



**Supporting NHS providers to deliver the
right staff, with the right skills, in the
right place at the right time**

Safe sustainable and productive staffing

This document has been developed by the National Quality Board (NQB), which comprises:

Care Quality Commission

NHS England

NHS Improvement

National Institute for Health and Care Excellence

Health Education England

Public Health England

Department of Health

Contents

Foreward	4
Policy Context	5
About this document	7
Section 1: Safe, sustainable and productive staffing: measurement and improvement	9
Patient outcomes, people productivity and financial sustainability	9
Reporting, investigating and acting on incidents	10
Patient, carer and staff feedback	11
Section 2: Care hours per patient day (CHPPD)	12
CHPPD for nurse staffing in acute inpatient settings	12
Section 3: Updated NQB expectations	14
Triangulated approach to staffing decisions	14
Expectation 1 Right staff	15
Expectation 2 Right skills	17
Expectation 3 Right place and time	19
Appendix 1 NQB recommended quality measures	21
Appendix 2 Units of staffing measurement	25
Appendix 3 Methods of workforce planning	27
Appendix 4 Key evidence-based guidance for nursing and midwifery staffing	28
References	29

Foreword

In 2013, the National Quality Board (NQB) set out 10 expectations and a framework within which organisations and staff should make decisions about staffing that [put patients first](#).¹ Putting people first remains our collective and individual responsibility and is central to the delivery of high quality care that is safe, effective, caring and responsive. This NQB document builds on our 2013 guidance to provide an updated safe staffing improvement resource.

Key to high quality care [for all](#) is our ability to deliver services that are sustainable and well-led. In the past, quality and financial objectives have too often been regarded as being at odds with each other and therefore pursued in isolation. As set out in the [Five Year Forward View](#),² it is vital that we have a single, shared goal to maintain and improve quality, to improve health outcomes, and to do this within the financial resources entrusted to the health service. This means a relentless focus on planning and delivering services in ways that both improve quality and reduce avoidable costs, underpinned by the following three principles:

- **Right care:** Doing the right thing, first time, in the right setting will ensure patients get the care that is right for them, avoiding unnecessary complications and longer stays in hospital and helping them recover as soon as possible.
- **Minimising avoidable harm:** A relentless focus on quality, based on understanding the drivers and human factors involved in delivering high quality care, will reduce avoidable harm, prevent the unnecessary cost of treating that harm, and reduce costs associated with litigation.
- **Maximising the value of available resources:** Providing high quality care to everyone who uses health and care services requires organisations and health economies to use their resources in the most efficient way for the benefit of their community – any waste has an opportunity cost in terms of care that could otherwise be provided.

As the [Carter productivity and efficiency report](#)³ makes clear, improving **workforce efficiency** can benefit patient care through better recruitment and retention of permanent staff, better rostering, reduced sickness absence, matching work patterns to patient need, and reduced dependency on agency staff.

The development of new service models means building teams across traditional boundaries and ensuring they have the full range of skills and expertise to respond to patient need across different settings. As provider and commissioner organisations work together to develop [Sustainability and Transformation Plans](#),⁴ staffing decisions must support these new models of care.

All this represents a significant people challenge. Now more than ever we need to help staff improve and innovate, enabling new ways of working in an environment of growing demand and rapid change.

This safe staffing improvement resource can only set the context and offer support to local decision making. It is local clinical teams – and local providers and commissioners – who will ensure we continue to provide high-quality and financially sustainable services. The challenges we face are steep – but our teams have a track record of delivery when we work together and focus on putting patients first.

Policy Context

In February 2013, Sir Robert Francis QC published his final report of the [inquiry into failings at Mid Staffordshire NHS Foundation Trust](#).⁵ The report told a story of appalling suffering of many patients within a culture of secrecy and defensiveness, and highlighted a whole system failure. [Compassion in practice](#),⁶ the strategy for nurses, midwives and care staff (2012), the Francis report and the government response, [Hard truths: the journey to putting patients first](#),⁷ led to fundamental changes in how NHS provider boards are expected to assure they are making safe staffing decisions. [The National Quality Board](#)⁸ in November 2013 set out these expectations in relation to getting nursing, midwifery and care staffing right. It provided a clear governance and oversight framework alongside recommended evidence-based tools, resources and examples of good practice, to support NHS providers in delivering safe patient care and the best possible outcomes for their patients. The National Institute for Health and Care Excellence (NICE) undertook work to produce guidelines on safe staffing for specific care settings, which led to the publication of [Safe staffing for nursing in adult inpatient wards in acute hospitals](#)⁹ and [Safe midwifery staffing for maternity settings](#).¹⁰

The [Carter report](#)¹¹ and the [NHS Five Year Forward View planning guidance](#)¹² make it clear that workforce and financial plans must be consistent to optimise clinical quality and the use of resources. The Carter report highlighted variation in how acute trusts currently manage staff, from annual leave, shift patterns and flexible working through to using technology and e-rostering. It underlined that, in addition to good governance and oversight, NHS providers need a framework to evaluate information and data, measure impact, and enable them to improve the productive use of staff resources, care quality, and financial control. Lord Carter's report recommended a new metric, care hours per patient day (CHPPD), as the first step in developing a single consistent way of recording and reporting staff deployments.

