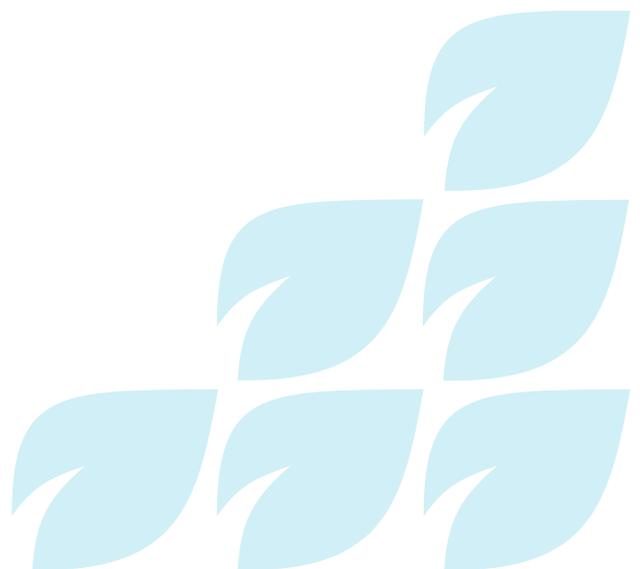

Safe Staffing Safe Workload Guidance



Contents

Executive Summary	1
Introduction	2
1. Aim	3
2. Objectives	3
3. Limitations	3
Overview of Current Dietetic Practice (within the NHS).....	3
Definitions.....	4
1. Caseload	4
2. Workload	4
3. Dietetic Activities	4
4. Patient Contact	6
5. Workload Safety.....	6
Workload Statistics.....	7
1. Dietetic Activities	7
2. Dietetic Activities and Pay Band	8
3. Workforce Perceptions of Safety	8
4. Dietetic Activities and Safety	9
5. Safety Concerns	10
Caseload Statistics	11
1. Patient Contacts	11
2. New to Follow-up Ratios	12
Making Decisions on Staffing – Guiding Principles.....	13
Triangulating Methods for Assessing Safe Workload and Staffing in Dietetics.....	14
1. Capacity	15
2. Capability.....	16
3. Safety Indicators	17
Members of Working Group	18
References.....	18

Executive Summary

Staffing levels in the NHS are recognised as a key indicator for patient safety having been under the spotlight as the nation has learnt from previous failings outlined in key government reports. Work is underway by NHS Improvement to standardise the collection of data around AHP staffing levels but at present there is little information around exactly what constitutes safe staffing in dietetics. This guidance was therefore commissioned to provide qualitative and quantitative information to help address staffing level concerns in dietetic services across the UK, both within and externally to the NHS setting.

A dietetic workload is now defined by six categories. On average across all settings and bands (within the NHS), a dietitian spends 72% of their work time in patient focused activities either communicating directly with the patient (or their representative) or doing all associated patient related activities – this is called ‘care contact time’. Self-focused, Service focused, Staff focused and ‘other’ activities make up the remaining 28%. Banding level has a large impact as to how an individual’s work time is divided across these six categories. This guidance recommends that the average percentage of work time allocated to care contact time should not exceed 75% as this has been shown to be the level where clinicians are likely to feel safe when practicing. For the average band 5 dietitian (who would generally spend less time on service focused activity) a figure of up to 85% is likely to be acceptable. For band 7 and 8 staff, up to 65% and 40% respectively is likely to be safe. This guidance also recommends that the safe mean number of patient contacts (new and follow up) per whole time equivalent (averaged across all pay bands and across all specialties) per week is likely to be 36 in the acute setting and 22 in the community. (Or, if averaging out over a year and allowing for 20% absence, 29 and 18 contacts respectively)

Whilst the numbers presented within this document are useful for benchmarking, they only provide part of the picture when considering safe staffing levels. This document recommends that within dietetic services, triangulation methods are used to take into account not just benchmarking figures on activities and capacity but also considerations of staff capability and also the safety indicators outlined herein. Using a combination of information sources enables a more reliable calculation of safe workload and safe staffing to support decision making. The accompanying toolkit and sister document ‘Workload Management’ provide further guidance for managing such decisions and there are also signposts to the BDA Influencing Action Pack¹ resources to help ‘make the case’ when increased staffing needs are identified.

Introduction

This guidance document is focused on the issue of safe workload and safe staffing levels in dietetics. It comes at a time when, at local through to national level, NHS staffing is under scrutiny both internally and externally of the NHS.

