Health and Care (Staffing)(Scotland) Bill. Nursing and Midwifery Workforce and Workload Planning Tools

Summary of staff survey responses

The Scottish Parliament Information Centre has been informed that the tools have not been evaluated or significantly modified since they were created. A survey was distributed to nursing and midwifery staff at various levels who are responsible for using or completing the workforce planning tools.

195 responses were received from staff working in eight of the fourteen territorial health boards. Most of the staff (128) who responded are those who have responsibility for running the tools on an annual or more frequent basis. Respondents were able to skip any questions that they could not answer or did not wish to answer.

The survey sought to discover how consistently the tools are used, what training is provided, whether they are deemed fit for purpose, whether they are run at the recommended frequency, how long they take to run, what action was taken as a result of running the tools and how concerns might be raised. It also asked what other means and methods were used to ensure safe staffing levels.

The questions varied between single answers to rating questions and multiple choice, with most having the opportunity to add comments. A general question at the end asked for any further observations on the workforce planning tools in use currently.

Responses were received from a wide range of nursing and midwifery staff working in a range of settings and working in a wide variety of roles: senior charge nurses, nurse and midwifery team leaders, community nurses in mental health, older mental health, learning disability, clinical nurse managers, theatre nursing, chief nurse, workforce planning co-ordinator, district nursing, health visiting, associate director, school nursing etc. However most were received from senior charge nurses, who are those most frequently running the tools.

A full report of all written responses is available to accompany this summary

List of nursing and midwifery workforce planning tools in use

1. Adult Inpatients
2. Small Wards
3. Neonatal
4. SCMPS (paediatric)
5. Maternity
6. Emergency Department & Emergency Medicine
7. Mental Health
8. Community Nursing (CNS)
9. Clinical Nurse Specialists
10. Community Children & Specialist Nurses (CCSN)
11. Professional Judgement
12. Quality

Training in how to use the nursing and midwifery workforce tools

Respondents were asked, as an open-ended question when they had last received training on how to use the tools.125 respondents answered and the responses were very varied.

36 of the respondents received training in 2018

30 received training over a year ago

38 had never received any formalised training.

Several people reported that the only training they received had been computer/online based and there was no face to face support available to ensure correct usage.

Some of the comments made under this question were:

- *'only received brief verbal training from a colleague when new in post'*

- *'never – just told to follow instructions'*

- *'Each year as a refresher before we complete it'*

- *'Approximately 2014'*

- '*too rushed'*

- *'half hour session which did not meet the needs of what was required. Did not fit the purpose of the service'*

- *'have never received training'*

- *'a few weeks ago*

- *'original session some years ago but regular refresher sessions available for staff to access. Can also request ad-hoc advice and support when required'*
- *'not specific training but discussion via workforce planning meetings'*

Which tools do you use?

129 people answered this question and most (60) used the 'adult inpatient' tool. However, we had responses that covered each of the tools, with a minimum of five people responding for each tool.

Tools run with the recommended frequency?

Respondents were then asked about whether the tools were run with the recommended frequency. Again, 125 of the 195 answered the question.

They could answer 'Always, Usually, Sometimes, Rarely, Never'. The answers however, ranged across all columns for most of the tools listed. This suggests that respondents weren't wholly clear on the recommended frequency. This assumption is made because of the comments made, responses to other questions, and some of the submissions received which suggest that the information from running the tools is fed up from staff to management, via the software platform used, but that most staff running the tools are not engaged in the subsequent analysis and discussion – ie the full triangulation process. This is reinforced by the responses on the training question: if staff have not been properly trained in their use, they will not be aware of either the full purpose of the tools, nor how frequently they should be run.