Jim Mackey, Chief Executive of NHS Improvement, and Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission, stated in a [letter](#) to trusts¹³ that provider leaders have to deliver the right quality outcomes within available resources. They reiterated their joint commitment to working together on a single national regulatory framework for this purpose.

Nursing and midwifery leaders have built on [Compassion in practice](#) to create a national nursing, midwifery and care staff framework, [Leading change, adding value](#)¹⁴. This framework is aligned to the Five Year Forward View, with a central focus on reducing unwarranted variation and meeting the 'Triple Aim' measure of better health outcomes, better patient experience of care and better use of resources.

The 2015 [Shape of caring](#) report¹⁵ recommended changes to education, training and career structures for registered nurses and care staff. We need to continue this work and identify both nationally and locally how we maximise the capabilities and contribution of healthcare assistants/support workers/nursing associates¹⁶ to meet patient needs and provide fulfilling job roles and career pathways.

As an integral part of developing their Sustainability and Transformation Plans, local health and care systems need to develop local plans for how they will develop, support and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations. This updated NQB safe staffing improvement resource provides advice and support to help NHS providers and commissioners as they go about this vital task.

About this document

The National Quality Board's 2013 guidance, [How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability](#)¹⁷ focused on supporting NHS provider boards to achieve safe nursing and midwifery care staffing. If we are to achieve the [Five Year Forward View](#)'s ambitions,^{18 19} the principles contained in this guidance now need to apply to nursing and midwifery staff and the broader multiprofessional workforce in a range of care settings, and do so in a way that optimises productivity and efficiency while maintaining the focus on improving quality.

This document includes an updated set of NQB expectations for nursing and midwifery staffing to help NHS provider boards make local decisions that will deliver high quality care for patients within the available staffing resource. In preparing this document we spent time talking with and listening to directors of nursing and chief nurses (in both provider and commissioner organisations) and to other key stakeholders, at local meetings, national events and via correspondence, to understand the impact of the previous safe staffing improvement resource, and to share ideas and early drafts of this document. This engagement and the feedback received were important for testing and ensuring that this updated document continues to provide a helpful framework for NHS provider boards when they are reviewing staffing and making decisions.

The [Carter report](#)²⁰ identified that one of the obstacles to eliminating unwarranted variation in the deployment of nursing and healthcare support workers has been the absence of a single means of recording and reporting how staff are deployed. From May 2016, CHPPD is the principal measure of nursing, midwifery and healthcare support worker deployment. This data collection is an important first step in the journey to providing a single, consistent metric for NHS providers to record and report all staffing deployment.

Another Carter recommendation was to develop a model hospital so trusts can learn what 'good' looks like from other trusts and adopt their best practice. Through the work on the model hospital, NHS Improvement is developing tools including a live model hospital dashboard that collects and presents patient outcome measures and staffing information in a standardised way.

In Sections 1, 2 and 3, we have updated the 2013 NQB guidance by bringing it together with the Carter report's findings, to set out the key principles and tools that provider boards should use to measure and improve their use of staffing resources to ensure safe, sustainable and productive services.

In Section 3, we identify three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions. An approach to deciding staffing levels based on patients' needs, acuity and risks, which is monitored from 'ward to board', will enable NHS provider boards to make appropriate judgements about delivering safe, sustainable and productive staffing. CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care. Appendix 1 shows measures that can be used alongside CHPPD to demonstrate and understand the impact of staffing decisions on the quality of care that people are receiving in acute inpatient wards.

Safe, Effective, Caring, Responsive and Well-Led Care

Measure and Improve

- patient outcomes, people productivity and financial sustainability -
- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -
- Implementation Care Hours per Patient Day (CHPPD) -
- develop local quality dashboard for safe sustainable staffing -

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	Right Skills 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	Right Place and Time 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Publishing this updated NQB safe staffing improvement resource is the first step in a journey to developing other resources that will support NHS provider trusts with making staffing decisions that will deliver safe, effective, caring, responsive and well-led care.

NHS Improvement is also coordinating work to develop safe staffing improvement resources for a range of care settings including: mental health, learning disability, acute adult inpatients, urgent and emergency care, children's services, maternity services, and community services. The core principles underpinning this work are: to identify and review the best available evidence on safe, sustainable staffing; to be multi-disciplinary in approach to staffing; to be outcomes focused; to complete an economic impact assessment on any proposed safe staffing improvement resource; and to develop these staffing resources with the appropriate experts, focus groups and other key stakeholder groups, including patients, families and carers. NHS Improvement will begin to release these improvement resources later in 2016/17, with approval from the NQB.

As this safe staffing improvement resource is implemented and used by NHS provider boards, clinicians and frontline managers, through their feedback and engagement, we will review and evaluate the impact of this resource over the next year to 18 months, to inform plans for future publications.

Section 1: Safe, sustainable and productive staffing: measurement and improvement

Patient outcomes, people productivity and financial sustainability

Providing high quality care to all patients means that NHS organisations and health economies must use their available resources in the most efficient way possible for the benefit of their community. There should be individual and collective responsibility as an NHS provider board for deploying staff in ways that ensure safe, sustainable and productive services. There should be clear lines of accountability for all professional staff groups. There should be collaborative decisionmaking between clinical and managerial staff, reporting to boards. NHS provider boards should have a proactive approach to reporting, investigating and acting on incidents and to driving continuous improvement.