The enquiry² into the Mid-Staffordshire NHS Foundation Trust and the subsequent high profile reports including that by Bruce Keogh³ highlighted the risk to patients of not having the right staff, with the right skills at the right time. This led to the 2013 National Quality Board (NQB) guidance⁴ which set out expectations of commissioners and providers when managing local decisions around staffing to keep patients safe. The National Institute for Clinical Excellence (NICE)⁵, NHS England and the Care Quality Commission (CQC)⁶ have all subsequently published guidance for trusts to support ward nurse staffing decisions. Whilst the initial NQB3 work was also mainly focused on nursing and midwifery, new NQB guidance recognises that staffing principles ring true across allied health professionals and subsequently there is more inclusion of the multi-professional workforce in the 2016 document Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time⁷.

In 2016, there are just short of 9000 HCPC registered dietitians each with a professional duty to provide high quality, safe and effective care. Within the NHS, provider boards are accountable for ensuring their organisations have the right culture, leadership and skills in place for safe, sustainable and productive staffing. In any healthcare provider service, there should be frameworks in place that incorporate a systematic approach to reporting and investigating safety incidents, including considering staff capacity and capability and act on issues identified. Within such frameworks, dietetic staff at all levels have a role in contributing to safe, effective responsive staffing levels. Dietetic managers and team leaders should nurture a culture that is supportive of peers including junior staff who raise concerns about workload or suboptimal staffing levels.

This guidance is part of a suite of documents to support dietitians and dietetic support workers to work through safe workload and safe staffing challenges in a holistic and pragmatic way. The suite of documents draws together insight from a survey carried out in 2015 of almost 20% of the NHS dietetic workforce as well as expertise from managers and clinicians from across the UK. The suite provides figures and statistics as well as practical tools that are applicable to the whole profession whether employed by the NHS or elsewhere. Whilst the methodology behind creating this document concentrated on the NHS dietetic workforce, many of the findings and recommendations are applicable across the profession.

Suite of Documents:

- *Safe Staffing Safe Workload Guidance 2016*
- *2015 Safe Staffing Safe Workload Project Report*
- *Safe Staffing Safe Workload Toolkit*
- *Workload Management (Updated 2016)*
- *FAQs*

1. Aim

The purpose of this document is to:

- Provide data and resources that can inform and support decision making on safe levels of staffing and activity within dietetic services for BDA members, managers of organisations and commissioners.

2. Objectives

This document intends to:

- Report on average workload activities of the dietetic workforce in the NHS.
- Ascertain the average number of patient contacts per whole time equivalent of the NHS dietetic workforce.
- Identify any variations between workload activities and number of patient contacts between different workplace settings (acute or community) or pay band.
- Provide an understanding of any staffing or workload safety concerns of the dietetic workforce.
- Describe how capacity, capability and safety indicators need to be considered alongside each other when calculating staffing needs.
- Signpost to BDA and other supporting resources.

3. Limitations

The methodology, findings and conclusions of the BDA commissioned project were designed to be inclusive of as many NHS employed BDA members as possible. As such, care must be taken when applying the information herein to specialist areas. Obtaining data that is explicit to a specialty would enable guidance to be tailored accordingly. Resources to take this forward are included in the toolkit and it is hoped that BDA Specialists Groups will build on the work herein.

Overview of Current Dietetic Practice (within the NHS)

Dietetic work is undertaken in a wide variety of NHS settings. The majority of patient focused work can be grouped under the following categories:

- Acute:** Hospital wards and outpatient clinics.
Community: Community clinics, care homes, hospices and patient's own homes, day care services or schools.
Mental Health Services: A combination of settings, where work is carried out for a mental health trust.

Whilst many dietetic posts are either acute, community or mental health, some dietetic staff work in a combination of acute and community settings often within the same week, or even day. Dietitians are also employed in other NHS settings such as those employed by clinical commissioning groups for work in medicines management or those in public health roles or even catering and procurement; the latter may have a more strategic approach rather than holding a clinical caseload.

It is only relatively recently that those external to the profession have recognised non-patient focused activities (other dietetic activities) as an integral part of a dietetic workload. Activities such as training and supporting others to deliver nutritional care have previously been overlooked when it comes to considering workload. Service focused, staff focused and self-focused activities must be considered key elements and be given appropriate emphasis when reviewing or developing posts and services.

