Staff Survey - Health and Care (Staffing) (Scotland) Bill

Introduction - Health and Care (Staffing) (Scotland) Bill

As part of the Parliamentary scrutiny of the Scottish Government's Health and Care (Staffing) (Scotland) Bill, the Health and Sport Committee of the Scottish Parliament would like to gather the views of those who are involved with local workforce planning. This survey is primarily aimed at those staff who run and implement the current set of 12 mandated workload planning tools.

For further information on the tools being considered please go to: http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/

Full details of the Bill can be found at: http://www.parliament.scot/parliamentarybusiness/Bills/108486.aspx

You can also access our GDPR Privacy Notice for online surveys at: http://www.scottish.parliament.uk/SPICeOnlineSurveys.pdf

The survey will run until 1 August 2018.

2. What is your role within the Board?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	193
	1 Chief nurse		
	2 Nurse Manager		
	3 Band 6 Theatre Nurse		
	4 Senior charge nurse		
	5 SCN		
	6 Nurse Manager Band 8A		
	7 SCN		
	8 Nurse Manager		
	9 Senior Charge Nurse		
	10 Lead nurse for workforce planning		
	11 Nurse Manager		
	12 manager		
	13 perinatal mood disorder nurse		
	14 SCN		
	15 Team Lead		

2. What is your role within the Board?

		Response Percent	Response Total
16	Team Lead/Advanced Nurse Practitioner		
17	SCN		
18	Senior Charge Nurse		
19	District Nurse Team Leader and Community practice teacher		
20	Team Lead		
21	CBT therapist		
22	scn		
23	senior charge nurse		
24	District Nurse		
25	Nurse Manager		
26	Service Manager Older Adult Mental Health		
27	Community Mental Health Nurse		
28	Memory Clinic Nurse		
29	District nurse		
30	SENIOR CHARGE NURSE		
31	Senio Charge Nurse		
32	SCN		
33	District Nurse Team Leader		
34	staff nurse		
35	SCN		
36	SCN		
37	SCM		
38	Senior Charge Nurse		
39	Senior Charge Nurse		
40	Senior Leadership and Management		
41	Nursing & Midwifery Workforce Planning Co-ordinator		
42	Team leader		
43	Team leader midwifery		
44	Manager		
45	SCN		
46	senior charge nurse		
47	Integrated Midwife		
48	Nurse Team Leader		
49	Senior Charge Nurse		
50	Midwifery Team Leader		
51	senior charge nurse		

2. What is your role within the Board?

		Response Percent	Response Total
52	Midwife		
53	Senior Nurse		
54	Nurse		
55	senior charge nurse		
56	Dn Team leader and TV lead		
57	Advise and support		
58	SCN		
59	Senior Charge Nurse		
60	Senior Charge Nurse		
61	Senior Charge Nurse		
62	SCN		
63	nurse		
64	SCN		
65	Community Nursing Programme Manager		
66	charge nurse		
67	Senior Charge Nurse		
68	Community Learning Disability Nurse		
69	Manager		
70	Clinical Nurse Manager		
71	Employee - SCN		
72	Senior Charge Nurse		
73	District Nurse		
74	Nursing		
75	community nurse		
76	Nurse manager		
77	Clinical Nurse Manager		
78	Senior Charge Nurse		
79	Team lead		
80	AHP PEC		
81	Nurse		
82	Nurse		
83	Team manager		
84	District Nurse		
85	Health Visitor Team, Manager		
86	SCN		
87	charge nurse		

2. What is your role within the Board?

		Response Percent	Response Total
88	CNM		
89	Health Visiting Team Manager		
90	Senior Charge Nurse		
91	Health Care Assistant Band 3		
92	Health Visitor		
93	Community Staff Nurse		
94	health visitor		
95	Senior Nurse		
96	Charge Nurs		
97	scn		
98	SCN		
99	Community Nurse		
100	health visitor		
101	Advanced Practitioner/Team Lead		
102	senior charge nurse		
103	Healthcare Assistant		
104	Epilepsy Nurse Specialist for adults with learning disabilities.		
105	Associate Director of Nursing		
106	SCN		
107	Staff nurse		
108	nurse		
109	staff nurse		
110	Health Visitor		
111	District nurse		
112	Senior Charge Nurse		
113	Senior Charge Nurse		
114	Acting nursing sister		
115	senior charge nurse		
116	Nurse Consultant		
117	Staff Nurse/Staff Side representative		
118	NMWWPP Programme Advisor		
119	Manager		
120	Staff Nurse		
121	community nurse		
122	Team Manager		
123	Senior charge nurse		

2. What is your role within the Board?

		Response Percent	Response Total
124	health visitor		
125	District Nurse		
126	Clinical Nurse Manager		
127	Senior Charge Nurse		
128	health visitor / team lead		
129	hv		
130	Team Lead		
131	Clinical Nurse Manager		
132	charge nurse		
133	Midwife		
134	Professional lead / Manager		
135	Clinical Nurse Manager		
136	team manager		
137	Senior charge Nurse		
138	Senior Charge Nurse		
139	Charge Nurse		
140	Health Visitor		
141	Nurse		
142	Health Visitor		
143	senior charge nurse hdu		
144	Clincal Nurse Manager		
145	stfaf nurse		
146	District Nurse		
147	Community Midwife		
148	Senior Charge Nurse		
149	Midwife		
150	Clinical Nurse Manager		
151	Senior Charge Midwife		
152	Deputy Charge Nurse		
153	Senior charge Nurse		
154	midwife		
155	Senior Charge Nurse		
156	Nurse Therapist		
157	Nursing team leader		
158	Senior Charge Nurse		
159	Senior Charge Nurse		

2. What is your role within the Board?

		Response Percent	Response Total
160	Team Manager		
161	District Nurse		
162	deputy ward manager		
163	SCN		
164	Deputy Charge Nurse/Senior Charge nurse		
165	senior charge nurse		
166	Senior Manager		
167	Acting Senior Charge Nurse		
168	CNM		
169	nurse		
170	school nursing development manager		
171	Operational Lead Nurse		
172	Partnership Lead Nurse		
173	Senior Charge Nurse		
174	Nurse Service Manager - Lead Health Visitor		
175	Nurse manager		
176	Nurse Manager		
177	Service manager		
178	Chief Nurse		
179	Associate Director of Nursing		
180	Deputy Director Nursing		
181	Senior Charge Nurse		
182	Community LD Nurse		
183	charge midwife		
184	senior charge nurse		
185	deputy charge nurse		
186	Senior Charge Nurse		
187	Nurse Consultant		
188	Clinical Nurse Specialist		
189	CLINICAL NURSE SPECIALIST		
190	Nurse Manager		
191	CNS		
192	Nurse Manager		
193	Specialist Nurse		
		answered	193
		skipped	2

3. Do you personally use any of the current set of workload planning tools to plan staffing in your work area?				
			Response Percent	Response Total
1	Yes		65.98%	128
2	No		34.02%	66
			answered	194
			skipped	1

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4. When did you last receive training in how to use the workload planning tools effectively? Please comment below.			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	125

1	Self taught using online videos and user guides
2	april 2018
3	Never
4	June 2018
5	Original session some years ago but regular refresher sessions available for staff to access. Can also request adhoc advice and support when required.
6	July 2018
7	March / April 2018
8	Approximately 4-5 years ago
9	4 years ago
10	never
11	MARCH 2018
12	never
13	2018
14	not specific training but discussion via workforce planning meetings
15	Brief training November 2017
16	TWO YEARS AGO
17	Awaiting training
18	April 2018
19	2 months ago
20	trained on the job by nurse manager learn as you go
21	June 2018
22	last year
23	never received face to face, peer led guidance and explanatory notes only.
24	Approx 8 weeks ago

4. When did you last receive training in how to use the workload planning tools effectively? Please comment below.

		Response Percent	Response Total
25	April 2018		
26	When tools first came out - 3 - 4 years ago		
27	About 4 years ago but have kept up to date via the NMWWPP site		
28	Unsure		
29	Never		
30	4 or 5 years ago		
31	few weeks ago		
32	Never, Managers give a bief instruction on their use.		
33	Can't remember		
34	unsure if ever had formal training		
35	Have never received any training		
36	4yrs ago		
37	Training received in December but not adequate to ensure correct or effective data collection		
38	05/07/2018		
39	12 months		
40	May 2018		
41	6 months ago		
42	Never		
43	annual		
44	oVER 5 YRS AGO		
45	Last year		
46	never		
47	Within the last year		
48	February 2018		
49	Never		
50	Never		
51	never		
52	Approximately 2014		
53	never!		
54	Never received official training, only basic instructionfrom other user.		
55	2010		
56	Have never received any training		
57	Never		
58	Never		
59	At start of introduction to it		
60	Not had formal training		