NHS provider boards will need to collaborate across their local health and care system, with commissioners and other providers, to ensure delivery of the best possible care and value for patients and the public. This may require NHS provider boards to make difficult decisions about resourcing as local Sustainability and Transformation Plans are developed and agreed.

In this context, it is critical that boards review workforce metrics, indicators of quality and outcomes, and measures of productivity on a monthly basis – as a whole and not in isolation from each other – and that there is evidence of continuous improvements across all of these areas.

To help optimise allocation of workforce resources and improve outcomes, NHS provider boards should implement in full the Carter recommendations, together with the findings from the model hospital and its equivalents for other care settings. This includes:

- using local quality and outcomes dashboards that are published locally and discussed in public board meetings, including the use of nationally agreed quality metrics that will be published at provider level
- developing metrics that measure patient outcomes, staff experience, people productivity and financial sustainability
- comparing performance against internal plans, peer benchmarks and the views of NHS experts, taking account of any underlying differences
- reducing wasted time by supporting and engaging staff in using their time in the best way possible to provide direct or relevant care or care support

- using national good practice checklists to guide improvement action, as well as taking account of knowledge shared by top performers.

Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability create risks for quality, commissioners work in partnership with providers and consider how best to bring about improvements. Quality Surveillance Groups provide an opportunity for commissioners and local partners to work together to identify any risks to quality and safe staffing and coordinate actions to drive improvement.

NHS provider boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources. While boards will use published national metrics to support the discharge of those responsibilities, more timely and more detailed local sources of data and information are typically available for local monitoring and improvement. Boards should use this local quality monitoring to support their judgements and decisions about safe staffing. While staffing capacity and capability are vital to all aspects of quality, they are particularly likely to affect specific quality indicators or measures. The NQB has developed recommendations for local providers to consider when monitoring the impact of staffing on quality: see Appendix 1.

Reporting, investigating and acting on incidents

High quality care produces excellent outcomes for patients, and is safe, effective, caring, responsive and well led. NHS providers should follow best practice guidance in the investigation of all patient safety incidents, including root cause analysis²¹ for serious incidents.²² As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified.

NHS providers should consider reports of the 'red flag' issues suggested in the NICE guidance,²³ ²⁴ and any other incident where a patient was or could have been harmed,²⁵ as part of the risk management of patient safety incidents. Incidents must be reviewed alongside other data sources, including local quality improvement data (eg for omitted medication)²⁶ clinical audits²⁷ or locally agreed monitoring information, such as delays or omissions of planned care.

NHS providers should actively encourage all staff to report any occasion where a less than optimal level of suitably trained or experienced staff harmed or seems likely to harm a patient. These locally reported incidents should be considered patient safety incidents rather than solely staff safety incidents, and they should be routinely uploaded to the National Reporting and Learning System.

Staff in all care settings should be aware that they have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk.²⁸ Policies²⁹ should be in place supporting staff who raise concerns as and when they arise.

All NHS providers should have an identified Freedom to Speak Up guardian and should be able to demonstrate commitment to the principles in the Freedom to Speak Up Review of February 2015³⁰.

NHS providers should adhere to Duty of Candour requirements,³¹ which require them to publish an annual declaration of their commitment to telling patients if something has gone wrong with their care and have support staff to deliver this commitment.

Boards should ensure that they support and enable their executive team to take decisive action when necessary. Commissioners, regulators and other stakeholders should be involved in

considering any decision to close a care environment, or suspend services due to concerns about safe staffing, and identifying alternative arrangements for patients should be a priority.

Patient, staff and carer feedback

NHS providers need a co-ordinated approach and the right leadership skills in place to drive continuous improvements in patient outcomes and productivity. They should do this by developing the appropriate culture and behaviours, where staff and teams are engaged in developing their organisations and they are supported, respected and valued.³²

Boards must ensure that their organisations foster a culture of professionalism and responsiveness in healthcare professionals,³³ so that staff feel able to use their professional judgement to raise concerns and make suggestions for change that improves care. This includes ensuring the organisation has policies to support clinical staff to uphold professional codes of practice.

NHS providers should proactively seek the views of patients, carers and staff and the board should routinely consider any feedback relevant to staffing capacity, capability and morale, such as national and local surveys, stories, complaints and compliments.

As the Carter report says, good staff engagement and robust local policies and procedures should be in place to tackle bullying and harassment, and to address variation in sickness absence and staff turnover.

NHS providers should have a strong staff engagement plan, which routinely monitors the impact of their policies, demonstrates an understanding of the links between staff experience, patient experience and outcomes, and which supports staff retention, as documented by available research.^{34 35}

Staff should work in well-structured teams. They should be engaged, enabled to practice effectively and able to make changes to delivery of care to improve quality and productivity.³⁶

When an establishment review has taken place within an organisation, the board should ensure it considers feedback from frontline staff as part of its assurance activities.

