns is accepted by NICE's expert advice group. . The 'red flags' section is aiming to cover several important issues that we believe could be better managed if separated out.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					The first issue is an extreme shortfall in staffing and how this should be escalated. Rather than a single threshold for concern (8 hours or 25%) as currently in the guidance, we recommend NICE requires an escalation approach, where any shortfall is escalated beyond the ward, but the more significant a shortfall which cannot be immediately remedied is, the higher up the organisation it is escalated. This approach would also address a problem in the text which places responsibility for response to 'red flags' with the nurse in charge of the ward, although staffing shortfalls of this level would clearly need escalating beyond them, and would typically already be known to site/directorate managers/matrons with oversight of activity and staffing each shift. Another 'red flag' section refers to omissions or delay in medications including pain relief, taking vital signs, and intentional rounding. We strongly support inclusion of these 'red flags' in principle, but the sole reliance on staff, patients or visitors to spontaneously report them will be ineffective, as a ward under so much workload pressure may not realise what activities are being missed, nor have time to report them. There is evidence that a significant barrier to reporting is workload pressure; for example 48% of nurses in Evans et al.'s 2006 study stated they forget to	

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					report incidents when the ward is busy.	
394	NHS England	16	301	1.2.19	The current wording also risks confusion between escalation (letting senior staff know the ward is under workload pressure in order to seek immediate help) and incident reporting (which is important to monitor longer term trends but will not remedy the immediate workload pressure). Care also needs to be taken with wording to ensure that the existing duties of staff to report all incidents that “could have or did harm a patient” are not diluted by reference to requiring reporting only for specific lapses in care. To supplement spontaneous reporting, we recommend the ‘red flag’ omissions/delay in giving medication, taking vital signs, and intentional rounding are reframed as a routine ‘red flag check’ undertaken by matrons/site coordinators as they visit wards. We are proposing this as a five or ten minute exercise of checking a handful of bedside charts for these omissions, whilst observing/listening for other indications of staffing workload pressure such unanswered call bells or equipment alarms. We are not suggesting this should be a formal data collection; monitoring longer term trends in the reliability of these processes is a separate concern from establishing systems that will recognise and respond at the shift-by-shift level to a ward where nurse staffing shortfalls	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					are affecting patient care. Please see Annex 1 for a proposed revision of this section to address these concerns, should their legitimacy be accepted by NICE's expert advice group. Additionally current phrasing could be read as meaning a single omission in any of these activities for any reason being a 'red flag'. Although every ward would aim for totally reliable delivery of all these activities, very few frontline processes are 100% reliable. We have suggested a rephrasing in Annex 1 that focuses the 'red flags' more clearly on workload pressure preventing delivery of activities rather than external causes such as medication unavailable, and is focused on inability to deliver these nursing cares in a timely way rather than human error in missing one patient's vital signs during observation rounds, etc. We support the specific mentioning pain relief in the red flag section, but the current phrasing of a 30 minute delay in planned pain relief is too arbitrary; a 40 minute delay in paracetamol planned for four times a day may not be a concern, but a ten minute delay in 'as required' opiates for a terminally ill patient could be too long.	
395	NHS England	19	318	1.3	Comment on safe nursing indicators: patient reported We strongly support the inclusion of these, and text in this section reflects key areas of concern to patients that could	Thank you for your comment. The guideline has been amended in light of your comments.

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					be affected by inadequate levels of nurse staffing or skill mix. We provide additional comment later on where more detail on these are given in Appendix 3 pages 74-75, as in Appendix 3 the detail seems to have moved slightly away from the principles outlined in Box 2, and includes indicators more likely to relate to nursing attitudes than indicators where adequacy of nurse staffing or skill mix would be most likely to affect patient experience.	
396	NHS England	19	318	1.3	Comment on safe nursing indicators: safety outcomes We understand the evidence on which these safety outcome indicators are based, which demonstrates that at large scale, in multi-hospital studies, falls, pressure ulcers, and medication error are associated with adequacy of nurse staffing levels and skill mix. However, we have considerable concerns that the NICE guidance is currently suggesting they are used at much smaller scale and frequency, to compare past and present levels on a ward by ward basis, and also suggests they can be used to directly compare wards with each other.	Thank you for your comment. The guideline has been amended in light of your comments.
397	NHS England	19	318	1.3	We explain our reasons for these concerns below, and provide an alternative way of presenting this part of the guidance as Annex 1, should their legitimacy be accepted by NICE's expert advice group. In summary:	Thank you for your comment. The guideline has been amended in light of your comments.

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					• Ward-to-ward comparison of these indicators is highly inappropriate because of case mix differences that can lead to a ten-fold difference in rates between different specialities. Safety Thermometer publications highlight that the data should not be used for comparison between wards or between hospitals, not only because of differences in case mix, but also in local data collection methods. • Ward level before-and after comparison is inappropriate because of lack of statistical power. For example, Safety Thermometer is currently recording 1.2% of patients have a hospital-acquired pressure ulcer on the day of survey. That equates to six patients in a five hundred bed hospital, meaning that most ward level trend charts will fluctuate between several months with zero and occasional months with single figures, and chance variation will be impossible to distinguish from true trends. We have applied some basic statistical modelling to ward level Safety Thermometer pressure ulcer data, and estimate it would take around 13 years to distinguish a true increase of 20% from natural variation at the level of a single average ward.	
398	NHS England	19	318	1.3	We are concerned that suggesting, as the current NICE guidance does, that these safety outcomes can be used as statistical indicators of adequacy of nurse staffing at ward	Thank you for your comment. The guideline has been amended in light of your comments.

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					level (with any rates higher than other wards, or any upwards trend in rate at single ward level, triggering consideration of an increase in nurse staffing levels) carries a significant risk of causing harm. The harm would result from redistribution of nurse staffing resources away from wards and specialities where patient case mix means there is an inherently lower risk of these harms, and from false reassurance that no significant trends over time at ward level means that nurse staffing levels remain adequate. We propose that at ward level these safety outcome indicators must be used qualitatively, not quantitatively; it should be a standard part of the investigation of all falls, pressure ulcers, and medication administration errors to determine if any nurse staffing issues were a contributing factor, as part of established incident/Serious Incident investigation processes.	
399	NHS England	19	318	1.3	We agree that statistical trends in these safety outcome indicators can be used to monitor trends over time at hospital level, but even at this level some caution needs to be taken with adequate sample size. We have undertaken some basic statistical modelling at hospital level, and for a 500 hundred bed hospital a 20% change in hospital-acquired pressure ulcer prevalence rates as measured by	Thank you for your comment. The guideline has been amended in light of your comments.

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					Safety Thermometer should be distinguishable from random variation within 21 months, with a similar change in medication error incidence rates (based on around 40 reports per month to NRLS from a hospital of 500 beds) should be distinguishable from random variation within 4 months. Falls with harm as measured by Safety Thermometer would be very underpowered (at around 0.6% of patients on day of survey, or an average of three patients per 500 bedded hospital) requiring over three years before a 20% change should be distinguishable from random variation. However, if moving to an incidence rather than prevalence form of data collection, trends over time in pressure ulcers and falls are much more likely to be detectable within a relatively short period. But as all incidence data are potentially affected by under-reporting, some secondary check of data completeness is required. Forms of checking to establish levels of under-reporting are already in common use in many NHS organisations (usually based on skin inspection by specialist nurses for pressure ulcers, and the FallSafe under-reporting check for falls) and we have provided a potential way of using these in our comment on Appendix 3.	

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400	NHS England	19	318	1.3	We have further concerns about the appropriateness of data sources suggested by NICE in the context of their proposed use as indicators of nurse staffing adequacy at ward level. Safety Thermometer focuses on health system-wide improvement, and only collects data on the current ward location of a patient with a hospital-acquired pressure ulcer, not the ward where the pressure ulcer developed, and only collects data on the current ward location of any patient with a recent fall, including falls that occurred in a care setting outside the hospital. This means, for example, patients with harm from recent falls are particularly likely to be admitted or transferred to orthopaedic wards, and those with pressure ulcers to rehabilitation wards. Safety Thermometer is therefore inappropriate as a ward-level indicator of where nurse staffing shortages may have affected patient outcomes	Thank you for your comment. The guideline has been amended in light of your comments.

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401	NHS England	19	318	1.3	Using reported medication administration error as an indicator of actual trends in medication administration error is also problematic, because, as outlined above, increasing workload pressure may lead to a reduced likelihood of incident reporting, and the nature of error is such that staff will not always be aware they have made an error; errors may be more likely to be detected where staff have time to review their own and others' work. We propose more systematic methods than relying on incident reporting alone are required to detect trends in actual rates of medication errors, accompanied by the investigation approach into individual reported medication errors outlined above. We suggested above that 'red flag checks' for omissions or delay in medications including pain relief, taking vital signs, and intentional rounding should not be a formal data collection on a shift-by-shift basis, but a real-time 'notice and act'. We would also recommend these key processes are more formally monitored for trends, through planned and structured data collection at less frequent intervals. The high numbers of these processes required in a single day means they will be powered to detect trends in at ward level in relatively short timescales.	Thank you for your comment. The guideline has been amended in light of your comments.

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402	NHS England	19	318	1.3	In terms of the numbers of measures recommended and the frequency of their collection, NICE may wish to consider the risks of frontline staff having excessive data collection burdens added to their workload; a careful balance needs to be struck. Reviewing too large a range of indicators can also risk management being distracted from what a few more significant indicators are telling them. We would also suggest the guidance points towards use of existing data sources wherever possible (e.g. electronic medication systems can monitor missed or delayed doses, vital signs can be captured by hand held devices).	Thank you for your comment. The guideline has been amended in light of your comments.
403	NHS England	20	329	1.3.2	Suggest re-affirming that the establishment review should use a staffing toolkit endorsed by NICE.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
404	NHS England	20	334	1.3.3	This section does not appear to take into account the fact that the establishment itself may be appropriate, but other factors may influence the red flags/nurse sensitive indicators such as actual staffing levels, clinical leadership etc.	Thank you for your comment. The actual number of available nursing staff is a key component of the safe nursing indicators. The recommendations have also been amended to clarify this issue that there may be other influences on safe nursing indicators other that

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						the ward nursing establishment size.
405	NHS England	28	501	5	A nurse working 8 hours will not contribute 8 hours of direct nursing care – The table and text does not reflect the non-direct care activities such as handover, breaks, attending other departments, supervision etc.	Thank you for your comment. The guideline has been amended in light of your comment.
406	NHS England	29	543	5	Suggest expanding this section to bring more clarity to the definition of non-direct patient care such as handover, ward rounds, supervision, teaching, communication with relatives, MDT, audits, staff meetings etc.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
407	NHS England	35	673	8	It would have been helpful to have access to the tools alongside the guideline for consultation. The tools may have enhanced understanding of the guideline.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have amended the guideline in light of your comment to clarify that this process could be facilitated by using a NICE endorsed decision support toolkit. We have added a

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						link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
408	NHS England	36	695	Appendix 1	economic considerations - The principle of providing additional nursing staff to maintain safe and effective care is clearly fundamental. The economic consideration statements indicate potential cost implications for some recommendations and suggest that these are strengthened to indicate that there are likely costs.	Thank you for your comment. The guideline has been amended in light of your comment.
409	NHS England	59	712	Appendix 1	1.2.14 - There is no consideration of a percentage uplift for leave etc. in this section	Thank you for your comment. The guideline has been amended in light of your comment.
410	NHS England	69	717	Appendix 1	NHS England nursing directorate do not support the principle of a single nurse:patient ratio. Although the guideline states that same, there are a number of references to 1:8 that have drawn the attention of the media, profession and public in general. The evidence to support a 1:8 ratio is drawn from a single study drawing data from the 1990s.	Thank you for your comment and support for this guideline. We have made amendments to help clarify this issue.
411	NHS England	73	728	Appendix 3	We note there appears to be some confusion over the term ‘outcome measures’ – measures are generally divided into structure measures (e.g. staff available v staff	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The

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					planned) process measures (e.g. prompt attention to patient's needs) and outcome measures (e.g. falls, pressure ulcers). Additionally the text under 'outcome measures' does not always reflect the detail described above. Because of the issues noted in our comments above on the different levels at which indicators are powered, and because of the need to use these data qualitatively (for local investigation) as well as to monitor trends, we would suggest adaptations to each Appendix 3 page to help guide users to the context in which they can best be used locally. We have adapted Box 2 in Annex 1 and prepared examples of how this could look in Annex 2, should the legitimacy of our concerns be accepted by NICE's expert advice group. Developing indicator definitions and data collection methods is complex, and needs extensive piloting and testing. For example, most Safety Thermometers went through months or years of piloting and refinement before final definitions and data collection methods were established, and results of questions to patients on their experience differ markedly if the route for collecting them changes. We would suggest the NICE guidance is limited to broad principles of the indicator rather than trying to	guideline has been amended in light of your comment, where possible.

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					establish a specific definition and denominator. Once NICE has established the principles of what care processes and outcomes should be monitored, we would anticipate other sources of advice and support on the detail can be developed to support their delivery, as has been the case for the staffing shortfall indicators.	
412	NHS England	73	728	Appendix 3	It is important in the context of this NICE guidance only to point towards indicators that are likely to be affected by nurse staffing and skill mix, rather than provide a full set of measures for all aspects of the quality of nursing care. Q30 and Q40 are very appropriate for this, but Q28 and Q29 are not – talking in front of patients as if they were not there is an attitudes issue, and patients may well still have confidence and trust in staff even when the staff are very overstretched. Q23. 'Did you get enough help from staff to eat your meals?' appears an appropriate addition here	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
413	NHS England	74	742	Appendix 3	Would need caution note on interpretation that pain relief not solely reliant on nursing activity	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
414	NHS England	75	751	Appendix 3	It is important in the context of this NICE guidance only to point towards indicators that are likely to be affected by nurse staffing and skill mix, rather than provide a full set of measures for all aspects of the quality of nursing care. Q27 does not appear appropriate as centred on staff knowledge and communication skills. Q43 and Q35 could be affected by staffing shortfalls but would need caution in interpretation as even nurses on overstretched wards can show compassion and give emotional support	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
415	NHS England	77	766	Appendix 3	As explained above, the Safety thermometer data source is unlikely to be powered to detect trends in prevalence of patients with harm from falls in the past 72 hours even at hospital level, and there are alternatives that could be used alongside it. The inclusion of content in the NICE guidance on how to define, collect and calculate the falls indicator within Safety Thermometer them risks confusion with the actual methodology. We would suggest just describing the principle of what is collected and referring to the source. The reference to the RCP Falls and Bone Health unit as a data source is in error; there is a one-off publication of a pilot National Audit that used data supplied by trusts from their local incident management systems, but no ongoing data collection.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					We have prepared examples of how alternative sources could be used in Annex 2	
416	NHS England	78	793	Appendix 3	Technical detail is incorrect in the summary of Safety Thermometer; it is prevalence not incidence, numerator is patients on day of survey with a pressure ulcer grade 2-4 that developed at least 72 hours after their admission, denominator is patients included in survey The NHS Outcomes Framework is a national measure that draws on Safety Thermometer data to assess national improvement and would not help local monitoring	Thank you for your comment. The guideline has been amended in light of your comment.
417	NHS England	79	812	Appendix 3	As above; reported incidents should be investigated and monitored but cannot in isolation be assumed to be a true measure of actual medication errors The NHS England national patient safety team have prepared examples of how supplementary sources could be used in Annex 3	Thank you for your comment. The guideline has been amended in light of your comment.
418	NHS England	83	891	Appendix 3	The data collection is based on numbers of staff and the outcome is based on expenditure.	Thank you for your comment. The guideline has been amended in light of your comment.
419	NHS Trust Development Authority	3	22	Introduction	Should be clear that this does not include community settings	Thank you for your comment. We have now added some more detail from the scope document to the introduction section of the

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						guideline to clarify what this guideline focuses on.
420	NHS Trust Development Authority	4	30	Introduction	Agree with this point very important that use of professional judgement is included in the guideline	Thank you for your comment and support for this guideline.
421	NHS Trust Development Authority	4	45	Introduction	Would it be possible to clarify that the endorsement is part of a future work programme?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
422	NHS Trust Development Authority	7	94	1	It is helpful to have this paragraph included re staffing ratios.	Thank you for your comment and support for this guideline.
423	NHS Trust Development Authority	8	108	1.1 Organisational Strategy	There is a requirement for consistent use of language, previously stated in line 25 'health care boards' now referred to as 'hospital boards', both are correct but would be good to use one throughout the document.	Thank you for your comment. The guideline has been amended in light of your comment.
424	NHS Trust Development Authority	16	261	1.2.12	Bed utilisation and bed occupancy are both referred to in this paragraph, bed utilisation is defined and is in the glossary later in the document, it would be helpful to also	Thank you for your comment. We are advocating the use of the term bed utilisation rather than

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					define bed occupancy	bed occupancy and do not refer to bed occupancy subsequently in the guideline.
425	NHS Trust Development Authority	16	305	1.2.19	Should a shortfall of health care assistant hours also be treated a s red flag, not only RN shortfall?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. However, the Safe Staffing Advisory Committee felt that it was important not to have a limited number of nursing red flags and that the evidence showed that registered nurse hours were most sensitive to patient outcomes.
426	NHS Trust Development Authority	19	328	1.3.1	We support patient experience indicators being included however think that using the national inpatient survey is not timely enough or gives a sufficient sample, would it be better to use the Friends and Family test as this data is submitted by ward on a monthly basis?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
427	NHS Trust Development Authority	20	328	1.3.1	Number of missed breaks would appear to be too crude in terms of variability and how it is reported, if this were to be used as an indicator guidance should be issued regarding how to calculate it. A more valid report although still open	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in

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					to interpretation would be the number of staff reports re. low levels of nurses on a shift or episodes of missed care.	Appendix 2.
428	NHS Trust Development Authority	20	334	1.3.3	Considering increasing the number of staff on a ward is an option, however if an establishment review has already been done and the nursing outcomes are not as good as expected another action should be to review the leadership capacity and capability on a ward and we think this should be included in the guideline as it should not be all about the numbers of staff, there are other influences on quality of care.	Thank you for your comment. The recommendations have also been amended to clarify this issue that there may be other influences on safe nursing indicators other that the ward nursing establishment size.
429	NHS Trust Development Authority	28	536	5	Should 'and complied with Prep requirements' be added. To maintain registration nurses have to do post registration development and self certify this periodically.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
430	NHS Trust Development Authority	50	708	1.2	Other considerations: The following sentence should be re written The committee felt that there is a need to set staffing requirements for each shift based on the strong evidence that mortality increases when required or the set staffing level is not met for particular shifts	Thank you for your comment. The guideline has been amended in light of your comment.

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431	NHS Trust Development Authority	67	717	Appendix 1	Considering increasing the number of staff on a ward isn option, however if an establishment review has already been done and the nursing outcomes are not as good as expected another action should be to review the leadership capacity and capability on a ward and we think this should be included in the guideline as it should not be all about the numbers of staff, there are other influences on quality of care.	Thank you for your comment. The guideline has been amended in light of your comment.
432	NHS Trust Development Authority	General comment	General comment	general comment	Would it be feasible/practical to consider including in the final guidance something about the need to take greater account of the multi-professional team contribution in certain locations such as therapeutic environments, stroke units, rehab wards etc. when calculating the total number of nurses required?	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
433	NIPEC & DHSSPS	8	133	1.1.5	NIPEC and the DHSSPS supports the flexible approach to staffing identified at 1.1.5	Thank you for your comment and support for this guideline.
434	NIPEC & DHSSPS	10	152	1.1.8	NIPEC and the DHSSPS would caution the use of data collection related to staffing on a daily basis as is mentioned at 1.1.8, which may put an extra burden on ward staff, taking them away from direct patient care. It is contended that information can be provided to offer a complete picture which is not reliant on daily capture of data.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee who felt it was important to assess patient needs on a daily basis to ensure safe care is delivered.