4. When did you last receive training in how to use the workload planning tools effectively? Please comment below.

		Response Percent	Response Total
61	unsure		
62	yearly update from administrator		
63	6 years ago		
64	1 Month		
65	email with on line instruction		
66	only received brief verbal training from a colleague when new in post		
67	about 15 minutes 6 months ago. No how to guide avialable		
68	1 year ago		
69	Not received any training - given written instructions on how to complete workload planning tool		
70	Unsure of date but approx. 6 years ago		
71	1month ago		
72	ongoing... use video resource on ISD website; present at Workload and Workforce Planning education in Fife		
73	I have never received any training		
74	I have never had any training		
75	June 2018 missed formal training as was on holiday.		
76	never		
77	September 2016		
78	Approximately 2 years ago		
79	In my former role I delivered training for staff all levels		
80	half hour session which did not meet the needs of what was required. Did not fit the purpose of the service		
81	never- just told to follow instructions		
82	no training		
83	we had brief training before we did it last time, and have a crib sheet Really this isn't the best preparation and the entire thing felt very last minute-as these things often do		
84	Have never received formal training		
85	Prior to completion this year in Feb 2018		
86	Each year as a refresher before we complete it		
87	around 5 -6 months ago		
88	I complete them. A couple of years ago		
89	2015		
90	2010		
91	2016		
92	2017		
93	Haven't received formal training		
94	have never received training		

4. When did you last receive training in how to use the workload planning tools effectively? Please comment below.

		Response Percent	Response Total
95	4 years ago		
96	2 years ago approx.		
97	Ongoing		
98	6 months ago		
99	4-5 years ago		
100	Have never received any training. Rolled out via an email with minimal information/guidance.		
101	No training received		
102	3 -4months ago		
103	within last 6 months		
104	Have never		
105	Never		
106	new to role formal training in September taught by others at present.		
107	2017		
108	several years ago		
109	never		
110	June2018		
111	I haven't		
112	Within past two years.		
113	3+ years ago		
114	A few weeks ago		
115	Training across MHLD service 26th July 2018		
116	Have never had formal training, I provide training and support to front line staff on the use of the tools.		
117	April 2018		
118	last year		
119	never had any 1:1 training only had guidance via email		
120	no training ever given		
121	very informal training at the beginning of this year . Sent an email to follow		
122	The beginning of the year prior to re-running the programme and there were Senior Charge Nurses who hadn't lead it before		
123	Never		
124	18th May 2018. An hours session provided by NHS Grampian Senior Nurse Elizabeth Wilson for Workforce Planning & Development.		
125	several years ago		
		answered	125
		skipped	70

5. Who does run the workforce planning tools for your area/ward? Please comment below.

		Response Percent	Response Total
1	Open-Ended Question	100.00%	61

1	SCN
2	No set tools, as far as I am aware are used for theatre, not in my area of speciality.
3	I have used the tools to capture data as requested by lead nurse - but do not use that data to plan staffing in my work area
4	Not relevant to education staff but I lead on wfp tools across nhs highland, deliver various training sessions etc
5	There is only me in regards to perinatal mental health. 1/3 of Scotland! I have asked for more resource over 15 yrs nothing has come of it. Now the Network are in place maybe things will change. I plan to retire very soon I am burnt out trying to provide a safe service. Also no psychiatrist nor proper admin support.
6	Head of Service
7	Head of Service
8	don't use
9	NHS Grampian yearly
10	Management
11	My manager
12	never
13	we don't use a workforce planning tool
14	No sure
15	Line manager
16	no idea
17	Mairi Milne, Midwifery Team Lead
18	Self
19	All the District nurse and ward based Senior Charge Nurses and their staff , I support with professional judgement tool
20	This is done intermittently and a set tool is provided where we analyse workforce and activity over a 1 week period. This is done by the senior charge nurse. Despite this being carried out multiple times over many years there has been no increase in nurses per shift!!!!!!!! despite the tool clearly displaying and increase required
21	I support staff t run them in their local areas
22	Team Lead
23	Highland Council
24	Team Lead
25	Charge nurses and clinical leads
26	I have run the workforce planning tool on occasions when have been asked to by management. but am hoping to incorporate it into a quarterly tool in the future
27	Team Mannager

5. Who does run the workforce planning tools for your area/ward? Please comment below.

		Response Percent	Response Total
28	nurse manager		
29	I have no knowledge of anyone using these tools		
30	Line manager		
31	N/A		
32	other SCN's in the unit		
33	manager/ team lead		
34	I don't know		
35	Band 7 and 8 managers		
36	Nursing staff collate the information over 2 weeks in Feb. This is run by improvement team and discussed with CNM		
37	Community staff including myself.		
38	Senior Charge NUrses		
39	cnm		
40	cnm		
41	Chief Nurse and Deputy		
42	All Charge nUrses		
43	It is run for all the HV staff		
44	No idea		
45	line manager		
46	Team manager and chief nurse		
47	I have run the workforce planning tools but it has never been explained to me that this was to plan staffing for my area.		
48	Services Manager		
49	N/A		
50	This is now being introduced our line managers did this in the past with our consultation		
51	i will. i have only recently come into post and will be using them soon.		
52	I am not aware of a robust tool applicable for communi9ty based services which I have responsibility for.		
53	Senior Charge Nurse		
54	school nursing team leaders		
55	We run it via the Community Nursing operational structure, supported by our workforce department		
56	There are no perioperative tools that work		
57	A caseload weighting method incorporating identification of areas of high deprivation is utilised by the Lead Health Visitors to estimate caseload sizes per whole time equivalent for each HV team.		
58	Senior management		
59	Elizabeth Wilson		
60	line manager		
61	NURSE MANAGER		

5. Who does run the workforce planning tools for your area/ward? Please comment below.		
	Response Percent	Response Total
	answered	61
	skipped	134

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6. Which of the workload planning tools do you use from the suite of 12 that are already developed? (select all that apply).				
			Response Percent	Response Total
1	Adult Inpatient		46.51%	60
2	Small Wards		13.18%	17
3	Neonatal		3.88%	5
4	SCAMPS (paediatric)		3.88%	5
5	Maternity		14.73%	19
6	Emergency Department & Emergency Medicine		4.65%	6
7	Mental Health		13.18%	17
8	Community Nursing		22.48%	29
9	Clinical Nurse Specialist (CNS)		6.20%	8
10	Community Children & Specialist Nurses (CCSN)		5.43%	7
11	Professional Judgement		54.26%	70
12	Quality		7.75%	10
			answered	129
			skipped	66

7. Thinking about the tools you use, are they run with the recommended frequency?						
	Always	Usually	Sometimes	Rarely	Never	Response Total
Adult Inpatient	17.2% (11)	35.9% (23)	28.1% (18)	10.9% (7)	7.8% (5)	64
Small Wards	15.0% (3)	25.0% (5)	40.0% (8)	10.0% (2)	10.0% (2)	20
Neonatal	57.1% (4)	14.3% (1)	0.0% (0)	0.0% (0)	28.6% (2)	7
SCAMPS (paediatric)	57.1% (4)	14.3% (1)	0.0% (0)	0.0% (0)	28.6% (2)	7
Maternity	47.4% (9)	31.6% (6)	10.5% (2)	5.3% (1)	5.3% (1)	19

7. Thinking about the tools you use, are they run with the recommended frequency?

	Always	Usually	Sometimes	Rarely	Never	Response Total
Emergency Department & Emergency Medicine	0.0% (0)	20.0% (2)	30.0% (3)	20.0% (2)	30.0% (3)	10
Mental Health	10.0% (2)	50.0% (10)	25.0% (5)	5.0% (1)	10.0% (2)	20
Community Nursing	25.0% (7)	25.0% (7)	14.3% (4)	25.0% (7)	10.7% (3)	28
Clinical Nurse Specialist (CNS)	0.0% (0)	27.3% (3)	18.2% (2)	18.2% (2)	36.4% (4)	11
Community Children & Specialist Nurses (CCSN)	33.3% (3)	33.3% (3)	0.0% (0)	11.1% (1)	22.2% (2)	9
Professional Judgement	28.8% (19)	27.3% (18)	27.3% (18)	15.2% (10)	1.5% (1)	66
Quality	25.0% (3)	16.7% (2)	8.3% (1)	16.7% (2)	33.3% (4)	12
					answered	125
					skipped	70

Comments: (36)

1	Has often been organisational led. Realise now SCN empowered to run tools more than minimum. Minimum not clear for many tools.
2	Since introduction of specific workforce team, tools are now being run more frequently. We aimed for 6 months before but were not always successful due to lack of training or awareness of importance. Have recently been run in May and will aim for a 6 months re-run. Sometimes used adhoc for support in short term workforce planning or options appraisal.
3	times have varied
4	Feel this is a paper exercise so management can say it has been completed
5	time consuming and do not give benefit to the ward more paper to complete
6	But they do not take account the staffing of my Minor injury unit from my ward staff establishment
7	on't know how often they should be run
8	I've said yes but I have no idea how often they should be run
9	They are run annually, but rates of completion of PJ tool and quality tool is low
10	CNS Tool newer and needs further understanding
11	We run these when we are looking at staff levels to ascertain if we are over staffed or not depending on our budget spend.
12	manager runs them when they want information usually once or twice a year
13	the information I have been given is that they are run yearly but this has been inconsistent
14	Not sure what recommended frequency is
15	only inpatient mental health tools in place- non for community- that is a gap
16	Annually . data collected for 2 week period is this the recommended frequency??? it is filled in daily for 2 week period at end of day
17	no clear guide to completing the tools. Safe care done by ward staff - again no clear guidance document available.