Section 2: Care hours per patient day (CHPPD)

CHPPD for nurse staffing in acute inpatients

From May 2016, all acute trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. Over time, this will allow trusts to review the deployment of staff within a specialty and by comparable ward. When looking at this information locally alongside other patient outcome measures, trusts will be able to identify how they can change and flex their staffing establishment to improve outcomes for patients and improve productivity.

The introduction of CHPPD for nurse and healthcare support staffing in the inpatient/acute setting is the first step in developing the methodology as a tool that can contribute to a review of staff deployment. Work has begun to consider appropriate application of this metric in other care settings and to include other healthcare professionals such as allied health professionals (AHPs).

As with other indicators, CHPPD should never be viewed in isolation but as part of a local quality dashboard that includes patient outcome measures alongside workforce and finance indicators. The aim is to help ward sisters/charge nurses, clinical matrons and hospital managers make safe, efficient and effective decisions about staff deployment: see Appendix 1.

CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare support workers and dividing the total by every 24 hours of inpatient admissions (or approximating 24 patient hours by counts of patients at midnight). CHPPD is reported as a total and **split by registered nurses and healthcare support workers** to provide a complete picture of care and skill mix.

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

During the pilot, data sets were used from 25 acute trusts, representing a variety of acute trust types from across England, testing a variety of local data collection methods to collate actual hours worked by registered nurses and support staff.

The pilot supported the future use of CHPPD at a national level by:

- developing consistent 'rules' for capturing data (eg whether or not to include senior supervisory sisters/charge nurses)
- considering how in future to capture important contextual factors that affect nurse workload (eg whether a ward has high or low levels of housekeeping and ward clerk support, percentage single rooms)

- undertaking in-depth reviews to understand the impact of acuity and dependency
- exploring the challenges of collecting accurate data on patient hours/days for the CHPPD metric denominator
- reviewing international best practice where nursing hours per patient day (NHPPD) are used, including Western Australia, New Zealand and South Africa.³⁷

In testing the CHPPD data collection with 27 trusts before implementation in May 2016, it was found that, although collecting patient count at midnight did not capture all the activity on ward areas, it was the least burdensome on trusts and ensures consistency in the data for comparison. As NHS Improvement develops the CHPPD metric further with NHS providers, it will continue to review and refine ways of reflecting activity throughout the day.

NHS Improvement will be working with NHS providers to develop and inform the 2016/17 implementation plan for CHPPD. The programme's initial focus will be to assess and evaluate the acute inpatient data collection for nurse staffing by October 2016 to inform the next phase of implementation. In parallel, NHS Improvement will engage with providers to scope the development of the CHPPD metric for other care settings and consider application for other healthcare professionals, such as AHPs.

A robust process for review and evaluation will underpin NHS Improvement's programme to assure the validity of CHPPD and its impact in supporting frontline decisions about staff deployment, as well as to inform future plans.

Section 3: Updated NQB expectations

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	Right Skills 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	Right Place and Time 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve

- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

Expectation 1: Right staff

Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.

Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (ie the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.

Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations.

Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.

Boards should ensure:

1.1 Evidence-based workforce planning

- The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).
- The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.
- Workforce plans contain sufficient provision for planned and unplanned leave, eg sickness, parental leave, annual leave, training and supervision requirements.

1.2 Professional judgement

- Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.
- Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.

1.3 Compare staffing with peers

- The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.
- The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.
- The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: eg for acute inpatients, the model hospital dashboard will include CHPPD.

Expectation 2: Right skills

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services.

Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.

Boards should ensure:

2.1 Mandatory training, development and education

- Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.³⁸
- Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.³⁹
- Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.
- The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.⁴⁰
- The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.
- The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.
- The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.

2.2 Working as a multiprofessional team

- The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.
- The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.⁴¹
- The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.

2.3 Recruitment and retention

- The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap⁴² demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.
- The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.
- In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development⁴³

Expectation 3: Right place and time

Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.

Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.

Boards should ensure:

3.1 Productive working and eliminating waste

- The organisation uses 'lean' working principles, such as the productive ward,⁴⁴ as a way of eliminating waste.
- The organisation designs pathways to optimise patient flow and improve outcomes and efficiency eg by reducing queueing.
- Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.
- The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.
- The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.⁴⁵
- Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.

3.2 Efficient deployment and flexibility

- Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.
- Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.
- Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.

- Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.
- Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers⁴⁶ and the Carter Review Rostering Good Practice Guidance (2016).

3.3 Efficient employment, minimising agency use

- The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.⁴⁷
- The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.⁴⁸
- The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP)⁴⁹, the place-based, multi-year plan built around the needs of the local population.
- The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.
- The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.

Appendix 1

NQB recommendations for wider measures to monitor the impact of staffing on quality

The definitive judgement of a provider's quality is its CQC inspection rating. Alongside this, a range of metrics relevant to aspects of patient safety, clinical effectiveness and patient experience are suitable for both regulatory and public use, either to compare aspects of a provider's quality with other providers, or to measure changes in aspects of quality over time. All NQB partners are committed to ensuring metrics used for regulation and performance management are increasingly aligned into a 'single version of the truth' to reduce burden and ensure effective commissioning and provider oversight.