Many dietetic one-to-one consultations take place in the efficient environment of wards or clinics. However, in the community, care is often provided in the patient's home or other settings, which can involve significant time travelling for the dietitian or support worker (an example of unproductive time). The current political climate has seen a drive towards more care being delivered in primary care to reduce admissions to hospital. Time spent travelling reduces the overall clinical time available to a dietitian. This will be an important factor to consider when comparing the workload of those who work in the acute setting and those who work in the community

At present, group education sessions are also a common way of delivering care to dietetic patients. This format of caregiving enables advice to be given to more than one patient with the same dietetic diagnosis at the same time. Initially, just a few specialties moved towards group education sessions for conditions such as diabetes and coeliac condition. However, group sessions have evaluated well and are now much more widely available across a variety of specialist fields.

Definitions

It is important to clarify the difference between workload and caseload before addressing safe workload. The elements of an individual's workload are defined below as dietetic activities. It is not enough to describe the work of a dietitian only in terms of clinical work. Depending on the pay banding and job role of a dietitian, non-clinical work elements can often be equal to or even greater than the clinical caseload.

1. Caseload

A caseload can be defined as the number of cases for which 1.0 WTE dietitian is carrying responsibility at any one point in time. It will include all cases which have been assessed and are under treatment/review, have not yet been discharged and for which the dietitian has a duty of care. In many situations there will also be a potential caseload which includes the population of patients for whom the dietitian carries some degree of monitoring/review responsibility in terms of identification of problems and providing input if required, but who are not being treated at the current time. Caseload can be expressed as a number of patients or care episodes, or hours of dietetic time to manage the patient population.

2. Workload

A professional workload is that work which can be dealt with/undertaken by 1.0 WTE dietitian. In total it comprises a variety of dietetic activities which together constitute the professional dietetic role. In most cases it will include work inherent in a defined clinical situation or caseload.

3. Dietetic Activities

Discussions with the NHS Benchmarking Network⁸ were held during the development of the following standardised definitions of dietetic activities. The following definitions have also been aligned to the terminology used in NHS England's document Safer Staffing: A Guide to Care Contact Time⁹. Of these dietetic activities carried out by the dietetic workforce, all are important in ensuring a high quality service.

Dietetic Activities (see pie chart 1.)

Patient focused activity (care contact time)		Other dietetic activity			All other time
Direct patient contact	Indirect patient activity	Self focused activity	Staff focused activity	Service focused activity	(Unproductive time)
<p>Any intervention or group of interventions that relates to a specific person's clinical care provided by the dietetics service.</p> <p>This includes direct contact with a patient or their representative – usually face-to-face and including all the associated activities such as note writing etc. Contact method includes face-to-face, telephone, email, skype.</p>	<p>Time spent in all other patient focused activities that do not involve direct communication with the patient or their representative.</p> <p>This includes MDT meetings, case conferences, telephone conversations or emails with other care professionals and all other patient related documentation.</p>	<p>Activities for own CPD e.g. practice supervision, 1:1 and appraisal meetings, mandatory training, own training, journal clubs. This includes training both internal and external to the employer organisation.</p>	<p>Activities to support and develop other staff e.g. to develop and provide resources or training for dietetic staff and students and to other health care professionals. Includes leading personal development reviews and supervision and feedback as required. Also included is recruitment and induction of staff.</p>	<p>Team and departmental meetings, clinical governance (including audit), service development, clinical research, service and staff management duties, non-patient related administration.</p>	<p>Travel, waiting times e.g. for colleagues, IT failure.</p>

4. Patient Contact

In a most simplistic theory based definition, a direct patient contact is a contact between a healthcare professional and a patient including proxy contact which is between a healthcare professional and another person on behalf of a patient, e.g. parent, carer.

In practice, a patient contact may be defined as the package of dietetic care for a patient per session or appointment which would include all relevant aspects of care contact time associated for that patient per session. This session may be one to one or in a group. The length of time expected for a patient contact needs to be sufficient to allow for data collection, assessment, treatment, liaison with relevant health care professionals and documentation. A patient contact may also be categorised as an initial contact (the first contact between a patient and the dietetic service) or a follow-up contact (all subsequent contacts for that same referral).

5. Workload Safety

Assessing when practice moves from safe to unsafe is a complex subjective process with multiple factors to consider. Under the HCPC Standards of Proficiency, dietitians are required by law to manage their own workload and resources and practice safely and effectively. They have a duty as HCPC registrants under the Standards of Conduct Performance and Ethics to manage risk and report concerns about safety.