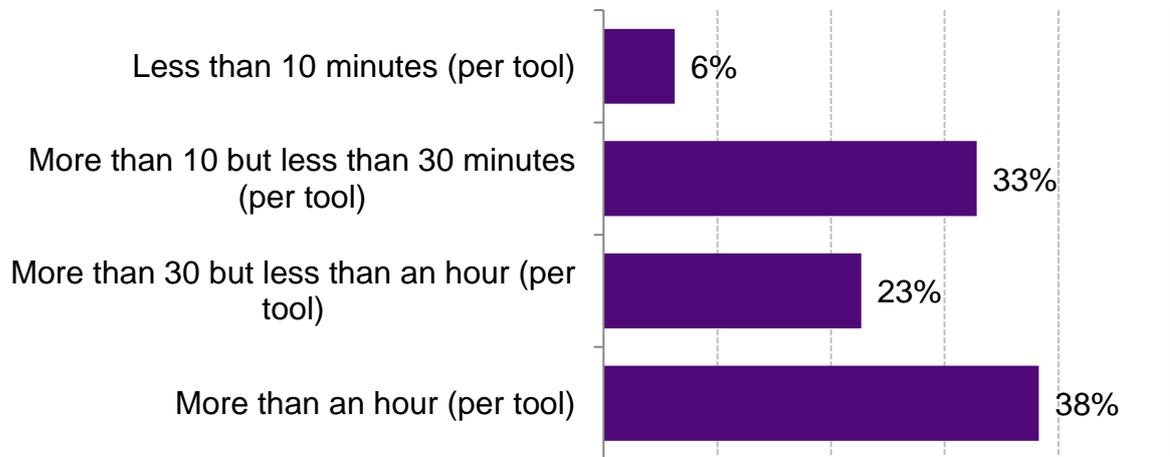**Comments were also invited under this question, and 36 were provided:**

- *'Has often been organisation led. Realise now SCN empowered to run tools more than minimum. Minimum not clear for many tools.'*
- *'Don't know how often they should be run'*
- *'the information I have been given is that they are run yearly but this has been in consistent'*
- *'A decision was taken to wait until the problems with the tool had been ironed out'*
- *'Once a year to audit a snap shot of service'*
- *'Annually, data collected for 2 week period. Is this the recommended frequency???'*
- *'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.'

Length of time taken to run the tools

In most cases (except the neonatal and paediatric tools), the tools are run daily for a fortnight annually or biannually. People were asked how long it took to complete the exercise each time they run the tool over that specified time.
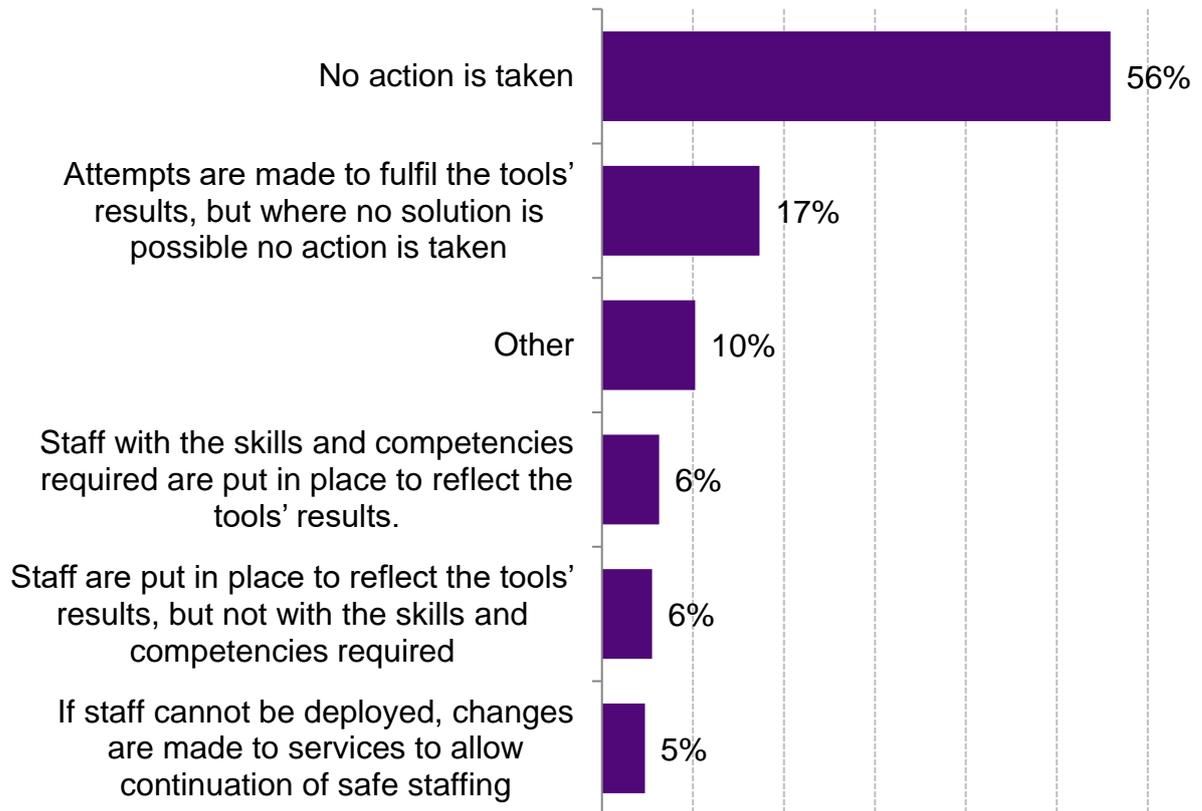
The table below shows the results of this question:

Category	Percentage
Less than 10 minutes (per tool)	6%
More than 10 but less than 30 minutes (per tool)	33%
More than 30 but less than an hour (per tool)	23%
More than an hour (per tool)	38%

The following question asked if they had sufficient time to run the tools properly. 75% (96) of the 128 who answered, said they did not have time.

Action taken as a result of running the tools

It should be remembered that the tools are not designed to provide data to inform the day to day staffing requirements, but to assist in decisions on staff establishments for nursing settings and wards.

No action is taken	56%
Attempts are made to fulfil the tools' results, but where no solution is possible no action is taken	17%
Other	10%
Staff with the skills and competencies required are put in place to reflect the tools' results.	6%
Staff are put in place to reflect the tools' results, but not with the skills and competencies required	6%
If staff cannot be deployed, changes are made to services to allow continuation of safe staffing	5%

Respondents were asked about the action taken as a result of running the tools. They were given a range of answers relating to staff deployment and service design to fulfil the tool outcomes, with an option for 'no action taken' and 'other'.

127 people answered this and 71 (56%) said that no action was taken and a further 22 said that attempts were made, but if there was no solution, then no action was taken.

48 respondents chose to make comments to amplify their choice of answer.

Some of the comments made under this question were:

- *'Recent results have supported contract for agency staffing to support areas at very high risk.'*

- *'High priority areas are discussed and where possible changes are made.'*

- *'Tools consistently show higher staffing levels required than budget provides for. Multiple business cases/escalations done with limited satisfactory outcome due to budget constraints.'*

- *'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'*

- *'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.'

- *'tool not sensitive to specialist areas – focused on dependency rather than acuity.'[1]*

- *'there is no clear action taken as a result of the tools from senior management'*

- *'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'*

- *'We have 20 staff wte[2], consistently the workload tool reflects the requirement for 25 wte, as does our annual bank usage. No action is ever take regarding this, as a result it feels like a pointless exercise'*

- *Action is taken at a local level to adjust skill mix within remit of Nurse Manager and Senior Charge Nurse. However, to date no action has been taken when clear shortfalls to funded establishment have been identified and evidenced.'*

- *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.*

How are concerns raised about staffing levels?

The next question asked how concerns were raised. This focused on day to day staffing levels.

A list of options was given, such as 'with a more senior nurse', or 'a formal report is submitted through the board, or 'team discussion', 'no discussion' with 'other' as an option. Again, further comment was invited. 33 said that there was no discussion and 49 said that concerns were raised with a senior manager or nurse

125 responded to this question and 35 made further comment.

- *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*

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[1] This distinction has some significance. Each tool has a 'dependency' rating for each patient. This grades capacity of the patient to manage to feed themselves or to go to the toilet themselves for example. It does not cover the 'acuity' of each patient – the technical nursing tasks that are increasingly involved with each patient.
Further explanation was given in a later response: *'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 (Personal Protection Equipment), RN(Registered Nurses) transferring patients to and from procedures etc. I'm not sure if there is an easy answer.'*

[2] Whole Time Equivalent

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.