7. Thinking about the tools you use, are they run with the recommended frequency?

		Always	Usually	Sometimes	Rarely	Never	Response Total
18	I haven't yet used it in my new role of Health Visitor but used it in the past when in Community Children's Nursing						
19	Tool was piloted with staff and ran in October 2016. This has not been done annually.						
20	It depends on which tools is being used as to whether the PJ tool is used						
21	does this mean the 10 days? Then yes						
22	If its yearly then yes						
23	once a year to audit a snap shot of service						
24	I do not know						
25	Once or twice per year						
26	Every 3 months						
27	They run with the locally agreed frequencu of 3 X 4week block per annum						
28	Don't know what you mean by this question						
29	End up being rerun due to low participation						
30	unsure what the frequency should be						
31	They are used annually. Reports are written and shared. We have used the findings to revise skill mix and patient to nurse ratios on certain shifts.						
32	A decision was taken to wait until the problems with the tool had been ironed out before we ran it again						
33	Staff do not see the point as establishments are historical and are unlikely to change due to financial constraints. I am relatively new in post and would encourage regular, probably monthly use of the tools.						
34	We operate a calendar for the use of the tools but owing to the resource required for some tools (ED, community, perioperative) we are not always able to run as planned. The level of analysis and the process of triangulation with other quality measures and other staffing metrics is extremely time consuming and there is currently no resource to undertake these tasks.						
35	Senior Charge Nurse are encouraged to use frequently however there are specific times when the whole hospital run it at the same time						
36	use 3 times a year						

8. How long does it take to run the tool or tools you use?

			Response Percent	Response Total
1	less than 10 minutes (per tool)		6.25%	8
2	more than 10 but less than 30 minutes (per tool)		32.81%	42
3	more than 30 but less than an hour (per tool)		22.66%	29
4	more than an hour (per tool)		38.28%	49
			answered	128
			skipped	67

9. Do you feel that you have sufficient time to run and discuss the outcome of the tools?

		Response Percent	Response Total
1	Yes	25.00%	32
2	No	75.00%	96
		answered	128
		skipped	67

10. In the majority of cases, how would you describe the action taken as a result of running the tool?

		Response Percent	Response Total
1	Staff with the skills and competencies required are put in place to reflect the tools' results.	6.30%	8
2	Staff are put in place to reflect the tools' results, but not with the skills and competencies required	5.51%	7
3	If staff cannot be deployed, changes are made to services to allow continuation of safe staffing	4.72%	6
4	Attempts are made to fulfil the tools' results, but where no solution is possible no action is taken	17.32%	22
5	No action is taken	55.91%	71
6	Other (please specify):	10.24%	13
		answered	127
		skipped	68

Other (please specify): (13)

1	
2	feedback is variable depending on results of the tool.
3	This is my first experience of running the tools so I am waiting to see what action is taken.
4	As I am invloved in all the tools, any of the outcomes above may be applied depending on the tool
5	
6	It is difficult to use the data because of low completion rates of PJ and quality tool so incomplete information
7	New HVs are being trained to fill vacant posts
8	I don't know where the information goes or what action is taken or if we are collating the correct information
9	It depends on the tool, application of triangulation and sessed against the level of risk and organisation priorities
10	
11	I do not know the results, I do not know if it influences staffing, we have not seen an evaluation
12	national strategy to increase workforce

10. In the majority of cases, how would you describe the action taken as a result of running the tool?		Response Percent	Response Total
	13	Unsure: I complete the tool as clinical staff, managers deal with results	
Comments: (48)			
	1	Information is fed up the nursing structure but action is risk assessments and risk register inclusion for majority of previous tools. Recent results have supported contracts for agency staffing to support areas at very high risk.	
	2	High priority areas are discussed and where possible changes are made.	
	3	There is not clear action taken as a result of the tools from senior management. Within our unit structure they are always run every 6 months and always looked at and referred to and some changes made	
	4	spoken about at meeting that we are under establishment for our acuity but organisation doesn't seem to be able to recruit staff at present and there is no funding for the correct amount of staff required for optimum patient care and the safety of staff.	
	5	Outcome is not discussed with managers. Had to once attend a challenge meeting where no changes resulted People have different expectations of how many staff are required to manage workload	
	6	tools indicate the staff compliment is accurate but due to significant recruitment problems we cannot often meet the need hence reduc tion in number of beds	
	7	these tools do not benefit the actual ward working environment we have become a tick box over paper worked working establishment. we are further from the patient and family care needs the generated paper is done but not useful	
	8	the tools clearly demonstrate a deficit which is discussed with managers but finances restrict any implementation of the recommendations	
	9	The tool is only a single aspect of the triangulated approach so staffing and workforce alterations are not made in isolation with this. Consideration is given to local area and our compliance with quality indicators, national measures for MCQIC etc. The progessional judgement also gives insight but unfortunately does not capture skill mix clearly. Unregistered staff can be variable between band 2-4 and the tasks undertaken vary vastly on a shift by shift basis depending on level of unregistered staff on duty.	
	10	Didn't really understand Q7 There is a organisational policy re establishment setting which is good however local / area managers do not always work by / follow this and feel partnership representation / support to teams and professional leads is not as good as it could be in following through on process.	
	11	In my recent post I have run 3 workload tools all consistently show the same that we are short of staff - there has been no action whatsoever to fill these gaps	
	12	Results of tools go to Clinical Area Managers who alter the results using their professional Judgement. These managers however have never worked as a staff in these wards. Most alter them back to the traditional staffing numbers they have had in the past. Care has become much more demanding and complex and old traditional staffing does not work any more. Would be fairer to have more representatives to discuss results such as a member from Human resources, A working Band 5, a working band 3, Union representative and manager. Also the results could be based on a very unusual quiet or busy week.	
	13	The tool is completely useless for remote and rural community midwifery.	
	14	very time consuming to complete the tool and my area has never had a staffing uplift reflective of the tool.	
	15	Tools consistently show higher staffing levels required than budget provides for. Multiple business cases / escalations done with limited satisfactory outcome due to budget constraints.	
	16	I have not seen any actions come from the outcome of the tools as it normal shows that we are working with the correct numbers.	
	17	We have 20 staff 1wte, consistently the workload tool reflects the requirement for 25 staff 1wte, as does our annual bank usage. No action is ever taken regarding this, as a result it feels like a pointless exercise.	

10. In the majority of cases, how would you describe the action taken as a result of running the tool?

		Response Percent	Response Total
18	Action only taken when it shows reduction in staffing. We used meriden to assess the needs and there crap tool was taken as being a way of reducing staffing. The workload tool show we are under staffed int he community but NO ACTION taken. When saving identified in a useless piece of work which cost £50,000 by a private company this was seen as being more inportant than the national workforce tool		
19	Without the necessary training it is difficult to see how these tools are relevant and how they fit locally.		
20	Thus far when completing the tool we have had no feedback		
21	impossible to implement safe staffing levels at times due to lack of staff, workload pressures in other teams and sickness and holidays have to be factored in. Often it is mathematically impossible to cover teams safely and fairly		
22	Senior Managers currently using the Health Visiting weighting tool to determine staffing		
23	many new HVs are being trained to fill vacant post in order to undertake Universal pathway. we don't see results of the tool		
24	see above. Feels like another tick box exercise with no seen outcome.		
25	A lot of effort goes into completing the tools which adds to the daily workload and there is little or no feedback of the information gathered		
26	tool not sensitive to specialist areas - focused on dependency rather than acuity.		
27	We were not allowed to use professional judgement the last time the tool was used therefore the tool only reflects work done. The data is time consuming to collect unless you are mainly working within a clinic environment due to complexity of intervention e.g multiple calls to speak with GP. takes up to 30 mins a day to collect and insert data.		
28	I would agree there is scope for feedback to front line staff and improved transparency for patients/service users. I have mixed experience about the application of the tools and the outputs as such believe there is an inconsistent approach to managing the outputs I believe there is a heavy weighting on the tools outputs however this may not include full triangulation of quality and local context. The outputs can be a catalyst to service redesign however rarely the case		
29	never get any feedback. Staff frustrated as terrible tool then nothing in return		
30	nothing seems to happen- no more staff have appeared for the ever increasing patients . In a hospital setting when beds are full that it, not district nursing and we are getting more and more complex cases		
31	we have never had any feedback given the lack of planning I would be reserved about the quality of the results and would hope that there was great care in interpreting the findings before any major staffing upheaval happened		
32	The tools do not allow you to record all aspects of nursing demands such as the time that computer systems take to ensure that all mandatory admission documents and ongoing care plans are updated, far more complex medication rounds, as well as completing the general ward tasks that are priority to ensure that we pass environment inspections and are caring for our patients in a good, clean and safe environment.		
33	At no point have I seen a report		
34	There may be actions taken but unfortunately, it is felt that these are completed but with no consequence seen in overall staffing or suggestions of how to improve things. Also the inpatient tools / professional judgement do not reflect the actual ie there is nowhere to document what the actual staffing was, so for me it is not a true reflection of the pressure staff are under		
35	Following a significant piece of work throughout 2015, an uplift in staffing was achievedin 2016 in light of the evidence shown by the tools runs.		
36	Never receive feedback on results		
37	I never understand how they work, what the aim is and what we do with info, total waste of time as far as I can see		
38	Have never received any feedback on the information we provide via the tools.		