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435	NIPEC & DHSSPS	10	190	1.2.4	The assessment of nursing workload advocated at 1.2.4 could also be potentially time consuming when there are currently tools available that calculate nursing workload or have been proven to provide accurate frameworks for professional judgement. In the opinion of NIPEC and the DHSSPS, the nursing activity outlined at table 1 is not an exhaustive list and could potentially cause confusion when an activity is identified that is not taken into consideration – for example record keeping is not identified and is an integral part of practice which requires time, ‘care planning’ does not capture all of this activity. In addition a recent audit carried out in a Northern Irish Trust revealed that complex IV medication regimes can require well in excess of 30 minutes per patient. We would also like to point out that ‘toileting’ is not a term which reflects dignified and respectfully person centred care and should be changed.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits. The guideline has been amended where possible and indicates where components of the recommendations could be facilitated by a NICE endorsed decision support toolkit. We hope this would reduce the time taken to undertake some of the recommendations of this guideline. We have also amended the term "toileting" in light of your comment.

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436	NIPEC & DHSSPS	14	237	1.2.9	The process outlined at 14 – 18 contains high level steps which, NIPEC and the DHSSPS would suggest, requires further thought to explanation within a user manual or document to supplement the implementation of the guideline. Currently, detail which demonstrates how to approach incorporating factors such as geographical footprint or throughput are not addressed.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain all the information regarding the endorsement process of decision support toolkits.
437	NIPEC & DHSSPS	18	306	1.2.20	In terms of the red flag events, NIPEC and the DHSSPS would contend that some of this information can be captured within quality audits, rather than capturing separate data or presenting data separately for the purposes of workforce planning. In addition, we would suggest that missed breaks are not an accurate or objective method of workforce planning as staff often do not record missed breaks – staff productivity may also be called into question where this is used as a measure.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.

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438	NIPEC & DHSSPS	72	726	Appendix 2	The Planned and Unplanned Absence Allowance calculation on page 72 appears to be as a result of a snapshot of activity. NIPEC and the DHSSPS would assert that this is an inaccurate way to capture this data and does not accurately reflect the ongoing needs within the service. The Northern Ireland approach agreed mandatory training, set a sickness absence target level and calculated hours on the basis of commissioned posts at midpoint of the AfC scale and therefore holiday entitlement. This provided a robust calculation which applies across all services and does not include maternity leave which has backfill already attached to provision.	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in section 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments
439	NIPEC & DHSSPS	General Comment	General Comment	General Comment	This response has been prepared by a Senior Professional Officer at the Northern Ireland Practice and Education Council for nursing and midwifery (NIPEC) and the Nursing Officer for workforce at the Department of Health, Social Services and Public Safety (DHSSPS). The aim of the Delivering Care: Nurse Staffing in Northern Ireland Project is to support the provision of quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. A range of	Thank you for your comment and information about the programme of work in Northern Ireland which we have shared with our colleagues who are managing the toolkit endorsement programme.

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					policy and strategy documents have provided the motivation for the production of the framework. The primary commission can be found in A Partnership for Care: Northern Ireland Strategy for Nursing and Midwifery 2010 - 2015 - page 25 states: 'The Director of Nursing at the PHA in collaboration with Directors of Nursing will build a workforce planning toolkit to ensure the right people with the right skills in the right job. ...' Additionally, Transforming Your Care, Quality 2020 and The People's Priorities have provided the strategic direction and vision for services in the next 5 – 10 years. These documents have outlined the need to have the right numbers of appropriately skilled staff as crucial to the provision of safe, effective person-centred care. Higher numbers of people are now living to over 85 years old in Northern Ireland (NI), with a predicted increase of 40% in those living to over 75 years by 40% by 2020. More people are living with long term conditions and disabilities, which can be further complicated by more than one condition in some cases and a requirement for complex drug regimen. Activity snapshots taken in a number of medical and surgical wards in NI have	

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					demonstrated that 87% of people in medical care settings are aged 65 and over, whereas in surgical care settings this figure is 78%. The Delivering Care papers set out a framework that promotes a shared understanding of the essential components to set and review staffing levels to enable conversations between a range of individuals across organisations, such as commissioners, finance officers, human resource officers, nurses, midwives and senior managers. Prior to the development of this framework, there has been no 'common language' for nursing and midwifery workforce planning. The constitution of the Project Groups in the form of the Steering and Working Groups enabled engagement at a range of levels within HSC organisations and across professions. Senior nurses within organisations were tasked with the responsibility of keeping Trusts up-to-date with the progress of the Project through the dissemination of information and communiqués. A number of other engagement events were enabled throughout production to facilitate positive challenge. This included non-nurse commissioning and senior nursing and midwifery colleagues. On each occasion, comments were received	

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					to enable the amendment of the framework. In addition, the framework has been critiqued by Professor James Buchan, Queen Margaret University, Edinburgh who is also currently a member of the NICE review group for nurse staffing levels in England and an authority on workforce planning.	

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440	NIPEC & DHSSPS	General Comment	General Comment	General Comment	The framework comprises two key elements: the assumptions of the framework – i.e. those elements which must be either addressed or assured before agreeing a point on the range at which a particular care setting should be staffed; and, the staffing ranges. The assumptions of the framework are made up of the following components: • Key Performance Indicators – quality indicators can assist in the determination of appropriate or inappropriate nurse staffing in a care setting • Planned and Unplanned Absence Allowance – defined as periods of absence from work, which are expected or unexpected and, therefore, factored into the workforce planning process comprising annual, study and sick leave • Skill Mix - the ratio of registered to unregistered staff and includes 100% supervisory role of the Ward Sister/ Charge Nurse • Management of Recruitment – nursing vacancies should be filled within a prompt timescale • Influencing Factors – those factors which impact directly on competence and capacity to manage nursing activity and work load within a care setting. The factors are grouped within four domains: Workforce, Environment and Support, Professional Regulatory Requirements and Activity. that the NICE guidance as it states in the introduction is not applicable at a regional level for setting staffing levels – this must be agreed locally and regionally. Northern Ireland has sought to describe the regional prescription for a 1.8 million	Thank you for your comment and support for the guideline - as outlined previously we have shared information about your programme of work with our colleagues who manage the toolkit endorsement programme.

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					population health economy within the Delivering Care Framework. The framework is designed to support conversations at various levels within organisations through a commonly understood process. In relation to Phase 1:the process begins with a Ward Sister or Charge Nurse gathering information about his or her ward. The Influencing Factors are defined within the Delivering Care framework documents, which also provide direction as to how each factor might impact on competence and capacity to manage nursing activity and work load within a care setting. In advance of any discussion with a line manager and Assistant Director of Nursing Workforce, it may be necessary to manage some challenges, providing evidence that the current workforce in the care setting is being maximised. Using a workforce planning tool and several are provided as examples within the framework documents, the Ward Sister/Charge Nurse should then calculate the number of staff required to provide the nursing service within the care setting. This number is then converted to a nursing to bed ratio and the range is consulted to assure that the eventual ratio sits within the recommended range for the care setting. Where the ratio falls outside the range, the Influencing Factors may be used to have a conversation with a line manager and Assistant Director of Nursing Workforce as to why this might be case, or indeed the need for investment or redeployment of staff. Following agreement of a way forward, an action plan is submitted to the Executive Director of Nursing.	

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					It is within this context that this response is made.	
441	NIPEC & DHSSPS	General Comment	General Comment	General Comment	The guideline production, both in terms of the underpinning publications, expert teams and Advisory Committee has remained England centric. Whilst it is appreciated that a short time frame required a challenging process in terms of approach to production NIPEC and the DHSSPS believe that there should be the opportunity for other expertise within the four countries to contribute. The England centric context continues throughout the guideline with reference to a range of documents relevant to England, e.g. line 110 – National Quality Board (2013). NIPEC and the DHSSPS broadly agree with the underpinning approach to the guideline – being systematic assessment, considering a range of factors which impact on nursing workforce planning.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. NICE was commissioned to produce a guideline for England. We will be recruiting a new advisory committee in Autumn and this will be advertised on the NICE website.
442	NIPEC & DHSSPS	General Comment	General Comment	General Comment	Finally, NIPEC and the DHSSPS commend the Advisory Committee for the significant work that has been achieved within a 7 month time frame and wish them well through further phases.	Thank you for your comment and support for this guideline.

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443	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley CCG and Swale CCG	3	21	Introduction	Though the guidance states it does not cover workforce planning it is important that the guidance is intended for HEI's and commissioners of education too as the content can at least be helped to inform / provide a level of intelligence in relation to workforce planning. We should at least be able to build in evidence based guidance to our thinking for workforce planning as it will help to mitigate the risks of potentially very significant gaps between service plans and staffing to deliver safe care as part of transformation plans. It is essential demand and capacity move closer together and that we have assurance of this or any guidance related to safe staffing will be unlikely to help deliver safe care for patients or help providers in any sustainable manner.	Thank you for your comment. We have now added some more detail from the scope document to the introduction section of the guideline to clarify what this guideline focuses on. We have also added further detail in the introduction and the beginning of the organisational strategy recommendations to state that these recommendations are applicable to commissioners
444	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley	9	130	1.1.4	'Be aware' as opposed to 'ensure' appears inconsistent with the purpose of the guidance. It would be more consistent if this opening sentence was strengthened to reflect the evidence base in this regard.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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	CCG and Swale CCG					
445	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley CCG and Swale CCG	11	183	1.2.2	Professional judgement should refer to the NMC Code.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
446	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley	11	199	1.2.5	An alternative could be to set this need outside of the calculated requirements. For safe care, that does not detract from the care of ‘non specialised’ patients and also for assurance purposes, it could be helpful consider in this manner. Providers and commissioners could then have better assurance that a core component of staff for ‘non specialised’ patients and for those needing 1-1 care are clearly determined and understood.	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation in the organisational strategy section to address this issue.

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447	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley CCG and Swale CCG	12	202	1.2.5	Specifying approximate times associated with additional nursing care and significant nursing care needs is inconsistent with the thrust of the guidance in terms of individual need. Eg complex care conditions and multidisciplinary meetings could invariably require more time than the approximations. The danger is specifying times could detract from the individual need if applied as read. Nonetheless the examples given are a helpful guide.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used. This includes being in line with your comment of that they are to help guide professional judgement.
448	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley	13	203	1.2.5	Continuing with the examples noted as 'one off', discharge planning is an ongoing matter particularly for certain categories of patient and for patients with more complex need. In addition, many complex dressings could be / are likely to be part of ongoing care.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used.

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	CCG and Swale CCG					
449	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley CCG and Swale CCG	13	214	1.2.7	There is no reference to the experience of the nursing team in terms of what the team mix might look like as part of the shift. This seems to be an important gap in nursing staff factors. It is referred to in line 280 para 1.2.15 but this would seem late in the flow sequence and could be helpfully added to guidance and captured earlier in the analysis.	Thank you for your comment. Section 1.3 has been amended in light of your comment.
450	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley	16	250	1.2.10	Obviously it will not be possible to benchmark or have any comparative understanding where providers nationally use different staffing tools. At some point, as NICE undertake evidence reviews of these, it would be helpful to have some measure through which we can have useful comparisons and benchmarks.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.

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	CCG and Swale CCG					
451	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley CCG and Swale CCG	18	306	1.2.20	Para 1.2 20 suggests red flag nursing events could be reported to a range of people. If, as is paramount, any necessary immediate action as set out in para 1.2.21, is required, it must surely be imperative to make the first point of reporting of such incidents to the nurse in charge of the ward on any given shift. This could helpfully be made more explicit. These 2 paragraphs need to be more strongly linked and presently there does seem to be incongruity in what each one says.	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.
452	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley	18	313	1.2.21	Para 1.2 20 suggests red flag nursing events could be reported to a range of people. If, as is paramount, any necessary immediate action as set out in para 1.2.21, is required, it must surely be imperative to make the first point of reporting of such incidents to the nurse in charge of the ward on any given shift. This could helpfully be made more explicit. These 2 paragraphs need to be more strongly linked and presently there does seem to be incongruity in what each one says.	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.

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	CCG and Swale CCG					
453	North Kent Clinical Commissioning Groups. (Includes: Medway CCG; Dartford Gravesham and Swanley CCG and Swale CCG	19	328	1.3	For patient reported measures, use of the national patient survey will fall short. Patients do not always participate and where intentional rounding takes place this may be a better method of capturing patient reported view and at a time when any necessary changes might be actioned.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
454	Northern Ireland Practice and Education Council for nursing and midwifery **(NIPEC)** and the Department of Health, Social	8	132	1.1.5	It is unclear from the guideline what is described by planned and predictable variations – within this paragraph absence is alluded to – this may be confused with planned and unplanned absence allowances. It is out contention that this element needs further explanation.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
	Services and Public Safety **(DHSSPS)**					
455	Nottingham University Hospitals NHS Trust	3	1	Introduction	Fundamentally the paper is confusing and appears to have 4 main remits: Sets out broad guidelines Reviews evidence/research Makes recommendations Provides another tool for calculating staffing Unclear as to what the intention of the paper truly is.	Thank you for your comment. We have added detail to clarify the position of this guideline and the separate endorsement process of decision support toolkits.
456	Nottingham University Hospitals NHS Trust	11	180	1.2.1	Other toolkits for measuring staffing are mentioned lots but these have to be endorsed by NICE. No time frames here we note. We wonder who will endorse such toolkits? Suggest that NICE identify which other toolkits are available. It is unclear how toolkits might work with staffing Guidelines provided by NICE	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
457	Nottingham University Hospitals NHS Trust	12	202	1.2.5	There is no time factor indicated for routine nursing care needs Unclear as to how will be calculated	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have amended the recommendation which describes how Tables 1 and 2 could be

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Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
						used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
458	Nottingham University Hospitals NHS Trust	13	203	1.2.5	There is no time factor for routine nursing care needs. Unclear as to how to calculate.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
459	Nottingham University Hospitals NHS Trust	15	248	1.2.9	Under bed utilisation, need to be clear whether this is 24 hours.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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460	Nottingham University Hospitals NHS Trust	18	305	1.2.19	'Nursing Red Flags' – while understood this is not universally used term.	Thank you for your comment. The existing glossary contains a definition of this to address this potential issue.
461	Nottingham University Hospitals NHS Trust	21	388	2	Unsure as to why expert paper discussed New Zealand Public Health System. Very different system of care delivery, patient assessment and staff rostering.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
462	Nottingham University Hospitals NHS Trust	28	501	5	There appears to be some confusion over nurse to patient ratio and nursing hours per patient per day.	Thank you for your comment. The guideline has been amended in light of your comment.
463	Nottingham University Hospitals NHS Trust	28	503	5	The assumption that a nurse working 8 hours delivers 8 hours of nursing care should be challenged. Nurses roles are diverse and multifactorial.	Thank you for your comment. The guideline has been amended in light of your comment.
464	Nottingham University Hospitals NHS Trust	53	710	Appendix 1	There is a move away from using acuity/dependency to 'Use individual patients' nursing needs as the main driver for calculating the nursing staff requirement for a ward' and there is an emphasis on delivering staffing levels based on the actual patient demand on a given ward. However there is no explanation as to why. Acuity/Dependency is not described throughout document, however nursing needs are. Acuity/Dependency has been	Thank you for your comment. The guideline is aimed to encompass all patient factors that are likely to influence nursing staff requirements. We have amended the guideline text to state that patient nursing needs would include both patient acuity and

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					embedded within Trusts for 6 years and provides an objective view of patients understood by the whole clinical team. Nursing Needs could be seen as subjective and doesn't fully describe the sickness of the patient.	patient dependency.
465	Nottingham University Hospitals NHS Trust	71	720	Appendix 2	The actual tool is through but looks like it will take lots of time. The example spreads to 3 pages, but is poorly thought through, incomplete and confusing to senior nursing staff familiar with tools. The tool calculates using short shifts, while the majority of nurses in acute Trusts work long shifts. Stage 1 states 'over a period of a few weeks'. This is not specific enough.	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in section 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments
466	Pain UK	18	305	1.2.19	The first point is excellent, the second on vital signs should include pain, e.g. 'Patient vital signs and pain levels not assessed –' the third point first dash is excellent but pain management is not a care need but part of treatment.	Thank you for your comment This was considered by the Safe Staffing Advisory Committee, however definitions included are derived from what is currently being used in the literature and in clinical practice.

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467	Pain UK	18	306	1.2.20	Patients, their families and carers are often the first to notice problems with care, but how will they know what constitutes a red flag to be able to report it?	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation in the organisational strategy section to address this issue.
468	Pain UK	19	328	1.3	Very heartened to see that adequacy of pain relief will be a safe nursing indicator	Thank you for your comment and support for this guideline.
469	Pain UK	45	702	Appendix 1	Evidence would suggest that adequate control of pain on acute wards and on discharge will prevent chronic pain developing later at greater cost.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
470	Royal College of Anaesthetists	3	21	Introduction	In the scope of the guidance intensive care is specifically not included. Does this exclusion also apply to the operating theatres environment (including the postoperative recovery room) which is obviously of major interest to the RCoA? The exclusion of assessment and admission units is disappointing as these areas are often the pinch points in many hospitals due to the unpredictable workload and diverse acuity and range of needs of the patients being managed, which obviously impacts on safe nursing care.	Thank you for your comment. We have now added some more detail from the scope document to the introduction section of the guideline to clarify what this guideline focuses on.

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471	Royal College of Anaesthetists	4	43	Introduction	More detail is needed on how NICE will endorse individual Trust staff requirement toolkits to ensure that patients and staff are confident that there is a consistency of safe staffing across the whole country.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
472	Royal College of Anaesthetists	9	125	1.1.3	Agreed that there is a need to factor in planned and predictable variations in workload, but all too often hospitals are functioning at the edge of their capacity or beyond. These day to day pressures are too often treated as short term crises when in reality they are within the scope of their predictable activity and should be allowed for when calculating nursing establishments.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising nursing staff levels on one ward for other wards. There is also a detailed monitoring section which is recommended to be used to help amend the establishments in view of predictable events.
473	Royal College of Anaesthetists	9	133	1.1.5	We support that a more flexible nursing workforce is required, but this will need wider cultural change to ensure success. The current structure of nurse training, whereby students opt for a specialised area of nursing practice from the very start of training, mitigates against obtaining the	Thank you for your comment. The guideline has been amended in light of your comment where possible, including adding further detail of some of the ways in

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					generic nursing skills that are required to ensure a fully flexible workforce. There should also be explicit mention of the need for senior nursing staff to act down when required to support front-line delivery of patient care at times of extreme pressure.	which flexibility of the nursing staff across an organisation could be achieved.
474	Royal College of Anaesthetists	12	202	1.2.5	It is unfortunate that 'attend multidisciplinary meetings' appears at the top of the list in this table of nursing care and sends out a subliminal message, unintended or not, that this activity is a greater priority than patient-focussed activities such as hygiene, toileting and pressure area care.	Thank you for your comment. The list of activities in Tables 1 and 2 are in alphabetical order and not in order of any priority.
475	Royal College of Anaesthetists	17	280	1.2.15	Agreed that professional judgement should be used to decide the skill mix within the nursing team, but this must not be overshadowed by any financial benefits that may be perceived to benefit an organisation by overuse of untrained and unqualified, healthcare assistants particularly in clinical areas with patients with the most acute and complex healthcare needs.	Thank you for your comment and support for this guideline.
476	Royal College of Anaesthetists	18	306	1.2.20	Agree that patients and relatives should be empowered to comment on nursing red flag events, but this facility should also be explicitly extended to any health care professional working in the clinical environment and not just nursing staff	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation in the organisational strategy section to address this issue.