- *Usually everyone is in the same situation and the risk needs to be shared*

- *twice daily huddles across the hospital site to review clinical needs, risks and staffing situation*

- *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.*

- *work with staff we have, team manager informed of staff shortages /absences/sick leave*

- *Team leads maintain a close overview of staffing rotas. Attempts are made where possible to anticipate and proactively put solutions in place*

- *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*

- *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*

- *'because the tools do not operate in real time for day to day staffing requirements, the tools to not play a part in day to day deployments of available staffing. However, if there needs to be redeployment of staffing based on SAFECARE then the site managers will facilitate this'*

- *'there can be robust escalation process however the feedback and status of actions may not be fed back to staff'*

Other tools and methods used to ensure safe staffing

This question recognised that the Nursing and Midwifery Workforce and Workload Planning tools were distinct from many other means used in health settings to risk assess and plan staffing in real time, on a day to day basis. 138 people answered this question, providing information on a wide range of other methods that were used by staff and management to ensure that their ward or area had adequate staff of the right skill mix. 10 mentioned Safe Care explicitly, five referred to Datix, which is the electronic incident reporting system used in NHS Scotland, 10 referred to 'safety huddles', 4 referred to risk assessments, 8 use Shelford tool a 'safer nursing tool', 17 said 'none' were used, others listed a number of methods used together, some said that some form of rostering was the main means used, including locally devised means, such as the 'care assurance tool', others mentioned national guidelines and programmes such as the Scottish Patient Safety Programme.

Are the tools still fit for purpose?

People were asked if they felt that the tools were still fit for purpose (they were developed between 2004 –2012 but were reviewed for a number of years after that.

68.3% (72) said no, they did not believe that they were fit for purpose.

There were 66 comments provided in response to explain why they had agreed or not. Some respondents made general observations and some were explicit about problems with specific tools.

- *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 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(Emergency Department) tool could collect data in TRAK[3]) 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 (learning disability)

   The amount of manual manipulation of the data after completion of the tools is overwhelming.

   The reporting functionality is dreadful.

- *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.*

- *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*

- *do not take into account time spent on caseload, child protection, paperwork etc*

- *They have never been fit for purpose for remote and rural locations.*

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[3] Electronic Patient Record system

- *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!*

- *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.*

- *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*

- *No tool available for opd (outpatient department)*

- *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.

- *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.

- *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 today's very different expanded nursing roles.

Comments on specific tools

- *'capturing peri-operative work in the maternity field is a missed opportunity as this is a growing area and the peri-op tool may be more appropriate to assess workload rather than the maternity tool'*

- *The maternity tool fits well for the acute maternity hospital setting and busier CMU [Community Midwife Unit], but does not fit for small Remote & Rural teams covering vast geography. There is a huge variation on what the activity part of the tools shows in comparison to PJ tools and although this is a triangulation process often managers focus on activity/pt numbers and don't consider the wider context'*

- *'in my view the mental health planning tool which we have to use does not accurately assess the workload or staffing needs with elderly mental health. The tool is very loaded towards behavioural support and therapeutic activity. It does not take in to 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'*

- *'The mental health and LD tool is too 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 with specific environmental constraints…'*

- *'the tool is completely useless for remote and rural community midwifery'*

- *'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 23-hour period of cover equates to only 1WTE. The calculations and algorithms should be reviewed'.*

- *'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 then makes staff feel that completing the tools is not prioritised – a vicious cycle'*

- *'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 a caseload weighting rather than the activity'*

- *'Not at all suitable for rural community working. Does not adequately account for travelling times when can sometime be 4 hours to do one visit!'*

Subjective nature of the tools

- They are of use *'if used correctly and people are honest about staffing required and appropriate actions taken'.*

- *'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 inaccurately reflect needs due to the subjectivity'.*

- *'I don't think they do as they are open to an individual's interpretation…'*

- *'if the tools are run with good data in them, 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'*

Tools are acceptable with further amendment

- *'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'.*

- *'up to a point but there has always been a feeling that they could be redesigned to better apply to community working than they currently do'*

- *I am not aware if the tools have been revalidated to reflect changes in treatments eg. Haemotology/oncology settings.*

Any further comments?

Finally, respondents were asked if there was anything further, not covered in the questions that they would like to add to their response. 112 people took the opportunity to add further comment. The comments were very varied and it is difficult to produce a representative sample here from so many differing views that were expressed.

There is a **full survey report** to accompany this summary, providing *all* the written answers and charts. The only information removed has been the first question, identifying the health boards, because there were small numbers answering from some. (The responses are numbered in order but will not equate to the same individual each time because of non-responses. A response numbered 14, for example, for one question will not match a response numbered 14 in another question. It will not be the same respondent.)

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