10. In the majority of cases, how would you describe the action taken as a result of running the tool?

		Response Percent	Response Total
39	Again don't understand your question We are asked to complete the NMWWP attached to our SSTS yearly using the professional judgement tool Don have any results so don't know what plans are put in place		
40	no feedback		
41	Tend to see very little action		
42	Action is taken at a local level to adjust skill mix within remit of NM and SCN However, to date no action has been taken when clear shortfalls to funded establishment have been identified and evidenced.		
43	Thus far, we haven't managed to achieve meaningful results to be shared with the teams and acted upon		
44	Persistent inability to source recruit and retain registered nursing staff		
45	Some of the tools do not provide a staffing establishment number The tools are then triangulated with other care quality measures and staffing metrics before prioritisation of the "gap" is determined by senior nurses. Running the tools does not result in additional funding to support the totality of the staffing requirements identified.		
46	don't recall any actions implemented following results I understand that these results are reviewed at board level and finances are maybe made available.		
47	Ive never had feed back from manager about results of the tool		
48	The tools are run but nothing further happens .		

11. Where, on a day to day basis, staffing levels do not match the results produced by the tools, how are any concerns raised or discussed?

			Response Percent	Response Total
1	They are raised with a more senior nurse		12.80%	16
2	They are raised with a more senior manager		26.40%	33
3	A huddle/team discussion takes place		20.00%	25
4	A formal report is submitted through the board		3.20%	4
5	There is no discussion.		26.40%	33
6	Other (please specify):		11.20%	14
			answered	125
			skipped	70

Other (please specify): (14)

1	New process this year will ensure discussion through professional route
2	raised to senior manager and taken to the team safety. Feedback to clinical area of contingency.
3	Mentioned to line managers many times but told to still put staff elswhere to aid their staff ing thus leaving ward short. Staff return next day saying the ward they went to did not need them but kept them.
4	All of the above
5	we do not know the results of the tools

11. Where, on a day to day basis, staffing levels do not match the results produced by the tools, how are any concerns raised or discussed?		Response Percent	Response Total
	6	reflected upon not raised! Number crunching excercise.	
	7	Not applicable to CNS tool	
	8	There is more than one option in the above list. Concerns maybe highlighted at huddles and safety briefs and escilated through senior nurses and managers. In some instances staffing concerns can be recorded on the DATIX risk system	
	9		
	10	The results should be analysed and should be fed back with an action plan	
	11	Upline through the management structure	
	12	I would have liked to tick the first three options and possibly the 4th moving forward	
	13	All of the above	
	14	day to day shortfalls will be discussed in the huddle and escalated to senior staff if no mitigation can be found	
Comments: (35)			
	1	Escalation from ward to Nurse Manager for Unit review of safety. Escalated at 0800, 1200 and 1600 safety briefs. Discussions take place with NMs and CNs throughout morning and into evening to make as safe a plan as possible. Outwith hours, staff can escalate to site and capacity with an oncall team able to help.	
	2	discussed after the tool has been completed at a unit meeting then not discussed again until the next run of the tool	
	3	Usualy everyone is in the same situation and the risk needs to be shared	
	4	twice daily huddles across the hospital site to review clinical needs, risks and staffing situation	
	5	nobody actually follows through with these tools staffing is by actual word of mouth and sensible in house sharing of the load managers have to ensure that the load of staff are shared within units	
	6	the results and rationale for recommendations is discussed with senior managers at one to one meetings and with managers at SCN meetings	
	7	We complete the tools for a two week period but our day to day working staffing levels are not determined by the results at that particular time. we submit our staffing levels three times through the day to line/site management, highlighting our safety level/concerns. Re-deployment is then discussed and actioned if an area is unsafe.	
	8	My ward has currently for the past year been working with unsafe staffing levels despite this being escalated leading to increased sickness absence due to work related stress in registered nurses	
	9	It is a pointless exercise which keeps midwives away form women.	
	10	All of the above	
	11	highlighted via SBAR to general management team and nursing manager	
	12	Twice daily hospital huddles and adhoc escalation to nurse manager as required outwith these times	
	13	They are raised but have not seen anything regarding these at board level	
	14	Mostly it would be the first 3 together dependant on who is available/around (no option to select more than 1)	
	15	Little ever happens to deal with issues, left to get on with it. Terrible stress and anxiety as a result. This can go on for weeks and months with no action.	
	16	As above. Not sure how to access results for my area	
	17	work with staff we have, team manager informed of staff shortages /absecnces/sick leave	

11. Where, on a day to day basis, staffing levels do not match the results produced by the tools, how are any concerns raised or discussed?

		Response Percent	Response Total
18	Daily staffing is collated in the routine huddles. As previously stated I don't understand the tools so unsure of the results.		
19	No feedback		
20	There are a number of different forms of escalating concerns however maybe inconsistent mechanisms and feedback when concerns are identified by front line clinical staff. There can be robust escalation processes however the feedback and status of actions maybe not filtered back to staff. Front line are less likely to aware of the application of the workforce tools and the implications for staffing for them		
21	also a huddle discussion		
22	We rob peter to pay paul. eg we take staff from other bases to try and cover the base that's short as there is no spare staff.		
23	I do not know I previously used an American GRASP evaluation on a ward situation, It took a long time, but yielded accurate information and was used to influence staffing and organisation. Something like this I felt was valid and relevant, and all staff could buy into the objectively sought results.		
24	Safety brief on ward so team are aware. Raised at site huddle so that CNM and site management aware and opportunity to advise if feel staffing is unsafe - as a hospital our site is very good at supporting each other as and when we can but the reality is we are all running short every single shift, every single day, every single week whether it be short or long term sickness, vacancies not filling, financial implications as budget simply does not stretch to cover the gaps. As a SCN I would never leave my ward unsafe and would always put a hold on management tasks to ensure that patients and staff members are supported and cared for. The job of a manager has also snowballed though and the reality is that the tasks expected of us are unrealistic, with systems that don't talk to each other.		
25	It is really hard for managers to feed back on this as it would appear to me that they are never given any extra resource to manage this. It is like screening for a cancer with no available treatment. if you identify a gap, there needs to be resources made available to address it. It would appear to me that there is not. Actions are to some extent outwith even health board control, this can only be addressed at the very highest level		
26	Team Leads maintain a close overview of staffing rotas. Attempts are made where possible to anticipate and proactively put solutions in place. Bases work with an embedded culture of cross cover.		
27	As above.		
28	I have not received any formal report		
29	daily discussions at safety huddle on staffing levels which are given at the meeting by bleep holders		
30	Thus far, we haven't managed to achieve meaningful results to be shared with the teams and acted upon		
31	The tools do not provide any evidence of the day to day staffing levels required, that is determined by the patient acuity in real time. NHS Lothian use an alternative tool (SAFECARE) to measure the requirement for nursing care based on a twice daily census of patient acuity compared with the required nursing hours for the patient group. Re Q11 because the tools do not operate in real time for day to day staffing requirements the tools do not play a part in the day to day deployment of available staffing. However if there needs to be redeployment of staffing based on SAFECARE then the site managers will facilitate this		
32	discuss with CSDM		
33	Very difficult with lack of funding		
34	Staffing level concerns are escalated at a variety of opportunities but routinely and very effectively at the Safety brief which take place 3 times a day 8am, 12pm and 4pm.		
35	Not used on a daily bases to allow any of the above actions		

12. Who has the authority to redeploy staff to reflect tool results?

		Response Percent	Response Total
1	Me	9.52%	12
2	It is a team decision	9.52%	12
3	My line manager	22.22%	28
4	Senior management (site)	25.40%	32
5	Senior management (remote)	12.70%	16
6	Don't know	20.63%	26
		answered	126
		skipped	69

13. Are the workload planning tools still fit for purpose?

		Response Percent	Response Total
1	Yes	31.67%	38
2	No	68.33%	82
		answered	120
		skipped	75

Comments: (66)

1	Unclear. Healthcare changed so much since tools launched/researched. AiP used in critical care through to community hospitals. Unclear how sensitive to patient needs. Practice changed with increasing complexities of nurse interventions. Acuity if patients changing. Unclear how issue of patient flow is captured within speciality tools as consumes significant staff time.
2	But with adjustments. Areas are coded incorrectly ie infectious diseases prof judgement tool aligned to GI as it is 'closest match'. Understanding of the team discussion required every 4hrs for Prof Judgement is certainly improving results which are more reflective of activity. Does not take into account (or provide guidance) time required for staff education (approx 85hrs per RN per year minimum) nor for audit or care assurance time.
3	Does not seem that action is taken
4	The EDEM one has caused problems as not worked properly on the SSTS platform and a lot of data lost
5	They are excellent for showing what we need staffing wise but when nothing is followed up and nothing to show for the results it becomes deflating.
6	if used correctly and people are honest about staffing required and appropriate actions taken
7	pointless exercise often used to fudge numbers when looking for funding do not help when areas are high risk due to patient acuity or unsafe staffing levels often wonder who looks at them
8	a subjective tool that is wrapped up as an accurate measure. we need to accept there is not a perfect way of measuring staff needs, they will fluctuate almost daily. a concern for tools is that due to the lack of robust evidence of them being accurate they can innacurately reflect needs due to the subjectivity.
9	PROFESSIONAL JUDGEMENT TIME STRUCTURE DOES NOT FIT WITH SHIFT PATTERNS SO SOME GEUSSWORK TALES PLACE . MENTAL HEALTH TOOL DOES NOT TELL YOU TIMES ALLOCATED TO EACH TASK THERFORE AN INTERACTION OF 5 MINS OR AN HOUR HAS THE SAME VALUE ATTACHED TO IT !!!!!