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477	Royal College of Anaesthetists	18	311	1.2.21	We would like to see more discussion of the range of actions that might follow reporting of a red flag event. Although we would obviously support mobilisation of additional nursing resources, the reality is that they simply may not be available. In that scenario patient safety must be the priority and elective activity within the organisation should be curtailed to allow nursing staff to be released to assist with the crisis points in the organisation.	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.
478	Royal College of Anaesthetists	19	328	1.3	Staff reported indicators should include failure to participate in continuing professional development/in-service training due to staffing pressures	Thank you for your comment. The guideline has been amended in light of your comment.
479	Royal College of Anaesthetists	whole document	General comment	general comment	• As a first attempt to tackle this fundamentally important issue we welcome this document from NICE. However the scope is very limited and there will be an urgent need to tackle the clinical areas that have been specifically excluded and also paediatric care as an area requiring particular attention. The lack of good quality research/audit data available to evidence the guidance is a serious shortcoming which has been acknowledged and should prompt activity in this area, hopefully via bespoke commissioning by the key stakeholders. • We also think that the guidance is too long and complex, whilst at the same time not specific enough on staffing	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. We have included a series of research recommendations to help address the identified gaps in the available evidence base. The committee also felt it was important to assess nursing staff requirements in relation to changing patient needs as opposed to advocating

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					ratios for nurses. The public and the media demand a simple number of nursing staff who should be on a ward. This guidance does not answer the need, and its inevitable complexity could appear as a smoke screen to cover up staffing shortages.	a fixed ratio.
480	Royal College of Anaesthetists	whole document	General comment	general comment	• Although not the direct remit of the NICE guidance there should be recognition that there are often serious shortages of nursing staff in some parts of the country and in specific area of expertise. Where the algorithms state ‘seek more nursing resources’ the reality may be that they simply do not exist. In recognition of this all too common scenario, the emphasis should come from NICE that patient safety must be paramount and that if required elective activity should be curtailed or stopped altogether whatever the financial pressures within an organisation; patient safety must be the first concern. • This guidance will fail in its objectives if it increases the administrative burden on front-line nurses by taking them away from providing direct patient care. • There seems to be a lot of emphasis on inpatient wards in this guidance, which may be to the detriment of staffing in areas such as theatre recovery, high dependency and outpatients; each of these is affected by ward staffing (patients waiting in recovery for collection by ward staff, or	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team.

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					even recovery staff leaving recovery to return patients to wards, and holding up theatre throughout).	
481	Royal College of Nursing	3	1	Introduction	The RCN supports the emphasis in the guidelines on 'patient-centred care'. We would therefore suggest that it may be more appropriate for the recommendations to begin with a bottom-up, patient-centred approach to determining safe staffing, which in turn drives organisational strategy, rather than starting the recommendations with the current top-down, organisational strategy approach.	Thank you for your comment. This was discussed by the Safe Staffing Advisory Committee and it was felt that retaining the organisational factors at the start of the recommendations section was necessary to emphasise the importance of ensuring that these are in place in order to enable the subsequent patient centred recommendations. We have, however reordered the recommendations in the organisational factors section to start with the patient focused recommendation.
482	Royal College of Nursing	3	15	Introduction	The guideline refers to nursing as registered nurses and healthcare assistants. We believe NICE should clarify the position of nursing students, and make explicit that they should have supernumerary status in staffing calculations, and that nursing time of registered staff must also be factored in to allow for mentorship responsibilities.	Thank you for your comment. Section regarding staff factors that need to be considered has been amended to specifically state that nursing students are supernumerary

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483	Royal College of Nursing	4	35	Introduction	Consider inserting reference to the recent guidance on staffing levels produced by NHS England and the CQC in this paragraph (http://www.england.nhs.uk/2014/04/01/hard-truths/)	Thank you for your comment. The guideline has been amended in light of your comment.
484	Royal College of Nursing	4	43	Introduction	Will the published guidelines include further details of the toolkit endorsement process and a timeframe for implementation as there is currently very little information on this element of the process?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
485	Royal College of Nursing	5	56	1	"Care should take into account individual needs and preferences" – suggest this needs strengthening, along the lines of "Care should be based on individual patient needs and take into account individual preferences".	Thank you for your comment. The guideline has been amended in light of your comment.

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486	Royal College of Nursing	7	94	1	The guidance states that "There is no single nursing staff to patient ratio that can be applied across the wide range of wards to safely or adequately meet the nursing care of patients". The RCN agrees with the sentiment that ideal staffing levels should be determined by patient need, ward and staff factors. Notwithstanding this principle, there are safe staffing recommendations that have been developed and agreed for a number of other settings such as intensive care and children and young people's settings. In terms of adult inpatient wards, the guidance later concedes that there is the evidence-based recommendation that ratios should never fall below 8 patients per registered nurse during the day time, as beyond this the risk of harm significantly increases. This is an important patient safeguard, but it is definitely not a safe minimum to aim for, and we feel this distinction should be recognised in this section. The fact that the guidance states there is no specific staff to patient ratio, but then later identifies the 1:8 ratio, could be seen as contradictory, cause confusion and lead to calls for different ratios.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
487	Royal College of Nursing	8	108	1.1 Organisational	Suggest also referring to the recent guidance on staffing levels produced by NHS England and the CQC in this paragraph (http://www.england.nhs.uk/2014/04/01/hard-	Thank you for your comment. The guideline has been amended in light of your comment to include

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				Strategy	truths/)	this reference in the introduction section.
488	Royal College of Nursing	10	159	1.1.9	The RCN welcomes the aspiration that patients receive the care they require, including specialist care, regardless of the ward to which they are allocated and the time of day or the day of the week. However, our members have highlighted a number of challenges that currently cause difficulty in meeting this aspiration. Specifically, members have asked for guidance on how wards manage during times of escalation or a surge in medical emergencies and A&E. Many wards have these plans but patient safety is compromised by cancelling elective surgery or disrupting cancer pathways because of the need to meet targets such as A&E waiting times. Response to additional capacity or unprecedented demand, alongside delayed discharges means that many medical patients placed in elective surgery wards. Members have also raised concerns in cases when staff working in one type of ward are not always appropriately trained to deal with patients who are admitted to their ward because of a lack of bed capacity in other parts of the organisation. In these cases, nursing staff may feel their	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended to add further detail to the recommendations for "responsiveness to unplanned changes" and "promote staff training and education".

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					professional registration is at risk because they have no control over the nursing care demands arising from patient placement by non-clinical managers. This could be addressed in determining staffing numbers.	
489	Royal College of Nursing	11	190	1.2.4	Members have expressed concern that using the nursing care activities from tables 1 and 2 as a prompt to inform professional judgement may be too subjective a process and that the use of acuity and dependency tools may improve the objectivity of the staffing planning process. NICE should consider what acuity and dependency tools exist and specify whether these will be validated as part of the later workforce tool validation process.	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
490	Royal College of Nursing	12	202	1.2.5	The tables referring to nursing care activities may be helpful for illustrative purposes but give little indication as to their source and how they have been calculated. It should be specified if they are based on an external source, on the professional judgement of the guideline group, or by other means, preferably with input and evidence from frontline nursing staff.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations and evidence sources specific to developing individual

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						recommendations in Appendix 1.
491	Royal College of Nursing	13	220	1.2.7	"Managing the nursing team and the ward" and "Professional supervision and mentoring of nursing staff" are listed as additional activities and responsibilities other than direct patient care. However, the RCN recommends that staff acting in this capacity should be considered supernumerary, with provision made to that effect in any staffing level calculations. See RCN (2010) Breaking down barriers, driving up standards: the role of the ward sister and charge nurse (http://www.rcn.org.uk/__data/assets/pdf_file/0009/287784/003312.pdf)	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
492	Royal College of Nursing	14	239	1.2.9	Guidance recommends that planners should "Estimate total nursing requirement to deliver patient care needs throughout a 24-hour period", but does not discuss how often this should be done e.g. whether this is continual, real time monitoring, or the average of staffing required according to a number of sampled intervals. This process should be specified.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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493	Royal College of Nursing	17	280	1.2.15	NICE should consider evidence and provide guidance on nursing skill mix, in terms of what activities should be undertaken by registered nurses and what can be appropriately delegated to health care assistants.	Thank you for your comment. The guideline has been amended so that section 1.3 now contains more detailed recommendations on determining skill mix.
494	Royal College of Nursing	18	306	1.3	NICE should consider whether the recommendation that ratios on adult inpatient wards should never fall below 8 patients per registered nurse during the day time should form a 'nursing red flag', as evidence shows that beyond this level the risk of harm significantly increases. Having said this it should be noted that this is not ideal, as staffing should focus on patient acuity and dependency and the true safe ratio is likely to be significantly less than 1:8 on some occasions and in some areas.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised to clarify this point.
495	Royal College of Nursing	19	328	1.3	RCN members have suggested whether, in the case of surgical wards, a useful indicator would be a measurement of cancelled elective planned admissions, as this reflects the organisation's response to high activity and other organisational performance indicators. The admission of medical emergency patients, delayed discharge patients, all impact on the ability of nursing staff to provide safe care.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee; however the suggested additions were felt to be too specific to recommend as safe nursing indicators for all acute adult inpatient wards. There is however scope for addition of more safe nursing indicators locally where

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						this was felt necessary.
496	Royal College of Nursing	23	401	3	NICE identify a number of gaps in the available evidence and expert comment, however there is little further information on how this might be resolved. NICE should ensure that research questions are developed for the final version of the guidance and that there are proposals for how this research might be undertaken.	Thank you for your comment. The recommendations for research have been written to encourage more research in this important area and will be seen as priority areas for future research.
497	Royal College of Nursing	23	411	3	NICE identify a "lack of appropriately designed experimental studies" however, considering the topics of interest there would be significant ethical implications in designing experimental studies around safe staffing levels, as a result, most research to date has been necessarily observational in nature.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline contains recommendations for research including interventional studies where outcomes could be compared between enhanced numbers of nurses or enhanced skill mix and existing current practice in wards with a similar mix of patients.
498	Royal College of Nursing	27	476	5	The guidance should specify how discharged/transferred patients are accounted for, whether as a whole patient, or as a proportion depending on time present, or as a measure of hours of presence or in nursing hours required.	Thank you for your comment. The guideline recommends using bed utilisation (as opposed to be occupancy) for this very reason - to ensure the needs of patients

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						who are discharged or transferred are accounted for.
499	Royal College of Nursing	27	480	5	NICE should define what is meant by "good outcomes".	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
500	Royal College of Nursing	28	503	5	The RCN believes that it is misleading to state that a nurse working an 8-hour shift can contribute 8 hours of nursing care. Elsewhere, the guideline rightly discusses other non-patient-related activities that impact on available nursing time. The guidelines should be explicit about other local demands on ward nurses, including completing paper and electronic records to assist in providing evidence for CQUINS, Patient Experience, Safety Thermometer, Health and Safety standards and other nursing metrics. The guidelines should also recognise time required for mentoring students, and attending ward / hospital meetings, all of which impact on nursing time available for providing direct patient care.	Thank you for your comment. The guideline has been amended in light of your comment.
501	Royal College of Nursing	35	667	8	NICE remind "commissioners and providers...that it is their responsibility to implement the guideline", however, the guidance is largely provider-focused and provides little information for commissioners on how they might use their role to ensure safe staffing levels are in place. NICE should consider developing this guidance for	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					commissioners, considering issues such as how to enshrine safe staffing in service contracts, how to commission and fund safe staffing, and what corrective action to take if providers should fail to ensure safe staffing levels are in place.	
502	Royal College of Nursing	General comment	General comment	general comment	The RCN recognises that these staffing level guidelines are an important development and recognises the challenges faced by NICE in accessing and assessing relevant research to make evidence-based recommendations. These issues are likely to be even more challenging for later guidelines for settings such as community and mental health services, for which relatively less evidence exists than for adult inpatient wards in acute hospitals. We believe that NICE should make recommendations for any further work that needs to be undertaken.	Thank you for your comment and support for this guideline. We have included a series of research recommendations to help address the identified gaps in the available evidence base.
503	Royal College of Nursing	General comment	General comment	general comment	The RCN notes that NICE has been commissioned to develop these guidelines under a challenging timeframe, as such, the consultation process has been relatively short for such an important document. A number of members have expressed concern that the consultation process only allows for comment by registered stakeholder institutions, barring individual feedback. Concerns have also been raised that the consultation is too prescriptive, in a format	Thank you for your comment. Both individuals and registered stakeholders are able to submit consultation comments if wished. NICE's consultation response documents also allows for the submission of both general comments and section specific

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					that encourages technical comment rather than asking questions about the general content and structure of the guidelines. We understand that NICE follows a standard procedure when consulting on guidelines but would ask NICE to consider whether this format is best suited to the nature of guidance on safe staffing levels.	comments. We will review our website text and documents to see if these points can be made any clearer. We have also now inserted a table on the safe staffing website page outlining dates for future scope and guideline consultation periods.
504	Safe Staffing Alliance (SSA)	3	24	1	Responsibility and Accountability The responsibility of Trust Boards and Commissioners to sign off workforce levels with the Chief Nurse/Director of Nursing as the designated Board member is welcomed. However, the Directors of Nursing/Chief Nurses in many trusts, whilst accountable for the nursing workforce levels frequently have no direct management responsibility for the nursing and midwifery workforce but instead provide professional nursing advice to general managers who hold the budgets for this workforce. The guidance needs to be cognisant of this situation in its recommendations regarding the role of the Director of Nursing, to ensure recommendations take account of the reality of managing a 24/7 workforce in acute hospitals.	Thank you for your comment. The guideline has been amended in light of your comment.

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NICE National Institute for Health and Care Excellence

Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
505	Safe Staffing Alliance (SSA)	4	43	Introduction	Workforce Tools: We would like to see more about the availability of the workforce tools, and we are concerned about the lack of indent validity or reliability testing of existing tools. How will this be addressed?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
506	Safe Staffing Alliance (SSA)	7	94	1	Guidelines on safe nurse staffing levels: Following the Francis Inquiry report and the government's response to it, there has been much debate about staffing levels and eager anticipation across the NHS and beyond for NICE's guidance on safe nurse staffing levels in adult acute hospital wards. There has been an expectation that once the guidelines are published "we'll have a better idea what level of RN staffing is needed in different types of wards, to provide care safely". In light of the evidence reviewed, it would seem this expectation cannot currently be fulfilled. And we would agree that there is "no single nursing staff to patient ratio that can be applied across the wide range of wards". But some recommendations and guidelines on nurse staffing levels have been developed (in some cases jointly	Thank you for your comment. The guideline now contains completed gaps in the evidence and research recommendations sections to address these issues.

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					between the Department of Health, expert groups and professional bodies) and become widely used and accepted; for example in ITU, neonatal care, and labour wards. Should work not be undertaken to develop similar guidelines (indicating required minimums or ranges of levels) for the hospital wards caring for the majority of NHS patients – medical wards, surgical wards, care of older people's wards? We would ask that NICE respond to the identified knowledge gap and make recommendations as to the work that is required to fill this gap, so that specialty/setting specific recommendations can be produced.	
507	Safe Staffing Alliance (SSA)	8	108	1.1 Organisational Strategy	Responsibility and Accountability The responsibility of Trust Boards and Commissioners to sign off workforce levels with the Chief Nurse/Director of Nursing as the designated Board member is welcomed. However, the Directors of Nursing/Chief Nurses in many trusts, whilst accountable for the nursing workforce levels frequently have no direct management responsibility for the nursing and midwifery workforce but instead provide professional nursing advice to general managers who hold the budgets for this workforce. The guidance needs to be cognisant of this situation in its recommendations regarding the role of the Director of Nursing, to ensure	Thank you for your comment. The guideline has been amended in light of your comment.

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					recommendations take account of the reality of managing a 24/7 workforce in acute hospitals.	
508	Safe Staffing Alliance (SSA)	11	181	1.2.1	Workforce Tools: We would like to see more about the availability of the workforce tools, and we are concerned about the lack of indent validity or reliability testing of existing tools. How will this be addressed?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits. There is also a research recommendations section in the guideline which addresses the gaps in the available evidence base and covers this area.
509	Safe Staffing Alliance (SSA)	13	203	1.2.5	Workforce Tools: We would like to see more about the availability of the workforce tools, and we are concerned about the lack of indent validity or reliability testing of existing tools. How will this be addressed?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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510	Safe Staffing Alliance (SSA)	15	248	1.2.9	Workforce Tools: We would like to see more about the availability of the workforce tools, and we are concerned about the lack of indent validity or reliability testing of existing tools. How will this be addressed?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
511	Safe Staffing Alliance (SSA)	18	305	1.2.19	Given that 1:8 marks a 'high risk' level, we would like to see greater emphasis that this is a level that should not be exceeded, and the consideration of this as a 'red flag' event for immediate escalation, or even as a 'Never Event'. The SSA is concerned that without some form of mandate, the guidance will not be adhered to. Red Flag Events: The SSA welcomes the reporting of red flag events. However, this only provides a retrospective means of reporting patient safety issues - after the harm has occurred. Using 1:8 as a red-flag indicator would provide a prospective element – ensuring that higher risk situations are identified before any harm has occurred.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.

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NICE National Institute for Health and Care Excellence

Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
512	Safe Staffing Alliance (SSA)	19	318	1.3	Responsibility and Accountability The responsibility of Trust Boards and Commissioners to sign off workforce levels with the Chief Nurse/Director of Nursing as the designated Board member is welcomed. However, the Directors of Nursing/Chief Nurses in many trusts, whilst accountable for the nursing workforce levels frequently have no direct management responsibility for the nursing and midwifery workforce but instead provide professional nursing advice to general managers who hold the budgets for this workforce. The guidance needs to be cognisant of this situation in its recommendations regarding the role of the Director of Nursing, to ensure recommendations take account of the reality of managing a 24/7 workforce in acute hospitals.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
513	Safe Staffing Alliance (SSA)	19	318	1.3	Workforce Tools: We would like to see more about the availability of the workforce tools, and we are concerned about the lack of indent validity or reliability testing of existing tools. How will this be addressed?	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that contains information regarding the endorsement process of decision support toolkits.