Here we offer guidance for local providers on using other measures of quality, alongside care hours per patient day (CHPPD), to understand how staff capacity may affect the quality of care. It is important to remember that CHPPD should not be viewed in isolation and, even alongside this suggested suite of measures, does not give a complete view of quality.

The suggested measures draw on data sources in most or all providers without additional collection, are likely to be already in use locally, and provide up-to-date information. The suggested indicators in this Appendix are best considered as 'balancing measures' where the impact of any changes in workforce capacity may become visible. They are not intended to include all aspects of quality; other quality indicators will be needed to provide a rounded view of the overall quality in a care setting and the wider systems and structures that support the delivery of care.

Given that the initial rollout of CHPPD is in acute inpatient settings, the examples and suggestions for other measures of how staffing capacity affects quality have been selected as particularly relevant to acute hospitals, but have been organised in a framework that could be applied to any setting. Even within acute hospitals these suggestions can and should be locally adapted: for example, specialist areas such as maternity units will need tailored metrics; providers with sophisticated data systems will have more options available to them; and specialist providers may have to develop monitoring more relevant to their specialties. Although initial collection of CHPPD relates to nursing staff, healthcare requires a multidisciplinary team approach, and the suggested list of quality indicators to use alongside CHPPD relates to a range of staff groups.

It is vital that boards read and hear staff and patient voices and the findings of incident and serious incident investigations alongside the suggested list of quality indicators so that the nature and causes of any issues can be rapidly identified and acted on.

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings

	Rationale for using as a quality indicator alongside CHPPD	Example indicators <i>Italics = published indicator</i>	Existing local sources
Patient and carer feedback	Patient and carer feedback provides insight into the quality of their own care, and often extends into observations of the wider care environment and staff capacity	<p><i>Friends and Family Test (inpatient and maternity)</i></p> <p><i>National patient surveys overall rating of care and questions related to staff capacity</i></p>	<p>Local patient FFT data⁵⁰ submitted to UNIFY (published monthly but earlier data available to providers)</p> <p>National patient surveys⁵¹</p> <p>Local complaints and compliments data</p>
Staff feedback	Staff feedback provides insight into their own and their colleagues' capacity, capability and morale, and of their perception of the quality of care	<p><i>Staff Friends and Family Test (place to be treated/place to work)</i></p> <p><i>National staff surveys (place to be treated/place to work and questions related to workload)</i></p> <p><i>GMC trainee survey (questions related to workload)</i></p>	<p>Local staff FFT data⁵² submitted to UNIFY (published monthly but earlier data available to providers)</p> <p>National staff surveys⁵³</p> <p>Annual GMC trainee survey⁵⁴</p> <p>Local staff 'barometers' or feedback routes</p> <p>Local incident reports of lack of sufficient staff numbers, capacity or skills⁵⁵</p>
Access to care	While staffing capacity will never be the sole factor, lack of staff capacity will affect access to care; for example, operations will be cancelled if any key staff in theatre or ward are unavailable	<p><i>Cancelled elective operations – proportion of last minute cancellations</i></p> <p><i>Those not treated within 28 days of a last minute cancellation</i></p>	UNIFY submissions (published quarterly but earlier data available to providers)
Completion of key clinical processes	<p>Clinical process measures provide a very early indication of changes in the quality of care delivery, so action can be taken before outcomes are affected</p> <p>Processes are often the responsibility of a specific staff group, and so can help pinpoint staffing capacity issues for that group</p>	<p>Medication omitted for non-clinical reasons (registered nursing staff)</p> <p>Observations/Early Warning Scores not taken/calculated as planned (nursing staff)</p> <p>MRSA screening/decolonisation completion rates</p> <p><i>VTE risk assessment completion (medical staff)</i></p> <p>Mobilisation within 24 hours of surgery (AHPs)</p> <p><i>National Clinical Audits (range of staff)</i></p>	<p>Electronic prescribing systems</p> <p>Electronic patient records</p> <p>Electronic observation systems</p> <p>Pathology databases</p> <p>National Clinical Audits with continuous local data submission (eg Stroke Sentinel Audit)</p> <p>UNIFY submissions (published quarterly but earlier data available to providers)</p> <p>Local audits, CQuINS, process measures collected for local QI projects (eg Medication Safety Thermometer for omitted medication⁵⁶)</p>

NQB recommendations for monitoring the impact of staffing on quality in acute hospital inpatient settings			
	Rationale for using as a quality indicator alongside CHPPD	Example indicators <i>Italics = published indicator</i>	Existing local sources
Harm during healthcare	<p>While a wide range of measures need to ensure the system of care supports staff to do the right thing, some types of harm are particularly likely to be affected by staff capacity</p> <p>Pressure ulcer prevention typically requires constant nursing intervention in terms of skin care and position changes, and therefore monitoring of pressure ulcers can help pinpoint staffing capacity issues for that staff group</p> <p>Effective inpatient falls prevention relies on identifying underlying medical causes, medication review, early mobilisation, and nursing observation. Therefore monitoring falls can help pinpoint staffing capacity issues across medical, pharmacy, AHP and nursing staff</p>	<p><i>Pressure ulcer prevalence</i></p> <p>Pressure ulcer incidence</p> <p><i>Prevalence of inpatient falls</i></p> <p>Incidence of inpatient falls</p>	<p>Safety Thermometer data (published monthly but earlier data available to providers) alongside local assessments of data completeness⁵⁷</p> <p>Local incident data on falls and pressure ulcers and subsequent investigations alongside local assessments of data completeness⁵⁸</p> <p>'Occurred in this trust' field in National Hip Fracture Database</p> <p>Local data on post-admission transfers to orthopaedics as potential indicator of serious injury from falls</p>

Notes on indicator presentation

This guidance cannot encompass detailed advice on how local quality monitoring is presented, but it is important local presentations help leaders and boards see where changes are significant rather than likely to be due to chance or anticipated seasonal patterns, including the use of appropriate denominators. In the best trusts, wards, leaders and the board use statistical process control techniques both to understand change and identify sustained improvement, rather than just looking at the month-to-month change.