13. Are the workload planning tools still fit for purpose?

		Response Percent	Response Total
	THE TOOL ALSO DOES NOT ALLOW FOR MUCH OF THE THERAPIES LISTED TO BE COUNTED MORE THAN ONCE PER DAY ie A PATIENT CANT HAVE MORE THAN ONE THERAPUTIC INTERVENTION PER DAY - NONSENSE .		
10	Do not know		
11	i don't think they do as they are open to an individuals interpretation at the time ticking or fitting into boxes does not help. it has no place for all the background interruptions that take place such as phone calls family members interrupting staff spend more time with the paper trail than actual patient care		
12	Yes, how would a new tool change the actions required, when it is finance that limits action.		
13	Yes however they should be reviewed to ensure the changes in policy are reflected. Maternity tool needs to be adapted to incorporate the new Best Start project and the changing service delivery. Capturing peroperative work in the maternity field is a missed opportunity as this is a growing area and the pero-op tool may be more appropriate to assess workload rather than the maternity tool. Community tools need adapting but have common themes and could have a single underpinning framework with variance for midwifery, district nurse, health visiting etc. The tool data is not accurate within this tool as a 23hour period of cover equates to only 1WTE. The calculations and algorithms should be reviewed.		
14	As this is the first time I have used them, I am waiting to see what action comes from running them.		
15	The maternity tool fits well for the acute maternity hospital setting and busier CMUs but does not fit for small R&R teams covering vast geography, there is huge variation on what the activity part of the tool shows in comparison to PJ tool and although this is a triangulation process often managers focus on activity / pt numbers and don't consider wider context. Also does not fit with on call / OOHs models		
16	If the tools are run with good data in, then yes they are fit for purpose, the difficulty comes when running e.g. Community tool where we are reliant on many individuals to submit good data and sense checking input can be laborious.		
17	do not take into account time spent on caseload, child protection , paperwork etc		
18	The tools are only fit for purpose if the evidence provided is acted on which up until now has not been the case		
19	see other comments. They have never been fit for purpose for remote and rural locations.		
20	Not at all suitable for rural community working. Does not adequately account for travelling times when can sometimes be 4 hours to do one visit!		
21	Old and outdated		
22	No tool is built to reflect the requirements of a critical care area.		
23	In current climate, it does not feel like a productive exercise. Workforce tools may be helpful in identifying staffing requirements but unless resources are available to match outcome it seems a pointless exercise. Workforce tools are run over a 2 week period twice a year and I would question how that can accurately reflect staff requirements. Can data for 4 weeks out of 52 be considered an accurate representation when workload and staffing demands are so variable?		
24	In my view the mental health planning tool which we have to use does not accurately assess the workload or staffing needs within elderly mental health. The tool is very loaded towards behavioural support and therapeutic activity. It does not take into account the needs of patients with complex physical health needs. I also do not believe it fully reflects the administrative burden on nursing staff on an ongoing basis. I can see no reference nor means of recording training or other development activity, for example.		
25	they don't take into account the emergency admission coming through the door and the level of input necessary to assess patients, we need a specific tool developed for this speciality		
26	doesn't address workload of elderly mental health wards		

13. Are the workload planning tools still fit for purpose?

		Response Percent	Response Total
27	The community tool is very time consuming to complete - approx. 40 mins additional/day with additional time to then complete the PJ tool and quality tool. When staff are already stretched, it is difficult for them to prioritise completion of the tool which then leads to incomplete information which then makes it difficult to use the data submitted which them makes staff feel that completing the tools is not prioritised - a vicious cycle.		
28	Overall they do reflect the numbers of staff and dependency. Lack of action on them or poor interpretation is not a reflection on the tools themselves		
29	The adult inpatient / professional judgement tools including dependency assessment are still fit for purpose in the main. The CNS tool requires further development, engagement and training for all concerned.		
30	We collect accurate data but the way in which we need to input this does not reflect true workload/ clinical activity due to way it is designed. The tool implies that our workload/ clinical activity is less than it is.		
31	They do not reflect the work or take into consideration the complexity of the community nursing work		
32	The mental health and LD tool is to cumbersome and only reflects what you do and not what you should be doing. The tool does not reflect patient acuity and is of little use in specialist areas or areas with specific environmental constraints i.e. specialist areas like IPCU and forensic, small wards YPU and other specialist areas where there is not only environmental constraints there are Standard Operating Procedures that are not reflected in the tools.		
33	This is unknow, perhaps with the proper training and organisational understanding this would be effective and would be recognised as fit for purpose.		
34	No plan or escalation procedure in place to have any meaningful way of improving situation or having limit of minimum staff levels that cannot be breached for health and safety reasons		
35	Need to be aligned with weighting tool .		
36	not suitable for client group or extra / additional concerns with patients or staff workload.		
37	other reliable tools such as Safe Care in eRoster seem to capture issues in a simple/ staff friendly/ quick way		
38	Work load changes day to day, week to week, month to month. New births and child protection workload constantly changing, increasing or decreasing. tools do not reflect our workload it is only a snap shot , not everyone does it (as don't have time) and people are on holiday so those times no data recorded. the data cant capture an actual HV visit/client contact.		
39	I don't understand the tool and as there is no guidance I don't know if the data I am collating is correct. For Safecare the majority of my patients would be level 0, it doesn't feel like it reflects the challenges of caring for a ward of patients who are well on paper but demanding in reality or reflect the turnover of patients on a daily basis, including the stress of trying to discharge to promote admission of patients.		
40	No tool available for opd		
41	Tool is fairly accurate but pointless if there is no feedback		
42	not sensitive to vast differences in nursing need and does not account for regular use of higher level supervision patients, etc.		
43	Staff cannot be always be redeployed within CNS service as each CNS has their own caseload and there are not always staff available who are adequately trained to undertake role if there is long term absence,. this can cause particular difficulties where CNS have follow up, nurse led or chemotherapy prescribing clinics. As we were not allowed to use professional judgement the tool only shows what was done and not what the deficit is in providing care e.g being proactive rather than reactive.		
44	Yes these are an excellent starting point for assessing workforce requirements when using a triangulated approach. There is scope for more intuitive interactive workforce/workload assessment in real time with accessible feedback for all staff. Regular application of the workforce tools forms a pivotal part in a process when bring together all aspects of recourses management and offers and opportunity for all key stakeholders to be involved		

13. Are the workload planning tools still fit for purpose?

		Response Percent	Response Total
	I believe without the workload tools clinical areas would have been vulnerable to fiscal pressures and cash releasing efficiency savings. A trigulated approach to N&M workforce mitigates this risk		
45	Definitely not. Lots of work then when you input the wrong results come out due to it not meeting the needs of specific service e.g the time slots. You need to look at the individual services. Inaccurate results. Terrible tool		
46	Very time consuming and nothing changes if anything they are taking staff away and stretching the service as we now cover nights with the same amount of staff.		
47	The one we have used has been poorly implemented, it is open to too much interpretation, and the parameters within it do not enable an accurate reflection of our work and activity. It also did not take into any account staff mix, and therefore has failed to capture what really goes on. A more meaningful tool is required that really dissects tour job, its meaning, and looks at who does what and who is best placed to do things, right down to administration and telephone answering.		
48	No as per above.		
49	We use safe care, the categories do not match the dependency scoring on the workforce planning tool, takes longer to do and duplicates effort.		
50	It does not reflect the reality of what the situation actually is and what people have actually had. It is a professional judgement tool on what we require to safely staff an area. In reality many of us work under our minimum levels and the tool does not show this.		
51	up to a point, BUT, there has always been a feeling that they could be redesigned to better apply to Community Working than they do currently.		
52	If the results are not actioned it is a pointless exercise		
53	Provide snapshop of daily activities but do not include time spent training staff and supervision.		
54	They are not user friendly and very difficult to understand.		
55	Unsure of their worth & value.		
56	We have used the same tool every year and for my area it always indicates that I should have more nurses but have never had a review and my establishment has been the same for 6 years		
57	They don't reflect the complexity of care and the amount of coordination, planning, communication that is required aside from face to face care delivery to patient. Absolutely DON"T reflect the amount of documentation required.		
58	Some of the information can not always be recorded accurately		
59	far too complex		
60	The tools themselves are fit for purpose. What is not fit for purpose is the "what next" and level of accountability when the funded establishment does not compare to the required establishment. Additionally we do not know when the tools were last revised and whether the latest evidence, research and national guidelines which inform the tools are actually current to todays very different expanded nursing roles.		
61	In our experience they never have been. Staff who have multiple contracts weren't able to input their workload for both their posts, so it was difficult to interpret results and make decisions based on them.		
62	There are many things not captured in the tools. In particular the presence of cognitive impairment is not always adequately reflected in the outcomes. Day visitors to in-patient areas are also difficult to measure.		
63	New workforce tool being introduced		
64	The tools are based on aged data, in the majority of situations in adult acute the tools provide a lower staffing level than the current funded establishment. The tools do not provide a real time analysis of the staffing situation. The adult in patient tool is relatively easy to use but does not provide a staffing level that		

13. Are the workload planning tools still fit for purpose?			
		Response Percent	Response Total
	staff would recognise as appropriate. Some of the tools are extremely time consuming and could utilise data from other systems (eg the perioperative tool could use data from ORSOS , the ED tool could collect data in TRAK) rather than requiring nursing staff time to be spent completing data entry into a tool in a platform that is already recorded in the patient management systems. The community tool is extremely time consuming and provides only a description of how the different grades spend their time (at a very high level - direct care / indirect care / travel etc) and has not yet provided a funded establishment, a more appropriate tool for community nursing would be based on the caseload weighting, rather than the activity The mental health / learning disability tool is not applicable across all specialities in mental health / LD The amount of manual manipulation of the data after completion of the tools is overwhelming. The reporting functionality is dreadful.		
65	Currently there are toosl to reflect e.g. Neurosurgery I am not aware if the tools have been revalidated to reflect changes in treatments e.g hematology/oncology settings		
66	Does give the ideal overview of what the specialist nurses do.		