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514	Safe Staffing Alliance (SSA)	21	349	2	Economic evidence: NICE point to a paucity of good quality economic evidence regarding nurse staffing. What evidence does exist - from a few small scale studies, review in relation to a single adverse event, and from other countries - suggests that there may be potential savings to be accrued from investing in improved registered nurse staffing levels by reducing the risk of adverse events. But the findings are inconclusive. The SSA consider it a matter of urgency that robust economic research and analysis is undertaken to examine the costs and benefits associated with improved registered nurse staffing. Without this, we are concerned that regardless of the outcomes of staffing reviews and recommended levels derived from the use of tools, in an austerity stricken NHS, sustained investment in the nursing workforce will not be made in the short term, and so the longer term economic benefits from improved patient safety, quality, and effective use of resources will not be achieved.	Thank you for your comment. The guideline has been amended in light of your comment and the lack of economic evidence has been included in the research recommendations section.
515	Safe Staffing Alliance (SSA)	24	430	3	Workforce Tools: We would like to see more about the availability of the workforce tools, and we are concerned about the lack of	Thank you for your comment. We have added a link in the introduction section of this

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					indent validity or reliability testing of existing tools. How will this be addressed?	guideline to a separate webpage on the NICE website that will contain all the information regarding the endorsement process of decision support toolkits.
516	Safe Staffing Alliance (SSA)	24	435	3	Responsibility and Accountability The responsibility of Trust Boards and Commissioners to sign off workforce levels with the Chief Nurse/Director of Nursing as the designated Board member is welcomed. However, the Directors of Nursing/Chief Nurses in many trusts, whilst accountable for the nursing workforce levels frequently have no direct management responsibility for the nursing and midwifery workforce but instead provide professional nursing advice to general managers who hold the budgets for this workforce. The guidance needs to be cognisant of this situation in its recommendations regarding the role of the Director of Nursing, to ensure recommendations take account of the reality of managing a 24/7 workforce in acute hospitals.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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517	Safe Staffing Alliance (SSA)	24	445	3	Economic evidence: NICE point to a paucity of good quality economic evidence regarding nurse staffing. What evidence does exist - from a few small scale studies, review in relation to a single adverse event, and from other countries - suggests that there may be potential savings to be accrued from investing in improved registered nurse staffing levels by reducing the risk of adverse events. But the findings are inconclusive. The SSA consider it a matter of urgency that robust economic research and analysis is undertaken to examine the costs and benefits associated with improved registered nurse staffing. Without this, we are concerned that regardless of the outcomes of staffing reviews and recommended levels derived from the use of tools, in an austerity stricken NHS, sustained investment in the nursing workforce will not be made in the short term, and so the longer term economic benefits from improved patient safety, quality, and effective use of resources will not be achieved.	Thank you for your comment. Please see response to comment 514 as this appears to be a duplicate comment.

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518	Safe Staffing Alliance (SSA)	37	688	Appendix 1	Economic evidence: NICE point to a paucity of good quality economic evidence regarding nurse staffing. What evidence does exist - from a few small scale studies, review in relation to a single adverse event, and from other countries - suggests that there may be potential savings to be accrued from investing in improved registered nurse staffing levels by reducing the risk of adverse events. But the findings are inconclusive. The SSA considers it a matter of urgency that robust economic research and analysis is undertaken to examine the costs and benefits associated with improved registered nurse staffing. Without this, we are concerned that regardless of the outcomes of staffing reviews and recommended levels derived from the use of tools, in an austerity stricken NHS, sustained investment in the nursing workforce will not be made in the short term, and so the longer term economic benefits from improved patient safety, quality, and effective use of resources will not be achieved.	Thank you for your comment. The guideline now contains completed gaps in the evidence and research recommendations sections to address these issues.

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519	Safe Staffing Alliance (SSA)	39	696	Appendix 1	Responsibility and Accountability The responsibility of Trust Boards and Commissioners to sign off workforce levels with the Chief Nurse/Director of Nursing as the designated Board member is welcomed. However, the Directors of Nursing/Chief Nurses in many trusts, whilst accountable for the nursing workforce levels frequently have no direct management responsibility for the nursing and midwifery workforce but instead provide professional nursing advice to general managers who hold the budgets for this workforce. The guidance needs to be cognisant of this situation in its recommendations regarding the role of the Director of Nursing, to ensure recommendations take account of the reality of managing a 24/7 workforce in acute hospitals.	Thank you for your comment. The guideline has been amended in light of your comment.
520	Safe Staffing Alliance (SSA)	70	718	Appendix 1	In 1.3.3, the guidance states that consideration should be given to increasing the ward staffing establishment when there are red flag events, poor safe nursing indicator results and when registered nurses are caring for more than 8 patients during the day time on a regular basis, as this may lead to increased risk of harm. The Alliance welcomes the fact that NICE has identified this ratio as a level that is associated with increased risk of harm. We think that providing a concrete reference point	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					expressed as a patient to nurse ratio is critically important as it is a measure that has universal meaning, and can be consistently understood and applied. We would suggest however, that further clarification is needed regarding the 1:8 figure. The research that this relates to, measured the ratio of patients to each RN providing care on a day shift – i.e. it excluded the nurse in charge. We suggest the guidance makes explicit that RN staffing needs the support of a supervisory registered nurse in charge and from healthcare assistants (in sufficient number and with appropriate training) to ensure adequate staffing. We would welcome greater specificity regarding the need for supervisory support and management in nursing, which are essential for safe clinical outcomes and leadership of the nursing workforce. Given that 1:8 marks a 'high risk' level, we would like to see greater emphasis that this is a level that should not be exceeded, and the consideration of this as a 'red flag' event for immediate escalation, or even as a 'Never Event'. The SSA is concerned that without some form of mandate, the guidance will not be adhered to.	
521	Safe Staffing	71	720	Appendix	Workforce Tools:	Thank you for your comment. We

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	Alliance (SSA)			2	We would like to see more about the availability of the workforce tools, and we are concerned about the lack of indent validity or reliability testing of existing tools. How will this be addressed?	have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits. There is also a research recommendations section in the guideline which suggests research areas to address the gaps in the available evidence base.
522	Safe Staffing Alliance (SSA)	General comment	General comment	general comment	The Safe Staffing Alliance (SSA) welcomes the National Institute of Clinical Excellence (NICE) draft guideline on 'Safe staffing for nursing in adult inpatient wards in acute hospitals'. The SSA notes that this is planned as the first guideline for a new NICE work programme on safe staffing levels and is pleased that other settings will be addressed in future guidance.	Thank you for your comment and support for this guideline.
523	Safe Staffing Alliance (SSA)	General comment	General comment	general comment	Nature of the consultation: We have several comments about the consultation itself: - we would have welcomed the addition of some direct questions to guide responses - to get a more comprehensive view, responses to the	Thank you for your comment. Both individuals and registered stakeholders are able to submit consultation comments if wished. NICE's consultation response

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					consultation should not have been restricted to registered 'stakeholder organisations' but open to all (including individual nurses or members of the public) - the consultation period is very short, which limits the depth and breadth of discussion with frontline healthcare staff or members of organisations.	documents also allows for the submission of both general comments and section specific comments. We will review our website text and documents to see if these points can be made any clearer. We have also now inserted a table on the safe staffing website page outlining dates for future scope and guideline consultation periods.
524	The British Pain Society	3	1	Introduction	The British Pain Society welcomes the production of guidelines that help to ensure adequate nursing numbers and competence to ensure the delivery of high quality individualised patient care. However as a multidisciplinary organisation we would point out that, as with many aspects of care, pain assessment and management requires the input of a multidisciplinary team (MDT) and therefore the value of guidance relating to safe staffing numbers for any one professional group in isolation, without consideration of the input from MDT members is questionable.	Thank you for your comment. We have acknowledged the importance of the multidisciplinary team in the introduction section; however the focus of this guideline is on nursing staff as outlined in the referral we have received from the Department of Health and NHS England.

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525	The British Pain Society	8	107	1.1	The provision of staffing to ensure capacity also needs to take into account the provision of specialist support services. In relation to acute pain services there is some evidence that Acute Pain Teams (also known as Inpatient Pain Teams) with nursing input can have beneficial effects in terms of a range of indicators. McDonnell, Nicholl and Read (2003) found an association between the provision of multidisciplinary Acute Pain Teams (APTs) in acute English hospitals performing adult in-patient surgery (excluding maternity) and higher estimates of patient controlled analgesia and epidural use, regular in-service training for nurses and junior doctors, written guidelines/protocols for management of postoperative pain, routine use of postoperative pain measurement systems and audit/research in relation to postoperative pain issues. They also state that 'Since 1995, the number of hospitals offering in-patient surgery that are covered by an APT has risen. However, despite repeated endorsements from professional bodies, some acute hospitals still have no APT and recent evidence indicates that some APTs face financial problems and provide a 'token' service only. Recent policy recommendations may have little impact on the current situation' The BPS is aware that this pressure is continuing with in some cases a	Thank you for your comment and support for this guideline. The guideline is aimed to encompass all the factors that are likely to influence nursing staff requirements and pain management has been included amongst these.

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					reduction in availability of APS and downgrading of staff. The availability of such support needs to be taken into account in calculating the appropriate staffing requirements on wards. Where appropriate APS are not provided increased staffing numbers and adjustment in the skill mix may be required to ensure appropriate pain assessment and management. These factors need to be taken into account by commissioners and hospital boards, particularly in light of the evidence that poor postoperative pain management can lead to increased levels of chronic pain (Perkins and Kehlet 2000). References: McDonnell A1, Nicholl J, Read SM. (2003) Acute Pain Teams in England: current provision and their role in postoperative pain management. Journal of Clinical Nursing. 2003 May; 12(3):387-93. Perkins F M, Kehlet H (2000) Chronic Pain as an Outcome of Surgery A Review of Predictive Factors. Anaesthesiology 93:1123–33	
526	The British Pain Society	18	305	1.2.19	We welcome the inclusion of pain assessment as a component of intentional rounding and the inclusion of a delay of more than 30 minutes in providing planned pain relief however we would point out that pain assessment should be considered as the 5th Vital sign and included in	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where

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					the vital sign assessment. The pain assessment tool should be chosen to reflect the individual patient's clinical situation e.g. the presence of cognitive impairment, and it is important that assessment occurs during patient activity (movement /coughing and not just at rest. We would also suggest that the key action within the 4 P's is not in the assessment of pain, but in taking appropriate action and therefore would suggest the addition of: Pain: asking patients to describe their level of pain level using the local pain assessment tool, undertaking and documenting appropriate action	possible.
527	The British Pain Society	19	328	1.3	We welcome the inclusion of adequacy of provided pain relief as a safe nursing indicator although 'adequacy' is a vague term and difficult to assess, we would welcome additional clarification as to how this should be assessed for example use of the Pain Management Index (where the severity of pain is linked with the 'strength' of a medicine), relief from pain data and patient survey data.	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2.
528	The Christie NHS Foundation trust	3	1	Introduction	The recommendations echo the guidance and instruction already in the public domain (from the NQB paper and the DH Hard Truths document). There is nothing in the content of the draft guidance that gives cause for disagreement	Thank you for your comment and support for this guideline.
529	The Christie NHS	3	21	Introduction	Are there plans to produce guidance for Intensive care, admission units etc.?	Thank you for your comment. There is further information on the

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	Foundation trust					NICE website about the other topic areas that NICE have been asked to produce safe staffing guidelines on to date.
530	The Christie NHS Foundation trust	4	43	Introduction	It would be more helpful for endorsement of toolkits to incorporated into the guidelines rather than separate document	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
531	The Christie NHS Foundation trust	7	94	1	Agree that it is inappropriate to attempt to ‘prescribe’ a baseline nurse to patient ratio	Thank you for your comment and support for this guideline.
532	The Christie NHS Foundation trust	8	120	1.1.2	Strongly agree with specification that senior nurse manager signs off establishments following multi-professional discussions to ensure their professional views are not potentially overwritten by more senior non-clinical managers	Thank you for your comment and support for this guideline.
533	The College of Emergency	3	1	Introduction	The guidance appears to exclude assessment areas and it should be clarified whether a Clinical Decision Unit constitutes an assessment area: this would depend on	Thank you for your comment. We have now added some more detail from the scope document of

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	Medicine				what the definition of an assessment area is. I would think CDUs are specifically excluded given the terminology used but we should ask for specific confirmation of this. If Clinical Decision Units are included then it should be noted that these are often small areas, with a high turnover and acuity. The guideline does not specifically address these issues, nor does it address a minimum number of nurses required for staff and patient safety (e.g. minimum 2 staff on duty at all times overnight) If CDUs are specifically excluded then the only other comment from CEM would be to support staffing levels based on activity required to drive care, and facilitate discharge, since this is likely to improve flow through hospitals and may impact positively on crowding	the guideline to the introduction section to clarify what this guideline focuses on.
534	The Newcastle Upon Tyne Hospitals NHS FT	4	30	Introduction	Absolutely agree with comments in this line, guidance should not override the need for and importance of using professional judgement to make decisions appropriate to circumstances. Welcome recognition of professional judgement as key determinant of nurse staffing.	Thank you for your comment and support for this guideline.

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535	The Newcastle Upon Tyne Hospitals NHS FT	4	43	Introduction	It would be helpful to get endorsement of toolkits (acuity/dependency tools) as soon as possible. ? will this be an efficient process and aid consistency.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
536	The Newcastle Upon Tyne Hospitals NHS FT	7	94	1	Agree with this as overriding statement. – later in document (1.33)refers to number of registered nurse to patient ratio – contradictory.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
537	The Newcastle Upon Tyne Hospitals NHS FT	8	115	1.1.1	Please define here what is meant by assurance - ? Clinical outcomes or monitoring process.	Thank you for your comment. Please see response to comment number 537 as this appears to be a duplicated comment.
538	The Newcastle Upon Tyne Hospitals NHS FT	9	121	1.1.2	This seems to imply Nurse Director signing of rotas – not practical and important for local ownership /responsibility.	Thank you for your comment. The guideline has been amended in light of your comment.

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539	The Newcastle Upon Tyne Hospitals NHS FT	9	122	1.1.2	What is meant by actual staff roster posted, this infers that it's when the off duty is done and put up on the ward this would not be signed off by the Board member. Should be when staffing set and staffing agreed. Ie Board level agreement.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
540	The Newcastle Upon Tyne Hospitals NHS FT	9	144	1.1.7	Nurse sensitive indicators not currently monitored. Risk that culture of help, support etc. will be lost.	Thank you for your comment. Please see response to comment number 579 as this appears to be a duplicated comment.
541	The Newcastle Upon Tyne Hospitals NHS FT	10	176	1.21	Off duty is planned in advance and flexed on a daily basis to meet service needs. This infers that you are almost doing the off duty on a daily basis	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
542	The Newcastle Upon Tyne Hospitals NHS FT	11	180	1.2.1	Here specifically but overall more generally – all of this will remain from the staff and overburden clinical staff.	Thank you for your comment. The guideline has been amended where possible and indicates where components of the recommendations could be facilitated by a NICE endorsed decision support toolkit. We hope this would reduce the time taken to undertake some of the

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						recommendations of this guideline.
543	The Newcastle Upon Tyne Hospitals NHS FT	11	181	1.2.1	Need early guidance of toolkit recommended – take into account SNCT broad use.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
544	The Newcastle Upon Tyne Hospitals NHS FT	11	188	1.2.3	Links to comment above its difficult to use individual patients nursing needs when planning off duty in advance. Difficult to reach every individuals needs on every occasion.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised to help clarify planning nursing staff establishments which are planned in advance versus assessment of requirements on a daily basis.
545	The Newcastle Upon Tyne Hospitals NHS FT	11	199	1.2.5	Accept and agree as a point of principle this is correct. However, in an acute provider situation this would be very difficult to guarantee for every patient whom may require a “special”. The reality of dementia care on wards in acute hospitals would make this a very difficult standard to be	Thank you for your comment. Please see response to comment number 589 as this appears to be a duplicated comment.

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					reached in every circumstance. ~Cohort nursing often more appropriate.	
546	The Newcastle Upon Tyne Hospitals NHS FT	12	202	1.2.5	Is this to be used as a tool should there be a scoring system ? Table quite simplistic – for example enteral feeding is not necessarily any more complex than oral feeding.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
547	The Newcastle Upon Tyne Hospitals NHS FT	13	215	1.2.7	Additional factors to be taken into consideration are the skills and experience of nursing team available. The focus upon numbers of staff alone over simplifies and potentially undermines safe decision making. It is often the case that fewer numbers of more experienced staff is safer and more effective and higher numbers are very inexperienced staff, this should be taken into account in determining nurse staffing requirements. Too simplistic to just look at numbers – skills and experience of staff should be taken	Thank you for your comment. Please see response to comment number 593 as this appears to be a duplicated comment.

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					into account.	
548	The Newcastle Upon Tyne Hospitals NHS FT	14	230	1.2.8	This is saying maternity leave should be accounted for in 'uplift' is 20% sufficient? recommendation for uplift would be useful?. Also typo think it should say annual leave	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise. The example previously included in Appendix 2 was meant to be an example to illustrate the processes and calculations, not to recommend specific numbers.
549	The Newcastle Upon Tyne	14	237	1.2.9	Rather than recommending a process based upon average nursing hours per patient, per day, it would be a stronger more flexible and more effective recommendation	Thank you for your comment. Please see response to comment number 596 as this appears to be

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	Hospitals NHS FT				to list the factors to be taken into account with some textual guidance next to this as to why they are important.	a duplicated comment.
550	The Newcastle Upon Tyne Hospitals NHS FT	15	248	1.2.9	Very new concept for many organisations and over simplifies this model.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
551	The Newcastle Upon Tyne Hospitals NHS FT	16	255	1.2.11	This paragraph states that nursing hours per patient day enables the nursing needs of individual patients and different shift durations of the nursing staff to be more easily encountered for compared with the nurse to bed ratio. This is potentially misleading, nurse to bed ratio is a useful tool to make comparisons between and within in-patient areas. It is not a replacement for average patient nursing needs in hours, it is an additional tool which is useful. The way that this is written in this paragraph could be improved.	Thank you for your comment. Please see response to comment number 604 as this appears to be a duplicated comment.
552	The Newcastle Upon Tyne Hospitals NHS FT	17	290	1.2.17	It would be helpful if NICE were to suggest a percentage as there is huge variation and this is difficult to influence within individual Trusts. ? Which should be taken into account should be defined and determined and this should include maternity leave.	Thank you for your comment. Please see response to comment number 607 as this appears to be a duplicated comment.

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553	The Newcastle Upon Tyne Hospitals NHS FT	18	305	1.2.19	The bottom bullet point in this box which begins "shortfall of more than 8 hours or 25% of registered nursing staff present, compared with the actual nursing requirement for this shift" – if this comment is to remain, it should read compared with the planned staffing for the shift as opposed to the actual nursing total requirement. It is impossible in an acute setting to always be within 8 hours of the actual nursing requirement, because requirements vary so significantly. Escalation within nurse staffing numbers to this degree would not be possible. Not a real measure or valid in practice – not a red flag and where there is evidence this is a problem. This contradicts professional judgement and undermines this. In terms of other nursing red flags within this box, this is reliant on individuals fulfilling their required duties. This is a very low bar to set, the number of nursing red flags across in-patient areas would be significant every single day of the week. All consume time to monitor and is unnecessarily complex /detailed. Not clear how this is to be recorded or monitored or indeed why. This is not a safe approach	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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554	The Newcastle Upon Tyne Hospitals NHS FT	18	311	1.2.21	The wording here needs to be tempered and "urgent" removed. This is too prescriptive and does not reflect what happens in practice.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
555	The Newcastle Upon Tyne Hospitals NHS FT	18	314	1.2.22	Calculated actual total nursing requirements, different language from planned and actual in NQB therefore confusing. Actual here means what you need rather than what you have. How are we to keep these records on a daily basis??	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.
556	The Newcastle Upon Tyne Hospitals NHS FT	18	317	1.2.22	The example in appendix 2, which is 37 WTE's for a 28 bedded surgical ward is not achievable and where is the evidence base to support this?	Thank you for your comment. The example previously included in Appendix 2 was meant to be an example to illustrate the processes and calculations, not to recommend specific numbers.
557	The Newcastle Upon Tyne Hospitals	19	328	1.3	Planned, required and actual need clarification and similar terminology to NQB.	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in

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	NHS FT					Appendix 2.
558	The Newcastle Upon Tyne Hospitals NHS FT	19	328	1.3	Staff reported – not recorded and not felt to be helpful.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
559	The Newcastle Upon Tyne Hospitals NHS FT	20	334	1.3.3	This links to previous comments – professional judgement should be key determinant not prescriptive ratios.	Thank you for your comment which is in line with the intentions of this guideline.
560	The Newcastle Upon Tyne Hospitals NHS FT	23	399	3	This section is really helpful, how this will translate to research activity as national and regional level.	Thank you for your comment. The recommendations for research have been written to encourage more research in this important area and will be seen as priority areas for future research.
561	The Newcastle Upon Tyne Hospitals NHS FT	28	496	5	Nursing hours per patient day is oversimplified as to calculate this correctly needs to identify needs of patients and look at ward utilisation figures. If using this as part of toolkit needs to be identified as such, it is referred to a lot in this document.	Thank you for your comment. Please see response to comment number 615 as this appears to be a duplicated comment.
562	The Newcastle	28	503	5	This is over simplified, there is some "down" time in a shift of 8 hours.	Thank you for your comment. Please see response to comment

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	Upon Tyne Hospitals NHS FT					number 617 as this appears to be a duplicated comment.
563	The Patients Association	3	1	Introduction	The Francis inquiry made 290 recommendations which set out a clear blueprint for the creation of a care system which ensures that the safety, dignity and well-being of patients is paramount. The Patients Association made it very clear at the time that it was vital that the recommendations were implemented swiftly and in full. In order to ensure high quality patient care and safety, the recommendations must be taken seriously and acted upon. Whilst we welcome the findings of the various reviews and reports (Berwick, Keogh, Cavendish, Clwyd-Hart and the appointment of Professor Sir Mike Richards as the Chief Inspector of Hospitals by the Care Quality Commission), it is now time for action. It is becoming increasingly apparent that hospital managers are reluctant to take the radical steps demanded by the Francis inquiry. We need to see regulation of healthcare assistants, a reformed complaints system, improved training and a properly funded and structured regulatory system.	Thank you for your comment and support for this guideline.