Additional areas important for monitoring

Investigation and learning from patient safety incident and serious incident data

As set out in Section 1 of this document, *“Best practice guidance should be followed in the investigation of all patient safety incidents, including root cause analysis for serious incidents. As part of this systematic approach to investigating incidents, providers should consider staff capacity and capability, and act on any issues and contributing factors identified”*. Summarising these findings is a vital part of contextualising any quantitative data used for quality monitoring.

Workforce metrics that provide a window on staff capacity

While this Appendix on quality monitoring does not encompass wider workforce metrics (these will be developed as part of the NHS Improvement work on the model hospital) provider boards may wish to consider the wider quality implications of some workforce metrics. For example, staff turnover and staff sickness rates, particularly stress-related absences, can be an indicator of workload pressures. An additional example is completion of mandatory training; this is a direct measure of training completion, but as staff capacity issues can lead to cancellations of mandatory training, it can also act as a proxy indicator for workload pressures.

Workload metrics that provide context to CHPPD

As set out in Section 3, Expectation 1.3 *“the organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (eg length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.”*

Selection criteria for wider measures to help monitor the impact of staffing on quality

Healthcare is delivered by people; there is arguably no aspect of healthcare quality that staff capacity and capability will not affect. But in suggesting metrics to accompany CHPPD, selections have to be based on those areas of quality where changes in staff capacity are most likely to have a visible impact. This means any suggested areas:

- need to have very recent data available to providers or act as a periodic more robust source to compare with more frequently collected local data
- need to have a rationale where it is plausible or is shown that staff capacity is the major, or one of the major, factors affecting the metric (including a rationale for whether capacity of all staff groups or specific staff groups would be expected to have an impact)
- need adequate numbers (statistical power) if any true improvement or deterioration is to be distinguishable from random variation within a reasonable period in a typically sized provider
- if used to compare providers, have to be confirmed as appropriate for that purpose (ie not affected more by patient characteristics, differences in data collection, etc than by differences in actual quality)
- if used for a provider to compare against its own baselines, need to have stable data collection and completeness, and may need adjustment for seasonal factors (eg comparing against equivalent seasonal period, not past quarter, etc.)

Appendix 2

Units of staffing measurement		
Type of measure	Examples	How these can be used
Staff to patient rates/ ratios	<p>Care hours per patient day (CHPPD) reported as total and split by registered nurses and healthcare support workers to provide a complete picture of care and skill mix</p> <p>Nursing hours per patient day (NHPPD)</p>	<p>CHPPD is a unit of measurement that can be applied to any aspect of staffing, registered staff and/or whole care team.</p> <p>The Carter Report defines CHPPD as registered nurse hours plus healthcare support staff hours in a 24-hour period, divided by number patients at midnight (as a proxy for 24 hours of a patient stay).</p> <p>The concept of CHPPD can be adapted to all other staff groups with time allocated to wards or units: for example, physiotherapy hours per patient day, occupational therapy hours per patient day, etc.</p> <p>NHPPD is a unit of measurement used in inpatient settings internationally. It is able to summarise variations in numbers of staff and numbers of patients over the course of a 24-hour period. It typically refers to the number of registered nursing hours available per patient.</p>
Patient to staff rates/ ratios	<p>x patients per registered nurse</p> <p>x service users on caseload</p> <p>x women per midwife per year one-to-one observation</p>	<p>Typically used as a 'snapshot' of current responsibilities or as an average of responsibilities over a longer period. Actual numbers of staff and of patients/women/ service users will tend to vary over the course of a day in inpatient settings and over days/ weeks in community settings.</p>
Registered to unregistered staff rates/ ratios	<p>xx% of team are registered nurses</p> <p>xx% of team are midwives</p> <p>x:y ratio of registered nurses/ healthcare assistants</p>	<p>Difficult to interpret in isolation from other units of measurement, as a higher percentage/ ratio can be achieved by reducing healthcare assistants or by increasing registered nursing staff, but does give an indication of staff that will require supervision by registered nurses/midwives, in addition to their direct responsibilities.</p>