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14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels			
		Response Percent	Response Total
1	Open-Ended Question	100.00%	138
1	Using of Shelford score to articulate acuity. Will move to using SafeCare using Shelford in next 12 months		
2	RN to pt ratio Shelford		
3	Care Assurance Tool, Professional Judgement& Small Ward tools on SSTS, Pt Feedback(Care opinion), Person- centred project survey which obtains feedback from staff and patients, theses are used together to create a triangulated approach.		
4	Workforce planning meetings		
5	SANE template has been used. Ratios for RN to patient but this does not take into account acuity or dependence so not a very accurate reflection of areas.		
6	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf http://icmwk.com/wp-content/uploads/2014/02/nurse_staffing_in_critical_care_2009.pdf https://www.ficm.ac.uk/sites/default/files/gpics_ed.1.1_-_2016_-_final_with_covers.pdf		
7	Daily staffing meetings Escalation to Senior Manager Care Assurance Tools		
8	hospital safety huddle at 0800		
9	I'm aware of the nhs Lanarkshire complexity tool for community nursing, also aware of tools that are used in England which we sometimes use when no appropriate scottish tool available.		

14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels

		Response Percent	Response Total
10	Daily safety huddles		
11	nil, still waiting for a proper workforce evaluation after transfer from SPS to NHS in Oct 2011		
12	none		
13	shelford tool, noone looks at it		
14	AfPP guideloines		
15	None poor staffing levels, lost WTE last year even though I carried out work to justify my WTE		
16	Not aware of any (all kept at senior management meetings)		
17	none		
18	professional judgement tool		
19	We do not have any . We regularly work with low staffing levels and this is a long standing issue in nursing for many years		
20	Datix Shelford		
21	nothing specfic		
22	Datix if unsafe levels		
23	I work on my own.		
24	Anecdotal evidence. Caseload analysis Sickness / absence records		
25	NIL		
26	adapted tool from tay side and shelford		
27	Safety huddle		
28	funded establishment and current vacancy rate can identify potential areas of 'risk'.		
29	Best Start - mw to caseload ratios (for continuity of care and caseload holding model) RCM		
30	Clinical Quality indicators, MCQIC, staff surveys, patient surveys.		
31	Caseload management		
32	Daily number of visits clinics etc managed by manager on a daily bases		
33	I have used the RCN guidance on safe staffing levels and also NICE guidance		
34	Ward Staff generally know safe staffing Levels but line managers move staff to other areas regularly. Usually to areas with Chronic staffing problems. In the past Management looked in detail at such wards and aimed to assess what the problems were an finding solutions. All staff were questioned as were University for student comments about area, also Union reps. Then brainstorming and development groups were started to try and change cultures in area. This is not looked at these days and certain areas are always short staffed impacting other areas daily.		
35	Experience		
36	none		
37	effective creative rostering. if late sickness occurs there is little to no give in the system to cover safely and effectively. it is often "robbing Peter to pay Paul" Scrutiny of request for agency staff as a LAST resort is so high that it is rarely covered. Wards can work short as there are sometimes no safe way to safe a gap.		

14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels

		Response Percent	Response Total
38	None		
39	Risk Assessments in the ward environment, lone working, remote and rural, and the complexity of the patients, pregnant staff		
40	None		
41	Daily safety huddle CNM daily walk round presence of senior charge nurse and page holders		
42	We are fire fighting on a daily basis and do not have the time to be proactive		
43	Use the triangulation process which includes the local context, professional judgement and appropraite quality indicators		
44	National guidelines for critical care areas.		
45	At the Hospital morning huddles all staffing issues raised and management endeavour to do their best to ensure safe staffing levles		
46	Shelford Tool has been introduced to look a patient dependency but it is not popular among staff as it does not truly represent patient need.		
47	Huddles, regular contact with CNM		
48	none		
49	Environment, patient numbers and patients dependency.		
50	Testing out the 'Lanarkshire' tool on complexity/dependency to compare the results with those obtained from the community workload tool		
51	RCN Safe Staffing Levels		
52	Audits / Hefs		
53	Risk Assessments		
54	Triangulation of data - including activity in ward / eg daycases which are not accounted for properly in the tools; use of supplementary staffing; incidents / adverse events / complaints / staff absence information / quality measures of patient care		
55	We look at safe staffing as well as the numbers of falls.		
56	Safety briefs Huddles Situation report Equalisation meetings Contingency meetings Recruitment		
57	Meridian tool which has no details. This company has a very poor reputation within community and the teams which have used it. No staff would trust the workload tool they produced. did not help us		
58	??		
59	intranet sign guidelines		
60	Safe care		
61	Daily email staffing numbers from each ward to highlight areas of pressure and adjust staffing accordingly within the unit		
62	Measuring workload over time, skill mix and pragmatic approaches such as having staff in areas where they can work at several different levels. This ensures that staff are utilised effectively and a range of skills used.		

14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels

		Response Percent	Response Total
63	None. There is a safe care system attached to erostering but community nursing can not use it. We urgently need a tool to ensure safe staffing.		
64	workload planning tool for each base which is meant to be reviewed yearly. They never change to adequately reflect increase in demand from patients, complexity of work and increased time spent completing paperwork other no patient related duties		
65	Safe Care		
66	Local communication regarding workload and monitoring via a number of quantitative and qualitative data sources eg caseload numbers, child protection reports, wellbeing concern referrals.		
67	N/A		
68	not aware of any ? Trak recording UP data Filling in "scorecards" for managers recording CPCCs, Hearings , core group, child planning meetings		
69	When I came into post the levels were already set		
70	BSG/EAG WORKING GROUP		
71	Community Nurse data sheets used for Community Nursing by NHS Shetland		
72	Not sure		
73	None		
74	e-Rostering tool, allowing staff to see shifts and staff available.		
75	N/A		
76	BACCN guidance		
77	I don't know of any		
78	Not very aware but have taken part several times on the daily workload feedback tool when we have been given specific dates to keep accurate record of activity and insert information broken down into face to face contacts/client , admin and record keeping times		
79	There are no methodologies to ensure safe staffing levels. We have weekly planning meetings to discuss this but they don't always happen - due to staff shortages! When shortages are identified, we can request help from another team or from the nurse bank but if that is not available, we have no alternative but to work with low/unsafe staffing levels.		
80	Unit page holder to ensure all areas are safely staffed and report to duty manager		
81	None but incident repirting shoukd be used more often when staffing levels are low.		
82	none		
83	None.		
84	Wider quality measures i.e. Scottish Patient Safety Programme indicators and measures, local complaints, adverse incidents, supplementary staffing use, staff surveys, well being, absence rates, rostering practise, student feedback, staff turnover rates, patient opinion, leadership walk rounds, safety brief/pause, local escalations process etc etc		
85	there are no other workforce tool therefore stuck with one that is not fit for purpose and never get any feedback from		
86	Health & Safety		
87	Not aware of any- we are e-rosters		
88	Weighting tool developed to ensure staffing appropriate to support full implementation of Universal Pathway.		
89	none		

14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels

		Response Percent	Response Total
90	GRASP (which is ancient, but worked)		
91	e-roster- which is not user friendly. workforce tools on SSTS platform; again not fit for purpose. Professional judgement. Neuroscience Nurse Group - have a paper which advises about nurse workforce in neuro wards.		
92	safecare		
93	not aware of any other than basic caseload weighting /population data		
94	none		
95	Not aware of any others		
96	Safe care		
97	safe care but this is also too difficult to assess acuity as categories are inconsistently applied from ward to ward		
98	We take the view that safe staffing is a fluid situation give the ever increasing demands made on staff so the T/L's and myself meet regularly with this as a standing agenda item. Similarly with my upline meetings, peer meetings, and professional heads of service meetings. It is aslo a standing item on the Midwives Area monthly Forum. I feel that in my organisation / service, this is regarded as a front and centre issue. Evidence Sources include; various monthly data collection sources, the Maternity Dashboard monthly data, CQI's, measuring performance against national targets. Data collection around numbers of Antenatal Plans/ CCF's, social deprivation indicators. These and others all help to indicate requirements in relation to staffing levels.		
99	The SG workforce planning tool for Health Visiting		
100	healthroster		
101	Historical staffing		
102	Co ordination of annual leave to ensure safe staff levels.		
103	none		
104	No idea		
105	safe care-again no one looks at results discussions with finance hdu allocation so we know we need 1 nurse for every 2 hdu patients plus nurse in charge		
106	health roster		
107	Safe care has recently been introduced with health roster to help ensure safe staffing levels but I don't feel that it is being used effectively.		
108	Safecare		
109	recently implemented safe-care as part of e-rostering system, but feel little worth doing this as unsure who sees/actions results.		
110	Three times daily Site Huddles. SafeCare		
111	N/A		
112	We have looked at the Liaison services audits to compare like.		
113	Experience in looking after frail ill patients		
114	Discussions on varying pressures in different departments discussed at safety huddle		
115	nil		