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					We have been saying for many years now that the need to listen to patients, involve them in their care, value our NHS staff and for trusts to work together (rather than in isolation), are all key elements to ensure that standards improve and unnecessary deaths are avoided.	
564	The Patients Association	4	39	Introduction	The Patients Association has recently responded to the Department of Health consultation on "Fundamental Standards". We believe that the fundamental standards should aim to improve care for all service users of health and social care services, particularly those who are in vulnerable circumstances and so we endorse reading this NICE guidance alongside the "Fundamental Standards" consultation.	Thank you for your comment. The guideline has been amended in light of your comment.
565	The Patients Association	5	51	1	We believe that at the heart of patient-centred care, there should be the requirement that patients be informed of how they can make a complaint if they wish to do so. It is obvious that inadequate staffing levels and inadequately qualified and trained staff are going to have a direct bearing upon the quality of patient care. Patients therefore should have the right to complain if they feel that safe staffing standards are not being met. As patients are at the centre of healthcare (and it is they who ultimately benefit or suffer as a result of poor staffing), they have an important role to play in assessing and commenting upon	Thank you for your comment. The patient-centred care section of the introduction to the guideline has been amended in light of your comment.

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					the adequacy of staffing levels. Every year we receive many calls to our helpline from patients who are confused about the complaints procedures in health and social care settings. Many patients are either not aware that they are “allowed” to make a complaint or are reluctant to complain, particularly as they fear that the quality of the care that they receive may decline if they do so. Furthermore, those who did complain have had to deal with complex, bureaucratic systems and are unhappy with the response that they have received; and are even more confused about how to take the matter further. We believe that the NHS needs to do more to raise the awareness of the complaints procedure. We also feel that the NICE guidelines should make specific reference to the rights of a patient, as expounded in the NHS Constitution - as we have argued for in many previous consultations.	
566	The Patients Association	7	94	1	The Patients Association accepts that there is “no single nursing staff to patient ratio that can be applied across the wide range of wards”. There are staffing levels that have been developed and are in use in ITU and Paediatric departments. These have been developed by the	Thank you for your comment and support for this guideline.

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					Department of Health and with input from professional bodies.	
567	The Patients Association	8	114	1.1.1	The Patients Association would like to comment on the role more generally of healthcare assistants; as covered in the Cavendish Review into valuing and supporting healthcare assistants and care assistants in the NHS and care settings We are worried at what appears to be an imbalance between the utilisation of healthcare assistants in the place of registered nurses. We are concerned that as healthcare assistants are cheaper to recruit and pay, many Trusts and hospitals are becoming increasingly reliant upon them to bring up staff numbers of the ward. However, they lack even basic regulation and have minimal training. Many, it is reported, pick up skills (and indeed bad habits) as they go along rather than undergoing any rigorous training. Despite this, we are increasingly hearing that healthcare assistants are undertaking tasks which should only be performed under supervision from a trained and registered nurse. Indeed, even some more complex tasks like taking blood have been reported to have been performed by healthcare assistants. We have heard from	Thank you for your comment and support for this guideline. We have also amended a number of parts of the guideline in light of your comment to include reference to the Cavendish review and to add more details regarding the roles of healthcare assistants and registered nurses, including the delegation of tasks to healthcare assistants. There is also a section of the recommendations which covers training.

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					many patients who struggle with distinguishing between different nursing roles and healthcare assistants. We would reiterate our support for the proposals put forward by the Willis Commission with regards to its recommendations for the on-going professional development of nurses should be applied to the healthcare assistant profession also. We would want to take this opportunity, supported by Health Education England (and in association with the Royal Colleges) to ensure that the training offered was of an applicable standard, and of a correct focus; to ensure that the skills of healthcare assistants was such that they complemented, and ultimately supported, the skills of registered nursing staff.	
568	The Patients Association	10	158	1.1.9	We believe that there should be a greater emphasis on bringing specialist staff and equipment to the patient, rather than the patient having to be moved around the hospital. Spending time in hospital can be very distressing and disorientating for patients, especially for older people and those with conditions such as dementia. It is therefore very important that this distress is minimised by ensuring that services and staff are able to meet the needs of	Thank you for your comment. This important point is covered in the existing recommendation under the section of "focus on patient care".

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					patients in the ward that they are already in. This may require additional nursing staff to be recruited and trained.	
569	The Patients Association	11	187	1.2.3	It is also very important that nursing staff are available to offer nursing care to patients. We have been concerned for many years that skilled nurses are spending too much time dealing with paperwork and non-clinical duties. It is important that when establishing the required skill mix on a ward, that the appropriate numbers of registered and suitably trained nurses are available (please see previous section "ensure capacity" 114-118). The clinical needs of the patient must come first and this must be reflected in planning. This is particularly important in the case of end-of-life care, where it may be necessary to have 1:1 specialist nursing 24 hours a day. When dealing with patients (and their families) who are at the end of their life, the NHS has only one chance to get treatment and care right. It is therefore essential that adequate provision is in place to cover staff sickness, annual leave and maternity leave.	Thank you for your comment. The guideline is aimed to encompass all patient and staff factors, including annual, maternity and sick leave that are likely to influence nursing staff requirements.
570	The Patients Association	13	219	1.2.7	It is very important that when planning staffing numbers, managers do not underestimate the time that is required for nursing staff to communicate effectively with patients and their families. Communication is a key issue that continues to emerge from our Helpline. Patients and their	Thank you for your comment. We feel that this is encompassed within Table 1 in the row that discusses communication.

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					families expect (and deserve) to have adequate time devoted to an explanation of the issues surrounding their treatment. It is therefore essential that adequate numbers of trained staff are available to provide this level of care. For many patients, communication is just as important as the clinical treatment that they receive. Furthermore, a lack of communication can be very distressing for patients and their families.	
571	The Patients Association	17	301	1.2.19	Red Flag Events : This needs to be addressed before the higher risk situations are identified; before any harm has occurred.	Thank you for your comment. Although in an ideal situation the red flag events would be prevented so that they do not occur, the purpose of including them is to enable identification and action before potentially higher risk situations could occur.
572	The Patients Association	19	318	1.3	Responsibility and Accountability: The responsibility of Trust Boards and Commissioners to sign off workforce levels with the Chief Nurse/Director of Nursing as the designated Board member is welcomed. The Director of Nursing, together with the member of staff in charge of the ward/department should review staffing levels on a daily basis and agree the staffing numbers and expertise. They should be accountable for any shortcomings. Nursing and	Thank you for your comment and support for this guideline.

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					management responsibility for the nursing workforce should be the responsibility of Directors of Nursing/Chief Nurses but we know that in many trusts, whilst accountable for the nursing workforce levels, they frequently have no direct management responsibility for the nursing and midwifery workforce. Instead they provide professional nursing advice to general managers who hold the budgets for this workforce.	
573	The Patients Association	20	334	1.3.3	In section 1.3.3 the guidance states that consideration should be given to increasing the ward staffing establishment when there are red flag events, poor safe nursing indicator results and when registered nurses are caring for more than 8 patients during the day time on a regular basis, as this may lead to increased risk of harm to patients. NICE has identified this ratio as a level that is associated with increased risk of harm. The Patients Association would like further clarification and explanation regarding the 1:8 figure. We suggest the guidance makes explicit the RN staffing needs, and also requires the support of a supervisory registered nurse in charge, as well as sufficient numbers of healthcare assistants who have appropriate skills and have received appropriate up to date	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					training to ensure adequate staffing in order to provide safe, clinically effective care to their patients. Given that 1:8 marks a 'high risk' level, we would like to see greater emphasis that this is a level that should not be exceeded	
574	The Patients Association	35	651	8	Nature of the consultation: The consultation period was very short; we could have asked patients and the public if given more time. Workforce Tools Economic evidence: Should include the longer term economic benefits from improved patient safety, quality and effective and efficient use of resources as well as a happy workforce.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. In order to ensure we published the guideline with the request timeframe it was only feasible to offer a four week consultation period.
575	The Shelford Group Chief Nurses	3	1	Introduction	If this guideline is to be the gold standard against which established tools are measured, then evidence that the guideline is robust is needed and there are concerns that this cannot be achieved in the limited timeframe that NICE is working to. For example, one well-established, workload-based UK ward staffing method took ten years to build and another 25 years; both of these are refreshed weekly.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. Work had already begun on the

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						guideline before the anticipated referral and because of the very specific scope the usual thorough NICE process was able to be applied in a shorter timeframe.
576	The Shelford Group Chief Nurses	3	29	Introduction	It is suggested that line 30 be replaced with 'Using this guide will support professional judgement to ensure staffing decisions are appropriate to the clinical circumstances'.	Thank you for your comment. We have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
577	The Shelford Group Chief Nurses	4	44	Introduction	It is suggested that 'nursing staffing requirements' be replaced with 'nurse staffing requirements' here and throughout the document.	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
578	The Shelford Group Chief Nurses	7	94	1	There is agreement with this as an overriding statement. However, later in the document (1.3.3) there is a reference to a registered nurse to patient ratio, which seems to contradict the earlier statement.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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579	The Shelford Group Chief Nurses	8	114	1.1.1	Nurse sensitive indicators are not currently monitored. There is a risk that the culture of help, support etc. will be lost.	Thank you for your comment. We have added to the existing recommendations in the organisational strategy subsection to recommend board responsibility for ensuring nurse sensitive indicators are monitored.
580	The Shelford Group Chief Nurses	8	115	1.1.1	A definition of what is meant by "assurance" is needed – i.e. whether this is clinical outcomes or monitoring process.	Thank you for your comment. The guideline has been amended in light of your comment.
581	The Shelford Group Chief Nurses	8	116	1.1.1	The guideline focuses on funded rather than in-post (actual) staffing. Funded staffing is the ward's budgeted establishment; in-post, on the other hand, is FTEs on the duty rota, i.e. funded minus frozen and unfilled vacancies. Currently, 1211 wards in one NHS ward staffing database are funded for 2.02 FTEs per occupied bed. They have, on the other hand, 1.89 FTEs per occupied bed. The funded-actual gap is, almost, made up with 0.18 FTEs temporary staffing per occupied bed, which is a false economy. Describing wards in funded staffing terms only is therefore too simplistic; although this gap is discussed later, it should be detailed earlier in the document.	Thank you for your comment. The Safe Staffing Advisory Committee wanted to make recommendations to ensure ward nursing establishments are determined to meet patient's needs. The guideline also recommends monitoring use of temporary bank and agency staff where this is being used to supplement the ward nursing establishment. In order to limit the amount of repetition in the

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						guideline, these points are not repeated earlier in the recommendations section as it is expected that all parts of the guideline that are relevant would be read by those who are involved in setting the ward nursing staff establishments.
582	The Shelford Group Chief Nurses	9	121	1.1.2	"…final sign off by the designated board member (such as Chief Nurse or equivalent)": Is this to be interpreted that every roster is to have sign off by the Chief Nurse before publishing? Or is this meaning that a workforce review of nursing establishments is signed off when set/reviewed every 6 months? Further clarity is needed on this as it reads that every roster needs Chief Nurse sign off, which is not realistic. This is in practice delegated in most organisations to a Matron or equivalent level once a roster is produced at Ward Sister level. In addition, further clarity is needed on what is meant by 'actual staff roster' – this implies that when the off-duty is done and put up on the ward, this would not be signed off by the board member. This should be when staffing is set and agreed, i.e. board-level agreement.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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583	The Shelford Group Chief Nurses	9	143	1.1.7	Nurse sensitive indicators are those which are impacted on by quality, leadership skills, professionalism etc. as well as the number of nurses. Therefore, it is not always necessarily an increase in establishment that is required when negative outcomes are experienced by patients. This section needs refining to reflect a total review of nursing organisation on the ward as well as a review of the establishment. In isolation, increasing the number of nurses may have no effect on patient outcomes where other issues are the problem.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
584	The Shelford Group Chief Nurses	10	164	1.1.10	"Ensure nursing staff have appropriate experience and training to estimate total nursing requirements on a daily basis": This statement is bold, ambitious, and needs to be considered and reworded. It is felt that the "nursing staff" needs to be specified as senior nursing staff in conjunction with their Matron, or equivalent. In addition, we would recommend rewording it to "training to determine total nursing…" rather than "estimate", which is not evidence-based.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
585	The Shelford Group Chief Nurses	10	167	1.1.11	We would recommend changing "nursing sensitive outcomes" to "indicators" as we need to be proactive as well as reactive.	Thank you for your comment. The guideline has been amended in light of your comment.
586	The Shelford Group Chief	10	169	1.1.12	This needs rewording to "nursing staff should lead on the development" or "ensure nursing staff" rather than	Thank you for your comment. The guideline has been amended in

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	Nurses				"promote", in order to make it a stronger statement.	light of your comment.
587	The Shelford Group Chief Nurses	10	176	1.2.1	This section implies that the off duty is almost being done on a daily basis, where it is actually planned in advance and flexed on a daily basis to meet service needs. This issue applies similarly to lines 188-189. Moreover, it mentions a systematic approach to determining total nursing requirement, but does not give any guidance on when this should happen; it would be useful if the document includes what this is as a minimum. Line 179: the staffing toolkit suggests that this is agreed locally, but does not reference any that have been reviewed or what this is and where, e.g. is this Table 1? Moreover, there is confusion re. the statement on line 181 that endorsed toolkits should be used; later in the text (lines 248-249) NHpPD is advocated. It needs to be clear whether we will either have a choice of toolkit (line 181) or no choice (248-249).	Thank you for your comment. The guideline has been amended in light of your comment to clarify this issues. In addition we have added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
588	The Shelford Group Chief Nurses	11	188	1.2.3	The above lack of clarity also applies to line 188, where it is suggested that patient nursing needs are the main driver for calculating nursing requirement; whereas lines 248-249 advocates the use of NHpPD to 'estimate' total nursing requirement. A clear, consistent guide is needed.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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589	The Shelford Group Chief Nurses	11	199	1.2.5	It is accepted and agreed that this is correct as a point of principle. However, in an acute provider situation, this would be very difficult to guarantee for every patient whom may require a "special". The reality of dementia care on wards in acute hospitals would make this a very difficult standard to be reached in every circumstance; a cohort of nursing is often more appropriate.	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation in the organisational strategy section to address this issue.
590	The Shelford Group Chief Nurses	12	202	1.2.5	Chart/guidance needs refinishing with more explicit guidance over time of additional activities. The purpose of this table is unclear, as this is not aligned to an acuity and dependency scoring matrix or tool. Moreover, the time ranges are too vague and need to be more specific, i.e. more than 30 minutes per activity – what is the range? There needs to be a researched validated tool for this section.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have amended the recommendation which describes how Tables 1 and 2 could be used. We have also added a link in the introduction section of this guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
591	The Shelford Group Chief Nurses	13	205	1.2.6	This entire section is a useful prompt for professional judgement and these should be embedded in any endorsed toolkits. On their own they do not provide a quantitative basis for calculating nurse establishment/shift	Thank you for your comment and support for this guideline. We have amended the text in this section to reflect that this process

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					requirements.	could be facilitated by using a decision support toolkit.
592	The Shelford Group Chief Nurses	13	211	1.2.6	More specific guidelines around the impact of ward layout and size on workforce requirements would be of use. For reference, Keith Hurst has undertaken some work around this area and can provide further feedback.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations and evidence sources specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
593	The Shelford Group Chief Nurses	13	214	1.2.7	Additional factors to be taken into consideration are the skills and experience of the nursing team available. The focus upon numbers of staff alone over-simplifies and potentially undermines safe decision making. It is often the case that fewer numbers of more experienced staff is safer and more effective, than higher numbers of often very	Thank you for your comment. Section 1.3 has been amended in light of your comment.

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					inexperienced staff; this should be taken into account when determining nurse staffing requirements.	
594	The Shelford Group Chief Nurses	13	217	1.2.7	This should also include: • Mentorship of students • Communicating with the multidisciplinary team • Undertaking audit, staff appraisal and performance reviews	Thank you for your comment. Section 1.2 has been amended in light of your comment.
595	The Shelford Group Chief Nurses	14	230	1.2.8	This needs to include both mandatory and statutory training.	Thank you for your comment. The guideline has been amended in light of your comment.
596	The Shelford Group Chief Nurses	14	237	1.2.9	Rather than recommending a process based upon average nursing hours per patient, per day, it would be a stronger, more flexible, and more effective recommendation to list the factors to be taken into account with some textual guidance next to this as to why they are important.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. We have added a link in the introduction section of this

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						guideline to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
597	The Shelford Group Chief Nurses	14	239	1.2.9	What methodology will be used and what is the evidence base for 'estimating' nursing requirement that can be applied consistently? It is of great concern that nurse requirement is to be based on an 'estimation' rather than using an endorsed toolkit that demonstrates a strong evidence base.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
598	The Shelford Group Chief Nurses	15	248	1.2.9	Box 1 The process for calculating nurse establishments is too blunt, lacks consistency in application and, therefore, has the potential to negatively affect patient safety and quality. This approach is open to manipulation and being altered to best fit local budgets, rather than patient care needs – this would be difficult to assess whether this was accidental or deliberate in financially-challenged	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate

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					organisations. In addition, local estimation will prevent accurate benchmarking across the NHS.	webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
599	The Shelford Group Chief Nurses	15	248	1.2.9	Box 3 Clarity is needed surrounding the measurement for each of these individual points; what would be considered the 'norm' and how is that determined? How are nursing activities and responsibilities quantified? In addition, using retrospective data would be more accurate than estimating patient turnover.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits. The relevant recommendations have also been amended to clarify that retrospective data for turnover should be used.