Units of staffing measurement		
Type of measure	Examples	How these can be used
Whole-time equivalents (WTE)	Ward/unit/team has xx WTE in post Ward/unit/team is funded for xx WTE	Provides a unit of measurement that overcomes local differences in the proportion of staff who work part-time, converting all part-time contracts into their whole-time equivalent, <i>eg two staff working 30 hours per week plus one staff member working 15 hours is the equivalent of two staff working 37.5 hours per week, therefore 2.0 WTE</i>
Head count	Ward/unit/team headcount is xx registered nurses xx healthcare assistants x physiotherapists x occupational therapists	Provides a unit of measurement that is important when counting activity every employed staff member has to undertake, regardless of how many hours they work, <i>eg mandatory training.</i>
Fill rates	The ward/unit/team had xx% of planned staff overall The ward/unit/team had xx% of planned registered nurse/midwifery staffing The ward/unit/team had xx% of required staff overall The ward/unit/team had xx% of required registered nurse/midwifery staffing	This was previously calculated by dividing actual staff by planned or required staff and multiplying by 100 to convert to a percentage. Difficult to interpret in isolation from other units of measurement, as previous plans may not reflect patient acuity/dependency on the day, and the percentage total cannot distinguish between 'aiming high but delivering less' and 'aiming low and delivering even lower.' Where registered nursing/midwifery staffing gaps are covered by a higher number of healthcare assistants, or where fluctuating numbers of staff are required for special observation, overall fill rates become even more difficult to interpret.
Headroom/uplift	xx% uplift xx% headroom	Building in capacity to deal with planned and unplanned but predictable variations in staff available, such as annual leave, maternity and paternity leave, compassionate leave, jury service, sickness and study leave. If the headroom/uplift allowance is lower than actual requirements this can lead to greater use of temporary/agency staff.

Note: for all units of staffing measurement, creating averages over days, weeks or months can potentially be misleading: a ward/unit/team that fluctuates markedly between too few or too many staff to meet patients' needs on different days of the week, or from week to week, will not be able to deliver the same quality of care as a ward/unit/team where staffing is more consistent.

Appendix 3

Methods of workforce planning		
Type of workforce tool	Summary	Examples
Acuity/dependency models	Using a decision matrix, patients are categorised according to their requirements into levels of care with associated evidence-based staffing multipliers derived from wards delivering good quality care. In this way, it discriminates between patients with differing needs. Some models also factor in additional workload demands such as patient turnover.	<p>Safer nursing care tool for adults, inpatient wards, acute admissions units, children and young people wards:</p> <p>http://shelfordgroup.org/library/documents/Shelford_Group_Safety_Care_Nursing_Tool.pdf</p> <p>Mental health and learning disability tools:</p> <p>https://hee.nhs.uk/hee-your-area/west-midlands/about-us/our-governance/our-letcs/mental-health-institute-letc/safe-staffing-tools-mental-health-learning-disability</p>
The professional judgment model	Based on clinical staff views of the number of staff required for the usual patient casemix and usual activity on a particular ward/unit/team (or in high dependency environments, the number of staff required for a typical patient)	<p>Telford method</p> <p>http://www.who.int/hrh/documents/hurst_mainreport.pdf</p>
Activity Monitoring tools	Uses care plans/care pathways and related nursing time. Data are collected based on the tasks undertaken/assigned to nurses, providing insights into the needs of and intelligence to inform decisions about staffing numbers, staff deployment, models of care, and skill mix.	<p>Birthrate plus</p> <p>http://www.birthrateplus.co.uk/</p>

Appendix 4

Key existing evidence-based guidance for nursing and midwifery staffing			
Title	Summary	Link	Year
<i>Strengthening the commitment; the Report of the UK Learning Disabilities Nursing Review</i>	A UK-wide review of learning disabilities nursing supported by the four Chief Nursing Officers in the UK, published in 2012, made recommendations related to workforce planning	http://www.scotland.gov.uk/Resource/0039/00391946.pdf	2012
<i>Safe staffing for nursing in adult inpatient wards in acute hospitals</i>	NICE inpatient guidelines	www.nice.org.uk/guidance/sg1	2014
<i>Safe midwifery staffing for maternity settings</i>	NICE maternity guidelines	www.nice.org.uk/guidance/ng4	2015
<i>Mental health staffing framework: a practical approach</i>	Mental health toolkit	https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf	2015

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- ¹ <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf> *How to ensure the right people, with the right skills, are in the right place at the right time*
- ² <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
- ³ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
- ⁴ <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>
- ⁵ <http://webarchive.nationalarchives.gov.uk/content/20150407084003/http://www.midstaffspublicinquiry.com>
- ⁶ <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>
- ⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf
- ⁸ <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>
- ⁹ <https://www.nice.org.uk/guidance/sg1>
- ¹⁰ <https://www.nice.org.uk/guidance/ng4>
- ¹¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
- ¹² <https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf>
- ¹³ 15 January 2016. Available at: http://www.cqc.org.uk/sites/default/files/20160115_letter_nhstrusts_quality_and_finances.pdf
- ¹⁴ <https://www.england.nhs.uk/wp-content/uploads/2016/05/nursing-framework.pdf>
- ¹⁵ <https://hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf>
- ¹⁶ http://www.healthwatchcambridgeshire.co.uk/sites/default/files/hee_nursing_associate_consultation_document.pdf
- ¹⁷ <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>
- ¹⁸ <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
- ¹⁹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf
- ²⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf
- ²¹ <https://www.england.nhs.uk/patientsafety/root-cause>
- ²² <https://www.england.nhs.uk/patientsafety/serious-incident>
- ²³ <http://www.nice.org.uk/guidance/SG1>
- ²⁴ <https://www.nice.org.uk/guidance/ng4>
- ²⁵ <https://www.england.nhs.uk/patientsafety/report-patient-safety>
- ²⁶ https://www.safetythermometer.nhs.uk/index.php?option=com_content&view=article&id=3&Itemid=10
- ²⁷ <http://www.hqip.org.uk/national-programmes>