14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels

		Response Percent	Response Total
116	Eroster Safecare Empower workforce planning tool		
117	not aware of any		
118	I am aware that a triangulation approach is used looking at quality factors to ensure a robust estimate of safe staffing levels.		
119	daily morning huddle, mid morning huddle, equalisation		
120	eroster although still not that good		
121	Datix		
122	None		
123	We are investigating other tools that we could use, that are used in other Boards in Scotland top support the triangulation of the data, in addition to the professional judgement tools. We do use DATX our online reporting system, complaints and learning fro incidents. Plus professional feedback information form our service. Information re caseloads and vacancy and skill mix helps inform the decisions we make around safe staffing.		
124	Association for Perioperative Practitioners guidelines Professional judgement		
125	Skill Mix calculations Sick Leave Maternity leave Bank request & availability		
126	Professional judgement		
127	Shelford - only as a tool to discuss "acuity"		
128	Six Steps Work in progress with Vision Community Module which will eventually enable us to extract data & reports to influence safe staffing levels		
129	What we have is eked out to make the safest possible care in the highest risk areas.		
130	NHS G Nursing & Midwifery (NM) Governance framework (May 2018). The framework essentially describes an explanation of the process for all NHS G workforce together with the draft NHS G N&M annual workforce assessment template which provides the proposed reporting format. You will see this originates from NHS Lanarkshire.		
131	Safe Care is a system linked to our eRostering system that makes an assessment of the patient acuity against the available staffing in real time (based on the Shelford tools) Staffing Datix - reports / escalation of concerns Staffing / Workforce dashboards - establishment gap, supplementary staffing , absence data Workforce Plans		
132	Safecare LIve		
133	safe care live		
134	Safe care live		
135	They have a safe staffing tool		
136	I work independently of the ward and see patients in hospital, at clinics and at Surgical out-patient follow ups on the ward		

14. Please list other methodologies or evidence sources you use or are aware of that are used in your workplace to ensure safe staffing levels

		Response Percent	Response Total
137	Staff feedback Patient feedback Review of datixs for adverse incidents e.g. falls, drug errors, pressure sores, emergency calls such a clinical emergency or violence and aggression Number of complaints Care Assurance Tool -(specific to NHS Grampian) a measurement to determine the quality of nursing care given		
138	none		
		answered	138
		skipped	57

15. Is there anything further you would like to add about the workforce planning tools currently in use?

		Response Percent	Response Total
1	Open-Ended Question	100.00%	112
1	Occupancy- when should it be recorded? Services have day attendees to some ward's- how can they be captured. Day of Surgery, OPS, Dialysis units, day case units not captured with speciality tool yet this a direction of travel for services. How has single rooms and increased footprint impacted validity of tools?		
2	They are not sensitive to the complexities of providing the right level of patient care, by the right person at the right time.		
3	The dependency tool is very difficult to use given the often rapidly changing condition of patients within the acute sector. There are definitely variances in how the dependency is applied to each patient which could likely be overcome by further education or awareness and a consistency of application within each team. Shelford is challenging to use as it does not fit well with some categories of patients and does not take into account time required for PPE, RN transferring patients to and from procedures etc. I'm not sure if there is an easy answer.		
4	The small ward tool (we have 16 physical beds) does not reliably capture the dynamic nature of Intensive Care, nor does it fully cater to the dependency of certain patients - e.g. patients going to scan or theatre, patients on ECMO or other situations where there is requirement for an increase, albeit short-lived, in nursing resource required in the delivery of that patients care. The tool does not capture the fact that on a quieter day, we may have used any spare nursing resource to staff other clinical areas - as happens frequently.		
5	I generally they are good and helpful to have as long as applied correctly and used as part of triangulated approach to reviewing establishments.		
6	No tool developed or useful for the prison service needs other that professional judgement (others don't fit or adapt to give an outcome)		
7	It would be great to see positive results (more staff)		
8	Would be useful if used correcly and any actions could be seen to happen as a result of the outcome.		
9	They are more suited to secondary care, some of the settings are not relevant in community, and even the timing of the shifts is wrong		
10	If they are used then I never see them. As a senior clinician (Band 7) I am not involved in workforce planning, much to my chagrin. I can predict need better than most as I'm actually at the coal face with my team however, these decisions continue to be taken at a senior level without consultation. I'm now of the opinion that cost is seen as the primary difficulty and that people cannot think out of the box.		

15. Is there anything further you would like to add about the workforce planning tools currently in use?

		Response Percent	Response Total
11	very cumbersome, time consuming and do not reflect requirements shift times not in line with shifts actually worked professional judgement is very subjective		
12	paper exercise		
13	we are becoming too obsessed with evidencing something that can be intuitive and, at times, blatantly obvious - perhjaps we need to allow services freedom to identify the staffing needs?		
14	Very time consuming for all staff to complete. No clear paperwork to record time / duties completed throughout the day		
15	I SEE NO VALUE IN THEM AS THEY ARE AT PRESENT , ESPECIALY THE MENTAL HEALTH TOOL.		
16	there is too much emphasis on audits etc yet patients do not seem to benefit from actual time with staff and the staff themselves feel under great pressure and are of low moral in nursing as a profession not good for a workforce		
17	Yes I think we have to be mindful of our frail elderly . 30 years ago I nursed old people who were 75 , I now nurse very frail 95 year olds who often require much greater input and often from 2 members of staff not just one. The workload has also increased - audit requirements and action plans are very time consuming But meaningless if there is no time to do them properly due to workload pressures . I regularly work at least 45 hours a week to try to keep abreast of the workload in my 37.5 hour post		
18	that the tool is an excellent opportunity to capture the workforce and workload however investment in 'shop floor' education is essential as the message to senior management and CNNs is often not filtered fully. The results need to be fedback to the clinical staff and its up to departments how to do this but maybe some benchmarking would be useful as a performance indicator.		
19	We are using them however staff complain they are time consuming and regularly want updates on how to use - concern that not all Health Board areas are using in consistent way and is down to local interpretation. Welcome review of tool with regard to fit for purpose R&R setting , more training in use to ensure standard / consistency and robust monitoring and reporting systems which Boards must adhere to		
20	not fit for purpose		
21	Results are not always available in a timely manner		
22	The workforce planning tools are only useful if they are acted on. I am demoralised due to the amount of work that goes into these plans and then both myself and my staff see no action taken. We are increasingly expected to work short and our ward in particular for the last year has been running 3 wte trained nurses down on the staffing without the added staff the workforce tool says we need.		
23	Have not worked for years and have been manipulated by single line managers in offices. Perhaps a larger group of working staff should assess results.		
24	General tools not fit for emergency departments where workload is unpredictable		
25	No		
26	The current workforce tools appear not to be fit for purpose in the Community or for small wards of 15 or less, the staff find the tools onerous and take time away from direct patient care. They also feel that they are carrying this out on a yearly basis with no benefit when year on year the tools demonstrate the requirement of more Community staff /resources required to deliver patient centred safe effective care and support the shift of balance of care in the Community. I t would be helpful if we could have robust tools or legislation that stipulate a minimum staffing level to provide safe care both for the patient's and staff.		
27	Long and laborious to complete and no one acts on them		
28	Paper exercise as wards continue to be short and no increase in numbers. I have been a charge nurse for over ten years and have been competing them over this time.. The		