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600	The Shelford Group Chief Nurses	15	248	1.2.9	Box 4 How is the uplift/headroom to be calculated? It would be useful to have this process agreed to ensure a consistent approach across the NHS. Currently this can vary from 18% to 26% which impacts significantly on nursing establishment set. If the uplift % is at the lower end, the establishment recommended will be sub-optimal.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
601	The Shelford Group Chief Nurses	15	248	1.2.9	Box 5 It is essential to undertake this assessment at 3 distinct points, rather than just in the immediate 24-hour period. It also needs to be completed in the long and medium-term. Evidence from one Shelford organisation demonstrates that the earlier one identifies the gap, the greater the chances of getting temporary staff cover. Therefore, this needs to be completed when the rota is initially developed.	Thank you for your comment. The guideline has been amended to separate the process of setting the establishment and assessment on-the-day.
602	The Shelford	15	248	1.2.9	Overall, this is a complex process described here, which	Thank you for your comment. The

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	Group Chief Nurses				would require accurate data. However, it is noted that this process does not call for accurate data, but estimation. Estimation of care needs without a toolkit/accurate decision matrix allowing for individual patient needs, rather than general collective patient needs assessment, is essential to ensure high-quality care. Moreover, if this is to be completed in the way described here, there needs to be an indication of application, who in the organisations will be skilled to undertake it, and how will this training be supplied across the NHS. It is not realistic to expect a Ward Sister to do this on a daily basis. For this to be a tool for staff to use for workforce planning there needs to be an electronic tool to support this process and aid the calculation of a nursing workforce. Feedback from the testing of the process of determining nursing staff requirements in its basic form was that it is a useful tool, but results seem to significantly inflate a recommended establishment by over 4WTE+ to ward establishments that are professionally judged to be already above the national average. It is felt results produced from this tool will significantly challenge more disadvantaged organisations.	guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits. The relevant recommendations have also been amended to clarify that retrospective data for turnover should be used.

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603	The Shelford Group Chief Nurses	16	249	1.2.10	Most nursing staff articulate needs in FTE/WTE not NHpPD and therefore this is a very new language for estimating nursing requirements. This does not seem to be recognised and there will be a real challenge in adopting this approach.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
604	The Shelford Group Chief Nurses	16	255	1.2.11	This paragraph states that nursing per hours per patient day enables the nursing needs of individual patient and different shift durations of the nursing staff to be more easily accounted for compared with the nurse to bed ratio. This is potentially misleading: nurse to bed ratio is a useful tool to make comparisons between and within inpatient areas. It is not a replacement for average patient nursing needs in-house, but it is an additional tool which is useful. The way that this paragraph is phrased could be improved. Lines 261-277 apply only if using NHpPD as the methodology as other toolkits will have this measure built into the calculations. There are 2 distinct key elements to setting nurse establishments that should be encompassed: (a) based on individual patient needs which are assessed by following a systematic decision matrix within a toolkit and (b) based on overall staff and ward factors (e.g. sister	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The Safe Staffing Advisory Committee felt that the primary purpose of this guideline is to make recommendations to ensure safe staffing for nursing in adult inpatient wards. They felt there were significant limitations with using a nurse to bed ratio as are detailed in a number of places within the guideline. The preference was to use terminology that allows focus on patient needs, rather than the number of available beds on a ward.

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					supervisory status, single room facility) which is added as a % overhead. The establishment will then be calculated by adding (a) and (b).	
605	The Shelford Group Chief Nurses	59	271	1.2.14	This is not accurate: a % uplift/headroom needs to be added to this process.	Thank you for your comment. Uplift for planned and unplanned leave is already included in this section.
606	The Shelford Group Chief Nurses	17	278	1.2.15	This section is not accurate. It commences by setting daily requirements and developing the duty roster (287-289), and then moves to setting the establishment. The logical approach is to set the establishment as explained above, following which the Ward Sister will develop the duty roster based on local intelligence such as medical staff ward rounds, surgery times, meal times etc. However, in order to develop the duty rota, she needs to know the ward nurse establishment. Determining the establishment is a completely separate process and therefore this needs separating in the document.	Thank you for your comment. The guideline has been amended to separate the process of setting the establishment and assessment on-the-day.

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607	The Shelford Group Chief Nurses	17	290	1.2.17	It would be helpful if NICE were to suggest a percentage as there is huge variation and this is difficult to influence within individual Trusts.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise.
608	The Shelford Group Chief Nurses	17	295	1.2.18	Red Flags: This is felt to be an advantage in empowering ward staff/patients to raise a staffing concern with some structures. However, there are a number of areas set out that would trigger a red flag. Although this is welcomed, a governance structure needs to be in place to support this across any organisation as raising a red flag is only one part of the process – the response and what action was taken is the most important aspect. This could become a significant burden and may be best replaced by the nurse	Thank you for your comment. We have amended these parts of the guideline to clarify these issues. The existing nursing red flag regarding a shortfall of 8 hours/25% already states that this is in context of the "actual total nursing requirement of the shift".

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					in charge asking themselves one question: "Do I have enough staff with the right skills to care for the patients I am responsible for today?" Yes or No. If the answer is no, this escalates a red flag and triggers a Trust escalation. This would cover any of the elements you have set out rather than raising several red flags for different reasons. Guy's and St Thomas' NHSFT is trialling a new red flag escalation system and would be happy to share the results and learning from this on request. Lines 306-310: This needs rewording as it suggests that these should be recorded but then continues to suggest they can be reported to a variety of people. The guidance is not clear if this is a "clinical incident" and needs reporting as such, and there is concern that a lot of reporting could be generated which removes staff from direct patient care. Lines 311-313: This could be elaborated by stating additional staff could include the use of temporary staffing, support from senior departmental management, or reallocation of nursing staff from an alternative area. Moreover, the wording in line 311 needs to be tempered and "urgent" removed as it is too prescriptive and does not reflect what happens in practice.	

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					8 hours/25% of RN shortfall cannot be applied without context to patient needs and bed occupancy. There would be concerns if a specified time is recommended within the guidance. We would suggest adding "as determined by an agreed staffing toolkit", otherwise it is unrealistic to expect the nurse in charge of each shift to do this calculation.	
609	The Shelford Group Chief Nurses	18	305	1.2.20	Nursing red flags being reported by staff, relatives, patients and carers: There would need to be some work with patients and relatives around this in order to understand what they can do. Would we want "nursing red flags" to become the terminology that is used?	Thank you for your comment. The guideline has been amended in light of your comment, including the addition of a recommendation in the organisational strategy section to address this issue.
610	The Shelford Group Chief Nurses	19	328	1.3	This needs to be simplified and aligned to the Safety Thermometer, inpatient survey, staff survey and data set already being collecting regarding publishing staffing data as per Hard Truths. This will help organisations to streamline the data collection. Furthermore, it increases the ability to monitor key factors. Evidence demonstrates that the larger the number of data sets as well as the variation in the way this is collected and presented, the less effective the monitoring. Could the reader be signposted to the relevant NICE guidelines rather than putting the detail here? This would reduce the length of the	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. The Safe Staffing Advisory Committee were keen to ensure that the primary focus of the safe nursing indicators was to make recommendations to ensure safe staffing for nursing in adult

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					document and focus it further. The 'planned' vs 'required' vs 'actual' cannot be benchmarked and may lead to quality outcomes, if the planned and/or required is based on an estimation or according to locally set available resources. This may result in the actual available appearing favourable but in practice it being sub-optimal. Therefore, the use of a staffing toolkit to determine the 'planned' and 'required' and actual available should be stated.	inpatient wards and not to just to enable benchmarking. However the Safe Staffing Advisory Committee felt that it would be possible to benchmark using required number of nursing staff vs available nursing staff as determination of the required number of nursing staff could be facilitated by a NICE endorsed staffing toolkit.
611	The Shelford Group Chief Nurses	20	329	1.3.2	These data sets should be reviewed against nursing establishment set by a staffing toolkit endorsed by NICE otherwise the data being compared is not like for like.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
612	The Shelford Group Chief Nurses	20	337	1.3.3	This states the ratio for the daytime, but not for the night. There needs to be consistency; if giving a daytime ratio, the same principle must be applied for the night.	Thank you for your comment and support for this guideline. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1.

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						The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise. However there is a nursing red flag that has been developed to help ensure safety throughout a 24-hour period.
613	The Shelford Group Chief Nurses	24	430	3	This states that there is a lack of research of effectiveness of using a defined approach or toolkits. However, despite this, these guidelines are strongly advocating the use of NHpPD methodology. This raises significant concern for the robustness of these guidelines. Furthermore, whilst page 52, under the "Quality of evidence" section, identifies a strong evidence of association between acuity and dependency on patients and patient outcomes, it does not advocate an acuity and dependency approach to determining establishments.	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio

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						or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
614	The Shelford Group Chief Nurses	27	470	5	This needs to be at the front of the document so that people can understand the terms used. Moreover, this needs to include definitions around funded establishment, full time employees, in-post etc. All of these are referred to in the document and are likely to be interpreted differently by different individuals/organisations.	Thank you for your comment. The guideline has been amended in light of your comment.
615	The Shelford Group Chief Nurses	28	496	5	Nursing hours per patient day is oversimplified as to calculate this correctly the needs of patients must be identified and ward utilisation figures must be looked at. If this is being used as part of a toolkit it needs to be identified as such.	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have amended

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						the guideline in light of your comment to clarify that this process could be facilitated by using a NICE endorsed decision support toolkit. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
616	The Shelford Group Chief Nurses	28	501	5	Nurse to patient ratio is not a correct calculation; this does not equate into FTE as it does not cover breaks. This section is therefore not accurate.	Thank you for your comment. The guideline has been amended in light of your comment.
617	The Shelford Group Chief Nurses	28	503	5	This is oversimplified; there is some “down” time/handover time/meetings/audit-taking in a shift of 8 hours. This section needs to be reworked with expert input to ensure the calculations are accurate.	Thank you for your comment. The guideline has been amended in light of your comment.
618	The Shelford Group Chief Nurses	28	506	5	Nursing skill mix is usually presented as a % skill mix, e.g. 70:30.	Thank you for your comment. Section 1.3 has been amended in light of your comment. In addition the existing definition of skill mix in the glossary section has been amended.

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619	The Shelford Group Chief Nurses	28	521	5	Patient acuity is not a measure of how 'time-consuming' care is; this is more accurately reflected as 'patient dependency'.	Thank you for your comment. The guideline has been amended in light of your comment.
620	The Shelford Group Chief Nurses	28	533	5	Can be shortened to line 534 only.	Thank you for your comment. The guideline has been amended in light of your comment.
621	The Shelford Group Chief Nurses	28	543	5	This definition needs enhancing to explain the non-direct care elements such as ward handover, ward rounds, communication with MDT, family, audits, discharge planning meetings, mentorship of students, performance review of staff etc. It needs to also include aspects of student and RN training as well as general ward management e.g. rota development.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
622	The Shelford Group Chief Nurses	35	673	8	What tools have NICE developed to help organisations implement the guideline as stated here?	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision

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						support toolkits.
623	The Shelford Group Chief Nurses	37	688	Appendix 1	This section is too long, being 33 pages. It is repetitive and lacks clarity, and it is not written in an easily accessible format for busy frontline clinicians. There is no mention of how staff satisfaction impacts on patient outcomes which can be significant and extremely important when considering/reviewing nurse establishments.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible. However, please note that this is an Appendix to the main guideline and is designed to contain more detail on the how the evidence considered was used in the development of the recommendations for those who wish to refer to it. Staff satisfaction was one of the outcomes of interest and has been reported where the evidence permits.

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624	The Shelford Group Chief Nurses	46	704	Appendix 1	Whilst very important for frontline staff to be able to apply professional judgement to suggest daily staging requirement, it is equally important that they are trained in the effective use of resources, practical application and development of duty rotas, as well as the practical implementation of the organisation's agreed NICE endorsed staffing toolkit.	Thank you for your comment. The guideline has been amended in light of your comment.
625	The Shelford Group Chief Nurses	53	710	Appendix 1	In light of the evidence suggesting a strong association between patient acuity and dependency and nursing requirements, why has the acuity and dependency methodology been dismissed in these guidelines? Lines 709-710 state that there is only one study identified which assessed the effectiveness of NHpPD. This was rated low for internal validity but the reader is not informed of the estimation of its external validity. Given these facts, why does the guideline strongly advocate NHpPD throughout the document (from page 15 onwards) but dismiss acuity and dependency? Whilst the understanding of the terms 'acuity' and 'dependency' may be varied in the general population, it is widely understood in professional nursing arenas in the UK and therefore it is incumbent on the nursing profession to articulate the meaning of these terms more clearly.	Thank you for your comment. There is a misinterpretation of the recommendation relating to Nursing hours per patient day. This text is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient

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					In other considerations, paragraph 3, it suggests that specialist nurses, AHPs, medical teams, and admin support impact on nurse establishments. How is this to be measured and accounted for when determining the establishment, and does this need to be included in a toolkit? How is the variation in supply of these factors to be accounted for? Typically these staff are available on a 9-5 basis, covering Monday-Friday, but ward nursing is 24/7. This is the first mention of these in the document.	day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has also been amended to clarify this misunderstanding. The guideline is aimed to encompass all patient factors that are likely to influence nursing staff requirements. We have amended the guideline text to state that patient nursing needs would include both patient acuity and patient dependency.
626	The Shelford Group Chief Nurses	58	712	Appendix 1	This section needs to be simplified to clearly distinguish between ongoing training and development for ‘employed’ staff and supervision of student nurses. There are wards/hospitals with no student nurses and therefore this must be accounted for separately.	Thank you for your comment. The guideline has been amended in light of your comment.
627	The Shelford Group Chief	60	713	Appendix 1	It is not clear how frequently this process is being proposed; if it is daily it is unrealistic and unacceptable to	Thank you for your comment. We have amended these parts of the

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	Nurses				ask frontline clinicians to complete this.	guideline to clarify this issue.
628	The Shelford Group Chief Nurses	70	717	Appendix 1	Paragraph 3 if the guideline is making reference to the other studies being included to inform a 1:8 ratio, then they must be fully discussed here.	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. This has been further added to following your comment.
629	The Shelford Group Chief Nurses	70	718	Appendix 1	The basis for recommending a benchmark of 1RN:8 patients is deeply concerning. It is based on one study taken 7 years ago on general, orthopaedic and vascular surgery wards. This is a very poor speciality sample and its applicability to medical specialities cannot be deduced. Furthermore, the ratios it states are 6.9-8.3 patients per nurse, so why does the guideline advise a ratio at the higher ratio than the lower? The document does not state the internal and external validity despite doing so for the other studies referred to in this section – why is this?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. This has been further added to following your comment.

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630	The Shelford Group Chief Nurses	71	726	Appendix 2	There are calculation errors throughout this, the main being that on page 72 the calculation does not cover 24 hours, based on 7.5 hour shift pattern this only covers 22.5 hours. There has to be shift overlap and variation to cover 24 hours. Stage 1: Clarity is needed around the 5.32 NHpPH figure – is this empirically-based or an example only? In its current form, calculations suggest that this figure would seriously deplete ward teams. The example on page 71 doesn't give enough staff to meet the 1:8 rule, so the guideline is contradicting its own recommendations and at risk of being taken as a rule by some senior managers, who will try to use it to reduce ward staffing. Stage 2: This table refers to 68% RN skill mix for the example surgical ward. There is a need to ensure that there is further clarity in this example around the type of surgical ward as this example may be taken out of context and applied to all surgical areas. Skill mix is very specialty-specific and based on patient requirements. It is not acceptable to estimate these numbers; they should be patient-specific according to the individual patient needs, not based on an average overall ward figure. They	Thank you for your comment. Appendix 2 in the draft version was clearly labelled as an example scenario and the numbers used were not intended to represent any recommended figures. The numbers used were to only illustrate the various steps of the process that were described in the recommendations section of the guideline. We have amended the text in this text to further illustrate that this is an example.

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					will be most accurately developed by undertaking timed task activity analysis, and then categorised according to patient classification and built into a toolkit. If these numbers are illustrative, these need to be clearly stated.	
631	The Shelford Group Chief Nurses	77	793	Appendix 3	Hospital Acquired Pressure Ulcers: This uses the principles of the Safety Thermometer methodology which is prevalence not incidence as stated in the outcome measure. It counts patients with the highest grade of pressure ulcer and really is a measure of length of stay as much as harm. Where hospitals can measure incidence, they should.	Thank you for your comment. The guideline has been amended in light of your comment.
632	The Shelford Group Chief Nurses	81	842	Appendix 3	Nursing overtime: Providers will need to have in place clear processes and procedures to ensure that there is consistency in application and how this fits into any rostering procedures, as this may also generate pay variations.	Thank you for your comment.
633	The Shelford Group Chief Nurses	General comment	General comment	general comment	Positive: Overall, the guidance is comprehensive and gives readers a common national language surrounding nursing workforce. Bed utilisation as a marker rather than occupancy supports high turnover units where previous tools have missed this workforce pressure. The recognition of professional judgement as a key determinant of nurse staffing is welcomed. Furthermore, the recognition of the	Thank you for your comment and support for this guideline.

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					extra time required to meet supporting students and other training and supervision is also welcomed. It is a strong basis from which to build.	

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634	The Shelford Group Chief Nurses	General comment	General comment	general comment	To improve: • As a Group, a number of the Shelford Group Trusts have used the Safer Nursing Care Tool (SNCT) for a number of years, allowing objective decisions to be made on acuity and dependency, and how workforces should be profiled. This guide would be considerably strengthened if it were to include a tool similar to the SNCT. Having tested out the model using the SNCT and converting the acuity levels into NHpBD at one of the Trusts, staff feedback is that, without a tool such as the SNCT, the process was very time-consuming and also led to different results depending on who undertook the exercise. Therefore, as it stands, it is open to misinterpretation. There is no doubt that a national tool is needed, which will support the setting of staff levels based on the profile of patients, alongside professional judgement. However, for this to work, the guidance needs to be much more focussed, less ambiguous, and have a tool that is easy to use by frontline staff. • It is felt that the guideline needs a section related to professional judgement, what this is, how this can be validated with tools etc. There also needs to be some mention of other factors than staffing that might impact on poor nurse sensitive indicators, such as weak/poor leadership, poorly skilled workforce, poor organisation of ward etc. • The document itself, though comprehensive, is too long and	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					and an executive summary. It may be better for the evidence to go into an appendix, rather than in the body of the document. It is currently set out as an academic paper, rather than a digestible guidance document for staff. • There needs to be a distinction between Staff Bank and agency temporary staff; Staff Banks are based on provider's terms and conditions, procedures and policies. • It is unclear how and when NICE will be putting in place an assessment process to endorse toolkits. • Generally the guideline dismisses dependency-acuity too easily, for example page 60 underplays dependency-acuity data; i.e. throughput is an important workload driver in admission and assessment units, whereas dependency-acuity is the main workload driver in more stable wards. • There needs to be clarity and consistency throughout the document as to whether NHpPD is being advocated as the best practice approach or a staffing toolkit. To the inexperienced reader, this document could be interpreted as advising the use NHpPD and not acuity and dependency methodology – It needs to be clarified if this is the intention. • The timeframe for the review and response to this guideline is enormously challenging which may result in many key professionals being unable to respond. • Using this document as it is currently written to endorse staffing toolkits will not allow an equitable process.	

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635	UNISON	3	1	Introduction	• UNISON is the largest public sector union in the United Kingdom and Europe with over 1.3 million members. Our members work in a range of public services including Health, Local Government, Education and Police services. They are at the front line of caring for the most vulnerable in our society. We are pleased to have the opportunity to respond to this consultation by NICE looking into staffing levels in the acute sector. • As the largest trade union and the voice of the healthcare team, we are instrumental in influencing policy at regional, national and international level. UNISON has a long history of working with organisations and individuals who work and campaign in the areas of regulation, safeguarding, practise and care. • Our members are responsible for the delivery of high quality health and social care to the most vulnerable in our society. We have actively sought the views of our nursing and midwifery members who are responsible for the delivery of quality care services. In addition to registered nurses and midwives, UNISON's consultation included the views of healthcare assistants, assistant practitioners and students in nursing and midwifery as prospective registrants. • We hope that NICE will take into account the weight of	Thank you for your comment and support for this guideline.