- ²⁸ <http://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives> http://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp;
<http://www.hpc-uk.org/registrants/raisingconcerns/howto>
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- ³⁰ <https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review>
<http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>
- ³¹ http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
- ³² <https://www.rcplondon.ac.uk/guidelines-policy/work-and-wellbeing-nhs-why-staff-health-matters-patient-care>
- ³³ <http://www.hpc-uk.org/assets/documents/10003771ProfessionalismInHealthcareProfessionals.pdf>
- ³⁴ <http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>
- ³⁵ <http://qualitysafety.bmj.com/content/early/2013/07/08/bmjqs-2012-001767>
- ³⁶ <http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf>
- ³⁷ <http://ro.ecu.edu.au/cgi/viewcontent.cgi?article=7278&context=ecuworks>
- ³⁸ Health Education England is developing a set of e-learning modules on safe staffing for sisters, charge nurses and team leaders that will be published in 2016.
- ³⁹ https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf
- ⁴⁰ https://hee.nhs.uk/sites/default/files/documents/HEE_J000584_QualityFramework_FINAL_WEB.pdf
- ⁴¹ <http://www.nhsbenchmarking.nhs.uk/CubeCore/uploads/NAIC/Reports/NAICReport2015FINALA4printableversion.pdf> <http://www.ncbi.nlm.nih.gov/books/NBK269522>
- ⁴² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499663/Provider_roadmap_11feb.pdf
- ⁴³ <http://www.nhsemployers.org/~media/Employers/Documents/Plan/Mind%20the%20Gap%20Smaller.pdf>
- ⁴⁴ http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html
- ⁴⁵ Further support and guidance will be issued at a future date.
- ⁴⁶ <http://www.nhsemployers.org/your-workforce/plan/agency-workers/reducing-agency-spend/e-rostering>
- ⁴⁷ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478691/Agency_letter_to_trusts_post_consultation_final.pdf
- ⁴⁸ <https://www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs>
- ⁴⁹ <https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp>
- ⁵⁰ Local patient FFT can be used to measure change over time where providers have local insight into any changes in data collection and completeness, but cannot be used to compare providers with each other, as data collection will vary.
- ⁵¹ National patient surveys can be used to compare providers with each other, so even though they are only published annually, they provide important context for local FFT data. National patient surveys include questions on patients' perceptions of sufficient staffing and questions that act as indicators of staff capacity.

- ⁵² Local staff FFT can be used to measure change over time where providers have local insight into any changes in data collection and completeness but cannot be used to compare providers with each other, as data collection will vary.
- ⁵³ National staff surveys can be used to compare providers with each other, so though they are only published annually, they provide important context for local staff FFT data. National staff surveys include questions directly asking about staff perception of sufficient staffing, or that act as indicators of staff capacity.
- ⁵⁴ The annual GMC national training survey collects medical trainee feedback on a wide range of topics and pivotal issues, such as intensity of work (by day and night), work beyond rostered hours, an expectation to cope with clinical problems beyond the trainee's competence or experience and the ability to attend regular specialty-specific training.
- ⁵⁵ Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and serious incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (<http://www.sciencedirect.com/science/article/pii/S0965206X15000935>) and case note review and the FallSafe under-reporting survey (see <https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original>) for inpatient falls.
- ⁵⁶ These local sources can be used to measure change over time where providers have local insight into any changes in data collection and completeness but cannot be used to compare providers with each other, as data collection will vary and there are a range of factors other than quality of care that will affect outcomes.
- ⁵⁷ Safety Thermometer data can be used to measure change over time where providers have local insight into any changes in data collection and completeness (eg annual skin surveys <http://www.sciencedirect.com/science/article/pii/S0965206X15000935>) but cannot be used to compare providers with each other, as data collection will vary and there are a range of factors other than quality of care that will affect outcomes (eg age-related risk of falling).
- ⁵⁸ Data collected through incident reporting systems or as serious incidents should never be presented as though they represented actual incidents or actual harm; this is important not because they will inevitably have missing data (as this is true for many other data sources too) but because to do so is counterproductive to the purpose of incident reporting. To support this, NQB partners have committed to using metrics drawn from National Reporting and Learning System and Serious Incident data only to identify implausibly low levels or patterns of reporting that may indicate issues with providers' safety culture or reporting processes. In the context of quality metrics for local consideration alongside CHPPD there is another important reason not to present local incident rates as simple dashboard metrics; overstretched staff may be less likely to find time to report incidents and provider boards could take false reassurance from this. Methods for assessing levels of under-reporting include annual skin surveys for pressure ulcers (see above), case note review and the FallSafe under-reporting survey (see <https://www.rcplondon.ac.uk/guidelines-policy/fallsafe-resources-original>) for inpatient falls.