15. Is there anything further you would like to add about the workforce planning tools currently in use?

		Response Percent	Response Total
	funded establishment has never increased despite clearly showing the need for increased nursing staff on night duty. This then becomes an additional cost thorough extra hours, bank or overtime. This is not cost effective nor does it provide quality or continuity of care.		
29	The length of time it takes to input the information is too great which detracts from the benefits which may be available to us.		
30	General consensus around the country is that need to develop interfaces, electronic data collection tools and other electronic devices to reduce the data burden in clinical time		
31	Do not think that they are effective Waste of time and resources		
32	SSTS and Health Roster should be used to populate a weekly staffing report for the SCN. This could be used by the SCN to produce a very brief summary / report that explains any risks that have occurred that week as a result of skill mix vs patient dependency. No risks - no action. Risks identified - SCN describes actions / control measures / escalation plan.		
33	I do not feel the mental health tool is fit for purpose within elderly mental health.		
34	as previous		
35	We have used the Hefs to highlight health inequalities and to support the need for our service. Unfortunately we are a small team with a large geographical area so there is little chance of getting more staff but out team lead on many occasions has highlighted the benefits of increasing the workforce.		
36	These provide useful evidence to inform assessments and planning of staffing levels however without legislation and budgets to support they have limited impact.		
37	Our workload tool is done over a 2 week period yearly and usually done during a period of the year which doesn't tend to be as busy. I don't think this reflects the workload/ staffing levels accurately.		
38	Meridian tool which has no details. This company has a very poor reputation within community and the teams which have used it. No staff would trust the workload tool they produced. did not help us Need more interactive system that can be used on portable devices		
39	Not working		
40	Not compatible for community services		
41	The MHLD tool is outdated and not fit for purpose more specialist tools need to be developed for mental health and LD settings as having a tool that is not fit for purpose means triangulation is not possible or accurate and the addition of a out dated tool only muddies the waters when it comes to effective, therapeutic and safe staffing.		
42	It would be interesting to know how other areas are doing and how often changes are made to staffing in relation to tthe results of the tools nationally.		
43	They are not fit for purpose, there is not feedback and they are so time consuming that few people have the time to complete them. The last one that was run had a very low return rate.		
44	They appear to be a paper exercise in showing adequate staff are employed, in reality they do not reflect in any way the actual staff requirements the community nurses require to maintain high quality nursing care to patient, maintain effective health and safety and create and environment for staff of unimaginable stress and anxiety week to week, month to month which never changes and depletes morale within the nursing group		
45	Allocation of staff determined by weighting tool, vacancies and priorities across the city. May be more appropriate when fully staffed and allocating work in the bases		
46	not suitable do not reflect actual need of ward		
47	Find the current tools quite subjective and quite cumbersome to complete.		
48	No		

15. Is there anything further you would like to add about the workforce planning tools currently in use?

		Response Percent	Response Total
49	It is time consuming and cumbersome. usually have to complete it at end of day and get off late. I do not think it can accurately reflect our workload. I feel I am wasting my time completing it. Most years I have been on annual leave for one of the weeks it runs.		
50	Mental health tool does not capture the activity on the ward accurately. Eg only allows 1 x 1-1 interaction or inability to capture time/type of deescalation		
51	guidance on how to use them. Education sessions.		
52	.		
53	Workload planning tools take a long time to complete, no training given on how to complete them so variations by different people inputting similar information. The workload tool does not reflect the heavy workload of Community Nurses as it only looks at direct face-to-face patient contact and does not seem to take into account travelling time in a remote and rural location and administrative duties regarding patient care for example.		
54	I haven't yet used it within my new role		
55	No		
56	no		
57	N/A		
58	Need tools for specialist areas		
59	Our staffing levels are very low, so I'm assuming whatever is used is not working		
60	No		
61	The tools currently in use are extremely time-consuming to complete and, as we have not had training, very confusing. When we are already under pressure caused by low staffing, we don't have time to complete the tool. Additionally, there are many activities which happen during the day which are not written down/ logged, so it is extremely difficult to record our workload accurately		
62	The information is collated , but I have not gained any staffing levels as a result		
63	A total waste of time and effort as no changes made year to year to reflect them. Very time consuming. I belueve there are better ways in capturing tgat infprmation that coukd be incorporated into your everyday workload planning.		
64	more focus on action at funding levels. At present aware of shortfalls throughout but not within budget.		
65	I am delighted to be part of the team which will be working to review, develop, adapt and facilitate roll out of tools across Scotland. The development of the tools and supporting education materials has built up a wealth of intelligence as such essential in bringing this forward into refreshing and adapting tools. There is an opportunity to consider what tools are available, build on the similarities/transferability and where possible reduce variation/ confusion		
66	change it please.		
67	The work force planning tool is a general one and does not really take into account the enormous amount of admin / detective work we do to find out about patients, conditions why they were referred etc. Refering to social work ,marie curie, chasing doctors,prescription etc		
68	We have been running for years now and practitioners and managers do not appear to get any feedback that is used in operational management. If the information was of use it would be discussed at management meetings - this has never happened!		
69	I think we need more training on the workload tools. I think we need to complete them more frequently to get an accurate picture of our service.		
70	The information that is generated need to be in the same "unit", with e-roster some is in hours, some in %. It is much easier to use wte or hours from the budget statement		

15. Is there anything further you would like to add about the workforce planning tools currently in use?

		Response Percent	Response Total
71	They have felt like a tick box exercise for a number of years now, it would be nice to see some action as a result and recognition that the demands on nursing staff are far higher than the numbers employed to work.		
72	have found them labour intensive for minimal effective data output ,has not had added value . not well organised		
73	it appears to be time heavy for nurses who are already working over capacity . also when completed data out to inform us is variable ,not considered actively by mangers [not discussed with workforce] Thus its usefulness is hard to see at clinical interface . The most useful knowledge /methodology is Common sense ,this for active nurses in clinical area is tacit ,effective and dynamic . Nurses should be able to have their workbased knowledge directly received ,and some qualitative .		
74	No		
75	Its irrelevant- what we need to safe staff and the resources available to meet this demand are grossly different, even if the finance was available the staff required aren't.		
76	the workload tools need to consistently apply patient dependency as an essential part and should be considered not just as part of a snap shot in one day. The categories need to be easy and simple to apply so that they can easily reflect acuity. This would be more meaningful. There appears to be a focus on overall bed numbers to the detriment of dependency and acuity		
77	the current tools are time consuming, lengthy and do not reflect what is required to safely and effectively staff a ward. You need to have a more user friendly tool, simple and succinct and then you would have greater compliance with completion.		
78	Most staff find them onerous and don't fully complete them because they take up precious time that they don't have as they are already busy. So not accurate		
79	Not suitable for all clinical areas		
80	No		
81	Not fit for purpose and too time consuming for SCN's.		
82	Appears to make little difference to staffing levels - simply causes time constraints to complete the survey.		
83	need better planning, management, fairness, quality of tool, explanation!		
84	unaware of what is in use		
85	Would be beneficial to get feedback on what data has been collected and fed back to staff so not completing a tool with no feedback.		
86	I have run the tools many times over the last few years and I am not sure exactly why. Nothing ever changes. In my opinion we have not been completing them correctly as when asked to do this recently the information on what we should be doing was completely different. I have not had any real training on using the tools and have followed the guidance given to me by others.		
87	Waste of time.		
88	workforce plan tool not fit for prpose		
89	Onerous. Time consuming. Very difficult to navigate. No outcome or feedback		
90	N/A		
91	This will be new to me therefore to early to comment. I get the feeling that it will be a really useful tool but there is no money to further resource our service.		
92	Unless we gat feed back on what we have submitted it seems a pointless exercise It is also a very difficult process to manoeuvre round		
93	Extremely time consuming to use, several hours to input data for 2 week data collection for every patient being assessed in the department over 24hour period, emergency tool also requested medical staffing levels which I am unable to complete as not responsible for medical staffing.		

15. Is there anything further you would like to add about the workforce planning tools currently in use?

		Response Percent	Response Total
94	difficult to use in the community setting. Staff diary manage so if levels are poor work load reduces and priorities change		
95	Please include some front line staff on planned usage/changes. Managers don't understand teh realities of service delivery in community nursing		
96	no		
97	In community settings fluctuations in complexity are difficult to predict. It is essential that this is taken into consideration when attempting determine safe staffing levels.		
98	No comment		
99	unsure of how to effectively complete and no one else seems to be either		
100	The results will vary greatly depending on what time of the school year we are asked to run the tool		
101	Staff find the uploading of data cumbersome		
102	In Community we do have an issue that we don't have in Grampian a system the nurses or health visitors can use to document their workload, from a patient or a scheduling perspective. The issues of an electronic record has been spoken about for years but has never materialised. We do have a project to introduce the vision 360, however this is not a quick fix as it doesn't have reporting built into the first phase of the work. Ideally we would have a system that works for the nurses to manage their workload, and it would then automatically populate a data base where the information required re ISD and for performance management would then happen automatically. This is proving complex to progress quickly. We also have difficulty getting agreement for finance for hardware. We are also working much more integrated with our social work colleagues and would require to have some shared documentation and reporting systems in the future. The GP's want us to document in their electronic records and we are committed to having the vision 36o that would make sure we are working with them in terms of the importance of continuity and safe communication both fro an adult and a children's services perspective.		
103	I need a perioperative tool that is fit for purpose		
104	As we move forward towards legislating safe staffing levels I would welcome clearer guidelines from Scottish Government that supports parity of nurse staffing levels regardless of the area of the country. For example in a specialist wards such as neuro or trauma or general surgery or oncology what is a safe patient to RN ratio for that specific speciality? The resources should then follow. It is my opinion that the current funding model disadvantages patients and staff that work in health boards which receive a lower per capita funding that higher funded health boards.		
105	It's very disappointing that we haven't felt able to run the tool as don't have confidence that it produces meaningful data. Would be very happy to do so if the problems that we've fed back could be sorted out.		
106	Costing of supplementary staff is repeatedly raised as a challenge as it should be . However in the absence of staff to recruit this is one of a number of options		
107	There is no functionality to model staffing scenarios The majority of the tools are not user friendly		
108	no		
109	Sorry my input is limited in this as my role is more strategic with over arching support with educational/policy implimentation.		
110	no		
111	There needs to be a formal process after the tool has been used to mitigate risk if an area is understaffed.		
112	very time consuming on top of daily workload.		
		answered	112
		skipped	83