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					UNISON's views as a major stakeholder and representative of the majority of regulated healthcare professionals.	
636	UNISON	8	115	1.1.1	Ensure Capacity • The guidance states that assurance mechanisms should be developed which ensure nursing establishments funded. Whilst in principle this appears of the face of it to be appropriate we would suggest two elements are considered – firstly all of the research looks at patient care outcomes on nurse to patient ratios meaning registered nurses. It is important to also ensure additional funded establishments take account of the need to support, teach and supervise more junior members of staff. • We would also argue that ward managers should be supernumerary for a significant period of their time, to enable them to actively undertake the full functions of their management role and be the visible presence Francis called for. • However we do not feel that the figures should be based on safe care – we do not believe that this is good enough it has to enable high quality care. We do not believe patients and their families would be comfortable knowing that staffing was at a level that was simply safe. • Ward establishments do not tend to fluctuate rota to rota,	Thank you for your comment. The guideline has been amended in light of your comment where possible. This includes addition to the recommendation on nursing responsibilities other than direct patient care and also the recommendations that discuss responsiveness to unplanned changes.

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					it would be helpful to specify that you do expect that to be done for each rota.	
637	UNISON	9	130	1.1.4	This feels like an after thought as it comes at the end it would be better for it to be an opening paragraph expressing the importance and referencing literature which supports it.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
638	UNISON	9	140	1.1.6	Support Flexibility • We welcome the opportunity tor flexibility to allow for constant monitoring. However if flexible is robbing staff from one area & moving them to another to plug a gap – it is not flexible and simply moves the problem • We wondered if consideration should be given to creating a specific pool which could be called upon to work in a range of areas without depleting other care or specialised areas and roles. We have evidence of specialist nurses being told to drop what they are doing and to help on wards. • All of this would need to be subject to local consultation with staff and trade unions. We would suggest adding the consulting with trade unions locally to identify and consider other flexible options which could help to eliminate difficulties.	Thank you for your comment. The guideline has been amended in light of your comment to include a recommendation to warn against compromising nursing staff levels on one ward for other wards. We have also added further detail of some of the ways in which flexibility of the nursing staff across an organisation could be achieved.
639	UNISON	9	143	1.1.7	Monitor adequacy of nursing staff establishment	Thank you for your comment. The

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					• We do not believe that regular is twice a year – it has the potential to leave to long a gap in between periods where harm could have occurred which might have been prevented with more frequent reviews. We would initially suggest that this is undertaken on alternative months, with frequency increase after the first year once organisations have a sufficient amount of data to reassure them that there workforce plans are sufficient to deliver dignified and compassionate care across the organisation. • We would also welcome the involvement of staff and local trade unions to provide a degree of independence and scrutiny to the process. It would also help to build partnership working, trust and confidence of the system amongst staff & patients.	guideline has been amended in light of your comment where possible.
640	UNISON	10	150	1.1.8	Do you indent that the look at patient numbers and through put in considering this process?	Thank you for your comment and support for this guideline. The guideline is aimed to encompass all the factors that are likely to influence nursing staff requirements and patient turnover has been included amongst these.
641	UNISON	10	158	1.1.9	UNISON supports ensuring patients receive the care they require. However we would also wish to avoid them being	Thank you for your comment. This important point is covered in

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					repeatedly moved to ensure that they are cared for where there needs can be best met, which can sometimes happen.	the existing recommendation under the section of "focus on patient care".
642	UNISON	13	205	1.2.6	Ward Factors • We would like to see a stronger focus on the environment, which can often require additional staff although you mention cannot be observed a number of organisations have single or twin rooms which can complicate the opportunity to observe patients whilst undertaking other roles.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
643	UNISON	13	214	1.2.7	Nursing Staff Factors • Although the guidance talks about working with others it doesn't take account either multi-disciplinary working and more junior members of staff. We wondered if the language would be revisited to cite this more specifically.	Thank you for your comment. Section 1.2 has been amended in light of your comment.
644	UNISON	14	236	1.2.9	This only mentioned requirement to deliver patient care needs, it doesn't describe the number of patients being treated. We believe that the data needs to take account of all three elements.	Thank you for your comment. The subsequent recommendations directly deal with bed utilisation and the Safe Staffing Advisory Committee therefore felt the existing recommendations adequately addressed your comment

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Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
Stakeholder Comments and Response Table

Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
645	UNISON	16	250	1.2.10	We would value the opportunity to understand the tool kit more effectively. We would also again mention the need to consider patient numbers as part of the dependency process, this is better described in 1.2.12..	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits which could facilitate this process. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
646	UNISON	18	305	1.2.19	• We would like to add a definition to this which is care left undone. In our staffing survey on the 4th March 2014 a significant number of staff reported that care was left undone. This was despite most of them not taking their breaks and working over their required shift. • It is also not clear how these will be recorded and monitored.	Thank you for your comment. A number of the individual red flags have been derived for missed care items which are defined in the existing glossary. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events.

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Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
647	UNISON	19	328	1.3.1	Safe nursing indicators • We believe a stronger indicator should be used to replace adequacy – its too open to interpretation of only delivering the basics as opposed to high quality patient care • We would like to see care left undone added to the list of safety outcomes • We believe actual data on missed breaks and over time should be recorded rather than the proportion. We would suggest collecting data on whether the break was taken at an appropriate time e.g if you are working a long day but don't get a break until 8 hours in to your shift this is not safe. • We would also suggest any data on staff accidents, sickness and well being are records as factors which can contribute to attendance and therefore their over all well being.	Thank you for your comment. There is further information to assist with definitions and data collection of the safe nursing indicators included in Appendix 2. Aspects of care left undone (also known as missed care) are included in the nursing red flags. Furthermore we have amended the guideline in light of your comments to state that there is scope for addition of more safe nursing indicators locally where this was felt necessary.
648	UNISON	20	334	1.3.3	Consider increasing the ward staff establishment simply isn't sufficient and does little if anything to instil confidence in the guidance. They should increase the establishment or have an objectified document reason for doing so. We are concerned that anything less than this could cause conflict between practise and professional codes of conduct where it currently stipulates let no act or omission	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					on your part impact on patient care.	
649	UNISON	24	449	3	Economic evidence • A raft of information including evidence on the economics of nursing was identified in the prime ministers commission into nursing, much of it was not published in the final version but the full details could be sought from either the Department of Health or the writer of the report.	Thank you for your comment. The evidence review searched a large number of databases for published research. As this data was not publically available at the time of the searches it was not possible to be included in the evidence reviews.
650	UNISON	General comment	General comment	general comment	• There is currently a national shortage of nursing with organisations plugging gaps by the use of international recruitment and agency staff. We anticipate that this is likely to last for another two years as a result of the previous drop in pre-registration commissions. • Whilst we support minimum nurse to patient ratios we have to acknowledge that safe and effective patient care is more than numbers, it is also fundamentally about how staff are treated, valued and respected. Staff numbers are part of the solution but it will not be achieved without also looking at the role which staff motivation has to play in job satisfaction and the impact which this has on patient care. We believe its a missed opportunity for NICE not to have acknowledge this in the guidance. • We also want to ensure long term effective workforce	Thank you for your comment and interest in the guideline. However, a number of these points, such as work force planning, are outside of the remit of NICE's guideline programme - please see the scope document for further information.

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					planning measures are used effectively, whilst an increase in nursing numbers is urgently needed it should not be funded in the use of a short sighted approach where Peter is robbed to pay Paul. • We are already seeing staff including highly specialist's nurses being routinely moved from their own role and work to plug gaps in rostas, often leaving other area short. • We have also over the last three years conducted spot check on nursing staffing levels, the most recent looked at staff working on the 4th March 2014. As part of our	

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					survey we have also each year looked at and reviewed literature. For ease of information we have attached copies of these as PDFs. • We also published two infographics to provide a visual over view of some key elements of data, again this is attached for information. • We recognise that many individuals in opposing a national minimum nurse to patient ratio do so, stating that there is no evidence to support it. We acknowledge a lack of UK specific evidence but believe international research does support a mandated minimum. However we would support a pilot being undertaken which sets a minimum of 1:4 and a maximum of 1;7 within in patient medical & surgical wards, to test this and gather data. Undertaken over 6 month period it would give an opportunity prove or disprove the case for a national mandatory minimum, using patient care outcomes and staff and patient satisfaction surveys to articulate findings and impact.. • UNISON is also a founding member of the Safe Staffing Alliance and is also very supportive of their submission. Ours has sought to focus on areas where we believe we can provide a greater insight.	

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651	United Lincolnshire Hospitals NHS Trust	7	91	1	States 'nursing' is this registered (RN) and unregistered – needs to be clear when is it RN or not	Thank you for your comment. We have now included the definition of nursing staff that is provided in the glossary to appear in the introduction and the recommendations section to clarify what we mean by this term.
652	United Lincolnshire Hospitals NHS Trust	9	130	1.1.4	Clarity re mix of RN v Non RN. RCN states 65/35 minimum RN mix – what should be minimum	Thank you for your comment. The guideline has been amended in light of your comment where possible, however the Safe Staffing Advisory Committee felt it was not appropriate to recommend a ratio of registered nurses to healthcare assistants. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1.

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653	United Lincolnshire Hospitals NHS Trust	10	166	1.1.11	Would be useful to have access to national benchmarking data (such as harm free care) that can be viewed by speciality	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee, however this falls outside of the parameters of the scope of this guideline.
654	United Lincolnshire Hospitals NHS Trust	13	208	1.2.6	Pleased to see acknowledgement of turnover as requiring extra staff	Thank you for your comment and support for this guideline.
655	United Lincolnshire Hospitals NHS Trust	14	235	1.2.8	Need clarity on uplift – everyone does something different – give a % please	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available

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						evidence and their expertise.
656	United Lincolnshire Hospitals NHS Trust	18	306	1.3	Red flags – Is suggestion of shortfall of 8 hours loss of RN per shift?	Thank you for your comment. This is the intended interpretation of the nursing red flag
657	United Lincolnshire Hospitals NHS Trust	19	328	1.3	Would be useful to have a core template for indicators this would allow benchmarks and links to staffing numbers on unify submissions	Thank you for your comment. There is further information to assist with data collection of the safe nursing indicators included in Appendix 2.
658	United Lincolnshire Hospitals NHS Trust	20	337	1.3.3	States 1;8 in day time – what about night? Also says 'regular basis' – what is regular?	Thank you for your comment and support for this guideline. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was

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						possible to make any more specific recommendations in this area based on the available evidence and their expertise. However there is a nursing red flag that has been developed to help ensure safety throughout a 24-hour period.
659	University College London Hospitals	3	29	Introduction	Suggest replacing line 30 with 'Using this guide wil support professional judgement to ensure staffing decisions are appropriate to the clinical circumstances'.	Thank you for your comment. Please see response to comment number 576 as this appears to be a duplicated comment.
660	University College London Hospitals	4	44	Introduction	Suggest replacing 'nursing staff requirements' with 'nurse staffing requirements' here and throughout the document.	Thank you for your comment. Please see response to comment number 577 as this appears to be a duplicated comment.
661	University College London Hospitals	5	50	1	Add 'in-patient' between 'adult' and 'ward' to read adult in-patient ward here and throughout the document. This maintains consistency with line 19 and prevents confusion with adult day care wards.	Thank you for your comment. The guideline has been amended in light of your comment.
662	University College London Hospitals	7	91	1	Add 'in-patient' between 'adult' and 'ward' to read adult in-patient ward here and throughout the document. This maintains consistency with line 19 and prevents confusion with adult day care wards.	Thank you for your comment. The guideline has been amended in light of your comment.

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Safe staffing for nursing in adult inpatient wards in acute hospitals – Consultation on Draft Guideline
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Consultation period: 12th May 2014 to 10th June 2014

Comment Number	stakeholder organisation	Page Number	Line number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
663	University College London Hospitals	7	94	1	This statement re ratios is contradicted later in document in line 336 which states that '1 nurse caring for more than 8 patients…' Need to be consistent in approach either basing establishments on patient needs/requirements or on cruder ratios.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
664	University College London Hospitals	9	121	1.1.2	Suggest replacing 'final sign off' with 'agreed by ' Chief Nurse. Nurse staffing establishments should always be finally agreed by the Chief Nurse in consultation with the Executive Board.	Thank you for your comment. The guideline has been amended in light of your comment.
665	University College London Hospitals	9	123	1.1.2	Suggest adding to 'when the ward establishments are set' 'and at least bi-annually thereafter or where changes to the patient case mix/specialty are made/anticipated'. Suggest removing 'budget' here as making recommendation for nurse establishments NOT budgets.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
666	University College London Hospitals	9	127	1.1.3	Suggest adding ' requirement to include capacity to deal with planned (A/L, Study leave) and unplanned leave (sickness etc) as well as the clinical activity. Recommend replacing 'historical' with ' by reviewing the specific retrospective data' and applies to both the nursing requirement and staff availability.	Thank you for your comment. The guideline has been amended in light of your comment where possible.

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667	University College London Hospitals	9	143	1.1.7	Nurse sensitive indicators are those which are impacted on by quality, leadership skills , professionalism etc as well as the number of nurses. It is therefore NOT ALWAYS an increase in establishment that is required when negative outcomes are experienced by patients. This section needs refining to reflect a total review of nursing organisation on the ward as well as a review of the establishment. In isolation increasing the number of nurses may have NO effect on patient outcomes where these other issues are the problem.	Thank you for your comment. Please see response to comment number 583 as this appears to be a duplicated comment.
668	University College London Hospitals	10	164	1.1.10	Suggest rewording to ‘training to determine total nursing..’ rather than ‘estimate’ which is not evidence based and was the way this important decision was made back in the early 80’s.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
669	University College London Hospitals	10	167	1.1.11	Suggest changing ‘ nursing sensitive outcomes’ to ‘indicators’ as we need to be proactive as well as reactive.	Thank you for your comment. Please see response to comment number 585 as this appears to be a duplicated comment.
670	University College London Hospitals	10	169	1.1.12	This needs to be a shorter statement consider using ‘Ensure involvement of nursing staff in… nurse staff requirement’ rather than ‘promote’	Thank you for your comment. The guideline has been amended in light of your comment.
671	University College	11	181	1.2.1	This states the use of toolkits that have NICE endorsement. However 248-249 advocates the use of	Thank you for your comment. There is a misinterpretation of this

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	London Hospitals				Nursing Hours per Patient Day(NHpPD). This is confusing we need to know that we will either have a choice of toolkit as stated in line 181 or NO choice as stated in 248-249.	recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.

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672	University College London Hospitals	11	188	1.2.3	Line 188 stating patient nursing needs are main driver for calculating nursing requirement is contradicted in line 248-249 which advocates the use of NHpPD to 'estimate' total nursing requirement. Need a clear consistent guide.	Thank you for your comment. Please see response to comment number 588 as this appears to be a duplicated comment.
673	University College London Hospitals	11	190	1.2.4	Whilst this is a useful prompt especially for in experienced ward sisters to inform professional would suggest adding 'to be used in addition to a NICE endorsed toolkit'	Thank you for your comment. We have amended the recommendation which describes how Tables 1 and 2 could be used.
674	University College London Hospitals	11	200	1.2.5	replace 'nursing' with 'nurse'	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. We have reviewed the terms used in the document again to ensure consistency throughout.
675	University College London Hospitals	12	202	1.2.5	Whilst this is a useful prompt especially for in experienced ward sisters to inform professional would suggest adding 'to be used in addition to a NICE endorsed toolkit'	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
676	University College London Hospitals	13	205	1.2.6	This entire section is a useful prompt for professional judgement and these should be embedded in any endorsed toolkits. On their own they do not provide a quantitative basis for calculating nurse establishment/shift requirements.	Thank you for your comment. Please see response to comment number 591 as this appears to be a duplicated comment

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677	University College London Hospitals	13	221	1.2.7	Add 'mentorship of students, communicating with the multidisciplinary team, undertaking audit, staff appraisal and performance reviews'	Thank you for your comment. Please see response to comment number 594 as this appears to be a duplicated comment.
678	University College London Hospitals	14	239	1.2.9	How will staff 'estimate' nursing requirement? What methodology will be used and what is the evidence base for 'estimating' this vital resource that can be applied consistently? It is of great concern that nurse requirement is to be based on an 'estimation' rather than using an endorsed toolkit that demonstrates a strong evidence base.	Thank you for your comment. Please see response to comment number 597 as this appears to be a duplicated comment.
679	University College London Hospitals	15	248	1.29	What is the measurement for each of these individual points; what would be considered the 'norm' and how is that determined? Why would one 'estimate' patient turnover when using retrospective data will be more accurate? How are nursing activities and responsibilities quantified?	Thank you for your comment. Please see response to comment number 599 as this appears to be a duplicated comment.
680	University College London Hospitals	15	248	1.29	All these points are professional judgement but are not quantifiable and related to developing off duty rotas. Whilst these are used they are not well placed to be considered at this point in the process of determining establishments. How is the uplift/headroom to be calculated? It would be useful to have this process agreed so that a consistent	Thank you for your comment. Please see response to comment number 600 as this appears to be a duplicated comment.

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					approach is agreed across the NHS. Currently this can vary from 18% to 26% which obviously impacts significantly on the nursing establishment set. If the uplift % is at the lower end the establishment recommended will be sub optimal.	
681	University College London Hospitals	15	248	1.29	It is essential to undertake this assessment at 3 distinct points NOT just in the immediate 24 hour period. It also needs to be completed in the long & medium term. Evidence in this organisation demonstrates that the earlier one identifies this gap the greater the chances of getting temporary staff cover. Therefore this needs to be completed when rota is initially developed; when changes to staffing are notified e.g. sickness and on a daily basis following assessment of individual patient acuity & dependency needs BUT should NOT be based on an estimation alone.	Thank you for your comment. Please see response to comment number 601 as this appears to be a duplicated comment.
682	University College London Hospitals	15	248	1.3	The underlying principle of this concept is totally unacceptable. To commence the process of calculating nurse establishments is too blunt, lacks consistency of application and therefore has the potential to negatively affect patient safety and quality. This approach is open to manipulation and being altered to best fit local budgets	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.

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					rather than patient care needs yet it would be difficult to assess if this was accidental or deliberate in organisations that are financially challenged. Additionally local estimation will prevent accurate benchmarking across the NHS.	
683	University College London Hospitals	15	248	1.2.9	This states the use of toolkits that have NICE endorsement. However 248-249 advocates the use of Nursing Hours per Patient Day(NHpPD). This is confusing we need to know that we will either have a choice of toolkit as stated in line 181 or NO choice as stated in 248-249.	Thank you for your comment. There is a misinterpretation of this recommendation. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is

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						interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.
684	University College London Hospitals	15	248	1.2.9	Line 188 stating patient nursing needs are main driver for calculating nursing requirement is contradicted in line 248-249 which advocates the use of NHpPD to 'estimate' total nursing requirement. Need a clear consistent guide.	Thank you for your comment. The guideline has been amended to clarify that there is a separate process for endorsing decision support toolkits. We have added links to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.

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685	University College London Hospitals	15	248	1.2.9	Overall this is a very complex process described here which would require exact data if it is to be completed accurately. However it is noted that this process here does not call for accurate data just an estimation. Estimation of care needs without a toolkit/accurate decision matrix allowing for individual patient needs rather than general collective patient needs assessment is essential to ensure safe high quality care. If this is to be completed in the way described here, need to indicate frequency of application, who in organisations will be skilled to undertake it and how will this training be supplied across the NHS? Expecting a ward sister to do this on a daily basis is not realistic. It feels rather confusing to have a document recommending a definitive methodology at this point with no clear 'timed'(quantifiable) elements included. If NHpPD is being recommended as the best practice approach then this MUST be stated clearly at the beginning and then an Implementation guideline specific to this methodology be made available at the same time to avoid confusion.	Thank you for your comment. Please see response to comment number 602 as this appears to be a duplicated comment.
686	University College London Hospitals	16	250	1.2.10	The document now returns to advising a 'staffing toolkit' as in 1.2.1 immediately following specific instruction to use NHpPD. This is contradictory and confusing. However in line 255 it returns to recommending NHpPD. The user should be advised to use the 'denominator' of the staffing	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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					toolkit being used otherwise it is not workable in practice.	
687	University College London Hospitals	16	261	1.2.12	This entire section applies only if using NHpPD as the methodology. Other toolkits will have this measure built into the calculations. Agree that a toolkit is required but suggest it encompasses the following without recommending a specific methodology. There are 2 distinct key elements to setting nurse establishment: (a) based on individual patient needs which are assessed by following a systematic decision matrix within a toolkit and (b) based on overall staff and ward factors (e.g. sister supervisory status, single room facility) which is added as a % overhead. The establishment will be calculated based on adding (a) and (b).	Thank you for your comment. Please see response to comment number 604 as this appears to be a duplicated comment.
688	University College London Hospitals	16	276	1.2.14	1.2.6, 1.2.7 do NOT give a denominator/timing guide therefore what is the calculation to add this?	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.
689	University College London Hospitals	17	278	1.2.15	This section is not accurate. It commences by setting daily requirements and developing the duty roster (287-289), then moves to setting the establishment. The logical approach is to set the establishment as explained above. Following this the ward sister will develop the duty roster based on local intelligence such as medical staff ward rounds, surgery times, meal times etc. However in order to	Thank you for your comment. Please see response to comment number 606 as this appears to be a duplicated comment.

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					develop the duty rota she needs to know the ward nurse establishment. Determining the establishment is a completely separate process and therefore suggest this needs separating in the document.	
690	University College London Hospitals	17	297	1.2.18	Suggest adding 'using an agreed staffing toolkit' to sentence re systematically assessing daily needs. However unless this guideline is being instructive that NHpPD is the methodology to be used suggest removing 298 – 300. The staffing toolkit being used would/should include these elements.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
691	University College London Hospitals	17	301	1.2.19	The nursing red flags will be useful as retrospective data but cannot be anticipated at the outset of the shift.	Thank you for your comment. This is in line with the intended purpose of the red flag events. However a shortfall in available nursing could be identified at the outset of a shift.
692	University College London Hospitals	18	305	1.2.19	Final bullet point – What is the formula to calculate 8 hours/25% of RN staffing available compared with actual total nursing hours required for shift? Suggest adding ' as determined by an agreed staffing toolkit', otherwise it is unrealistic to expect the nurse in charge of each shift to do this calculation. Suggest adding a staff indicator such as 'staff sickness levels' to assess if these are workload/stress related.	Thank you for your comment. An example has been included in this nursing red flag to clarify what a shortfall of 8 hours or 25% of available registered nurse hours is.

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693	University College London Hospitals	18	314	1.2.22	Suggest rewording to 'Continuous monitoring and review of the red flag events should be an integral element of the quality and safety performance management of the ward and a key factor informing planning of the nurse staffing establishment'.	Thank you for your comment. There has been addition to the existing recommendations to clarify the reporting and monitoring of these nursing red flag events. We have also added a recommendation in the organisational strategy section to address this issue.
694	University College London Hospitals	19	328	1.3	This needs to be simplified and aligned to the Safety Thermometer, in-patient survey, staff survey and data set already being collected re publishing staffing data as per Hard Truths. This will help organisations to streamline data by collecting the same data sets in the same denominations. Furthermore it increases the ability to monitor the key factors. Evidence demonstrates that the larger the number of data sets as well as the variation in the way this is collected and presented the less effective the monitoring. Could the reader be signposted to the relevant NICE guidelines rather than putting all the detail here? This would reduce the size of this document and keep the reader focused on the purpose. The 'planned' versus 'required' versus 'actual' is not benchmarkable and may not lead to quality outcomes, if	Thank you for your comment. Please see response to comment number 610 as this appears to be a duplicated comment.

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					the planned and/or required is based on an estimation or according to locally set available resources. This may result in the actual available appearing favourable but in practice it being sub optimal. Therefore suggest stating 'Using a staffing toolkit to determine the 'planned' and 'required' and actual available.	
695	University College London Hospitals	20	329	1.3.2	These data sets should be reviewed against the nursing establishment set by a staffing toolkit endorsed by NICE otherwise it becomes a comparison of apples and pears	Thank you for your comment. Please see response to comment number 611 as this appears to be a duplicated comment.
696	University College London Hospitals	20	334	1.3.3	Suggest that prior to changes to establishments a full review of the ward is undertaken. Poor outcomes of care are NOT always related to the nursing establishment. Therefore review of the skill mix, ward factors, leadership, number of vacancies, number and frequency of temporary needs to be completed as part of the process.	Thank you for your comment. The recommendations have been amended to clarify this issue that there may be other influences on safe nursing indicators other that the ward nursing establishment size.
697	University College London Hospitals	20	337	1.3.3	This states the ratio for the day time, what is the ratio for night time? Need to be consistent if giving a daytime ratio MUST apply the same principle for nigh time. Otherwise how are negative outcomes for patients to be measured especially if these are being experienced at night?	Thank you for your comment and support for this guideline. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and

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						detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise. However there is a nursing red flag that has been developed to help ensure safety throughout a 24-hour period.
698	University College London Hospitals	24	430	3	This states there is a lack of research of effectiveness of using a defined approach or toolkits. However, despite this these guidelines are strongly advocating the use of NHpPD methodology. This raises significant concern for the robustness of these guidelines. However on page 52 'Quality of evidence' section it identifies a strong evidence of association between acuity and dependency of patients and patient outcomes, therefore why is this section here not advocating an acuity & dependency approach to determining establishments?	Thank you for your comment. Please see response to comment number 613 as this appears to be a duplicated comment.

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699	University College London Hospitals	27	473	5	Suggest rewording to read 'acute admissions/assessment units/wards'.	Thank you for your comment. The guideline has been amended in light of your comment.
700	University College London Hospitals	27	478	5	Suggest rewording - 'to achieve high quality, safe patient care and experience'	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee.
701	University College London Hospitals	27	493	5	Consider rewording - replace 'routine' with 'planned' to read 'an aspect of planned care'	Thank you for your comment. The guideline has been amended in light of your comment.
702	University College London Hospitals	28	501	5	Whilst nurse:patient ratios can be recalculated to number of nursing hours per patient day over 24 hours this table is NOT accurate. 1:1 nurse to patient ratio does NOT equate to 24 hours nursing care per 24 hours as it does not include handover communication time, meal breaks etc. The actual calculation is approx 27 hours. As this is incorrect but the same formula is being used to calculate the remaining ratios it can be assumed the entire section is NOT accurate.	Thank you for your comment. The guideline has been amended in light of your comment.
703	University College London	28	503	5	This is NOT accurate. A nurse working an 8 hour shift does NOT contribute 8 hours nursing care as they have to have a handover period, attend meetings, undertake audit	Thank you for your comment. The guideline has been amended in light of your comment.

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	Hospitals				etc. during this time. Therefore this entire section needs completely reworking with expert input to ensure the calculations are accurate/correct.	
704	University College London Hospitals	28	506	5	Nursing skill mix is usually presented as a % skill mix e.g. 70:30	Thank you for your comment. Please see response to comment number 618 as this appears to be a duplicated comment.
705	University College London Hospitals	28	521	5	Patient acuity is NOT a measure of how 'time consuming' care is, this is more accurately reflected as 'patient dependency'	Thank you for your comment. Please see response to comment number 619 as this appears to be a duplicated comment.
706	University College London Hospitals	28	533	5	Can be shortened to line 534 only.	Thank you for your comment. Please see response to comment number 620 as this appears to be a duplicated comment.
707	University College London Hospitals	28	543	5	This definition needs enhancing to explain the non-direct care elements such as ward handover, ward rounds, communication with MDT, family, audits, discharge planning meetings, mentorship of students, performance review of staff etc. It needs to also include aspects of student and RN training as well as general ward management e.g. rota development. Total nursing requirement is not usually expressed as NHpPD it is usually expressed as Full time equivalent (FTE) or whole	Thank you for your comment. Please see response to comment number 621 as this appears to be a duplicated comment.

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					time equivalent (WTE).	
708	University College London Hospitals	35	673	8	What tools have NICE developed to help organisations implement the guideline as stated here?	Thank you for your comment. Please see response to comment number 622 as this appears to be a duplicated comment.
709	University College London Hospitals	35	676	8	What process has been followed in endorsing toolkits, will that evidence be published?	Thank you for your comment. The guideline is aimed to encompass all factors that are likely to influence nursing staff requirements and a process to determining nursing staff requirements. We have added a link to a separate webpage on the NICE website that will contain information regarding the endorsement process of decision support toolkits.
710	University College London Hospitals	37	688	Appendix 1	This entire section is too long being 33 pages. It is repetitive, confusing and not written in a format that can be easily accessed by busy front line clinicians'. Can this be reworked with these key people's schedules considered please? There is no mention of how staff satisfaction impacts on patient outcomes which can be significant and extremely	Thank you for your comment, Please see response to comment 623 as this appears to be a duplicate comment.

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					important when considering/reviewing nurse establishments	
711	University College London Hospitals	42	698	Appendix 1	Paragraph 1, line 5, needs rewording incorrect sentence.	Thank you for your comment. The guideline has been amended in light of your comment.
712	University College London Hospitals	44	701	Appendix 1	Did the committee not consider the recommendations form the NQB guidance published in Nov 2013 for this section?	Thank you for your comment. The guideline has been amended in light of your comment.
713	University College London Hospitals	46	704	Appendix 1	Whilst very important for frontline staff to be able to apply professional judgement to suggest daily staffing requirement, it is equally important that they are trained in the effective use of resources, practical application and development of duty rotas as well as practical implementation of the organisations agreed NICE endorsed staffing toolkit.	Thank you for your comment. Please see response to comment number 624 as this appears to be a duplicated comment.
714	University College London Hospitals	53	710	Appendix 1	• The contents of Table 1 and 2 referred to here and in ‘Other considerations’ are all included in an ‘acuity-dependency’ methodology. The evidence presented here suggests a strong association between patient A&D and nursing requirements. The studies are rated as high for internal & external validity. In the light of this strong evidence why has the a&d methodology been dismissed in	Thank you for your comment. Please see response to comment number 625 as this appears to be a duplicated comment.

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					these guidelines? In contrast in the previous section lines 709 – 710 it states that there is only ONE study identified which assessed the effectiveness of NHpPD. This was rated low for internal validity but the reader is NOT informed of your estimation of its external validity. Given these facts why does the guideline strongly advocate NHpPD throughout the document (from page 15 onwards) but dismiss A&D? • Whilst the understanding of the term 'acuity' and 'dependency' may be varied in the general population it is widely understood in professional nursing arenas in the UK. We would therefore suggest that it is incumbent on the nursing profession to articulate the meaning of these terms more clearly rather than consigning them to the bin. • In other considerations paragraph 3, it suggests that specialist nurses, AHP's, medical teams, admin support impact on nurse establishments. How is this to be measured and accounted for when determining the establishment and does this need to be included in a toolkit? How is the variation in supply of these factors to be accounted for? Typically these staff are available on a 9-5 basis covering Mon-Fri but ward nursing is 24/7. This is	

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					the first mention of these in the document.	
715	University College London Hospitals	55	711	Appendix 1	Page 55 paragraph 2 by 'single bed' do you mean 'single room facility'?	Thank you for your comment. The guideline has been amended in light of your comment.
716	University College London Hospitals	58	712	Appendix 1	This section is confusing as it discusses the elements required to determine the % uplift/headroom, effects of different models of nursing e.g. team/primary nursing, leadership and organisational policy. Suggest it needs to be separated and simplified. Needs to clearly distinguish between ongoing training and development for 'employed' staff and supervision of students nurses. There are wards/hospitals that have no student nurses and therefore this MUST be accounted for separately.	Thank you for your comment. The guideline has been amended in light of your comment.
717	University College London Hospitals	59	712	Appendix 1	This is not accurate. A % uplift/headroom needs to be added to this process. Suggest the process of determining an accurate appropriate uplift be described as any establishment set based on an inaccurate uplift will produce an inappropriate establishment (either under or over).	Thank you for your comment. The guideline has been amended in light of your comment.
718	University College London	60	713	Appendix 1	The process here describes all the elements that should be included in a staffing toolkit. However how the numerator is expressed should be as used in the toolkit.	Thank you for your comment. We have amended these parts of the guideline to clarify this issue.

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	Hospitals				By that we mean it can be stated as either nursing hours or full time equivalents. Please see comments above re lines 709-710 It is not clear how frequently this process is being proposed, if it is daily it is unrealistic and unacceptable to ask frontline clinicians to complete this.	
719	University College London Hospitals	70	718	Appendix 1	The basis for recommending a benchmark of 1RN:8 Patients is deeply concerning. It is based on one study undertaken 7 years ago on general, orthopaedic and vascular surgery wards, although we understand that the data to support this study was collected in 1999. The delivery of patient care has changed considerably over this time period and it therefore further concerns us that we are basing a ratio on such outdated data. Additionally, this is a very poor specialty sample and its applicability to medical specialties cannot be deduced. Furthermore the ratios it states are 6.9 – 8.3 patients per nurse so why does the guideline advise a ratio at the higher ratio than the lower? The document does not state the strength of internal and external validity despite doing so for the other studies referred to in this section. Why is this?	Thank you for your comment. We have outlined how the best available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. This has been further added to following your comment.
720	University College	70	718	Appendix 1	Paragraph 3: What are the other studies referred to here? If the guideline is making reference to these being included	Thank you for your comment. We have outlined how the best

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	London Hospitals				to inform a 1RN:8Patients ratio then they must be fully discussed here.	available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. This has been further added to following your comment.
721	University College London Hospitals	71	719	Appendix 2	Why is NHpPD being advocated as the methodology as opposed to the A&D model most widely used in the UK? Please also see comments regarding the evidence for these above (re lines 709-711)	Thank you for your comment. Appendix 2 in the draft version has now been moved from the appendices of the main guideline to be a separate resource that will be available on the safe staffing webpages of the NICE website. It illustrates how the recommendations in sections 1.3 and 1.4 could be used in practice and has been amended to take into account stakeholder comments. Nursing hours per patient day is also used in the recommendations as a

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						measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the guideline glossary). The guideline has been amended to clarify this misunderstanding.

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722	University College London Hospitals	71	727	Appendix 2	How has 5.32 hours been derived? How has 5.6 hours been derived as additional hours? What is the evidence base for these figures? It is not acceptable to estimate these numbers, they should be patient specific according to individual patient needs NOT based on an average overall ward figure. They will be most accurately developed by undertaking timed task activity analysis and then categorised according to patient classification and built into a toolkit. It would not be practical to apply NHpPD on a daily basis. If these numbers are illustrative this needs very clearly stating.	Thank you for your comment. Appendix 2 in the draft version was clearly labelled as an example scenario and the numbers used were not intended to represent any recommended figures. The numbers used were to only illustrate the various steps of the process that were described in the recommendations section of the guideline. We have amended the text in this text to further illustrate that this is an example.
723	University College London Hospitals	General comment	General comment	general comment	• The timeframe for review and response to this extremely important guideline is enormously challenging which may result in many key professionals being unable to respond. • The size and layout of the document will further challenge the response rate. • There is much repetition in the document which does not add significantly to the guideline already published by NQB in Nov 2013. • Would suggest the use of algorithms and signposting layout which may make reading easier. A format	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. A number of revisions have now been made to the document to help reduce the repetition.

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					suggestion could be:	
724	University College London Hospitals	General comment	General comment	general comment	Overall comment: • This document is meant to be a guideline setting out principles and guidance on safe nurse staffing on adult acute in-patient wards. It does that up to page 14 when it states the 'use of toolkits consistent with this guideline. At page 15 it changes to advocate a specific methodology i.e. NHpPD and the remaining document is heavily underpinned by this. This is done at the expense of no discussion on the strengths, weaknesses or applicability of an A&D methodology. However the elements of an A&D model are highlighted as essential components of setting establishments without it being overtly stated. Additionally in the evidence section 709-711 it states that there is a strong association between patient a&d and nursing requirements. But this is not included in the main section. • To the inexperienced reader of this subject this guideline could be interpreted as use NHpPD NOT A&D methodology. Is this the intention of the document? If it is then more robust evidence from its use in the UK needs to be included. • Furthermore using the document as it is currently written to endorse staffing toolkits will NOT allow an equitable process.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. Nursing hours per patient day is used in the recommendations as a measurement (rather than to advocate specific methodology) to quantify in time the nursing needs of individual patients over a 24 hour period. It enables different shift durations of the nursing staff on a particular ward to be more easily accounted for compared with simply a nurse to patient ratio or the number of nurses that are present. Nursing hours per patient day is a common denominator that allows more accurate representation of the available staff capacity and is interchangeable with a nurse to patient ratio (as illustrated in the

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						guideline glossary). The guideline has been amended to clarify this misunderstanding. We have also inserted a link in the introduction section to the toolkit endorsement website pages which will provide further information about the endorsement process.
725	University College London Hospitals	General comment	General comment	general comment	Setting establishments: Are you using a NICE endorsed toolkit →Yes →Complete data collection exercise Don't know/No → A list of NICE endorsed toolkits and how to access them are available on page 5 etc	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee and the NICE team. The recommendations relating to using toolkits has now been amended in address the comments received.
726	Warrington & Halton Hospitals NHS Foundation Trust	9	132	1.1.5	I think we should state 'temporary' staffing to enable flexibility.	Thank you for your comment. The guideline has been amended in light of your comment where possible.
727	Warrington & Halton	11	199	1.2.5	This may change on a daily / hourly basis?	Thank you for your comment.

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	Hospitals NHS Foundation Trust					
728	Warrington & Halton Hospitals NHS Foundation Trust	12	202	1.2.5	? Routine and additional are both routine ?? ie 2 categories Routine and Significant.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. This section of the guideline has now been revised.
729	Warrington & Halton Hospitals NHS Foundation Trust	13	205	1.2.6	Add – number of consultants.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
730	Warrington & Halton Hospitals NHS Foundation Trust	13	214	1.2.7	Add – consultant ward rounds.	Thank you for your comment, which was considered by the Safe Staffing Advisory Committee. The guideline has been amended in light of your comment, where possible.
731	Warrington & Halton	14	228	1.2.8	? State % uplift ie 23% - calculation of 20.4% looks light, ? study leave and revalidation coming on board.	Thank you for your comment. We have outlined how the best

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	Hospitals NHS Foundation Trust					available evidence has been considered by the Safe Staffing Advisory Committee in developing the recommendations and detailed the considerations specific to developing individual recommendations in Appendix 1. The Safe Staffing Advisory Committee did not feel it was possible to make any more specific recommendations in this area based on the available evidence and their expertise. The example previously included in Appendix 2 was meant to be an example to illustrate the processes and calculations, not to recommend specific numbers.

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