The following aspects are key components of such an assessment and are explored in more depth in the 2016 BDA document Workload Management¹⁰.

1. benchmarking
2. practice supervision
3. good practice
4. job description/contract of employment
5. risk assessment.

Reference to workload safety in the remainder of this document is based on the perceptions of individual clinicians rather than verified entities that have been assessed based on the components above. Nonetheless there is significant value in clinician concerns that can be indicative of a system failure with potential impact on patient safety.

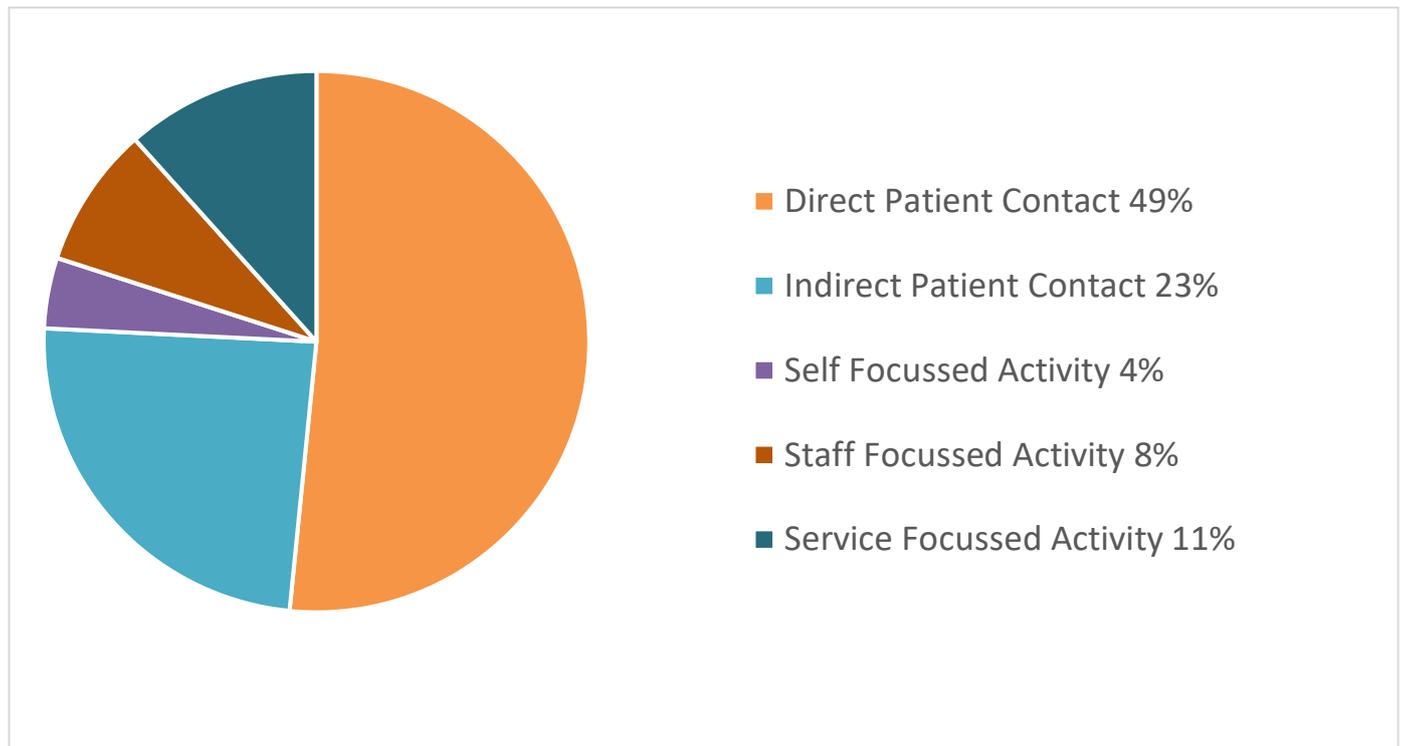
Whilst this document reports on workload activities and perceptions of safety, its sister document Workload Management¹⁰ provides direction on how to address the problem of a workload that has been assessed as unsafe and provides guidance on protecting the staff member from having to manage an unsafe caseload. To this end the Workload Management guidance provides advice from a professional, ethical, as well as employment relation standpoint.

Workload Statistics*

*Based on data from BDA commissioned project 2015

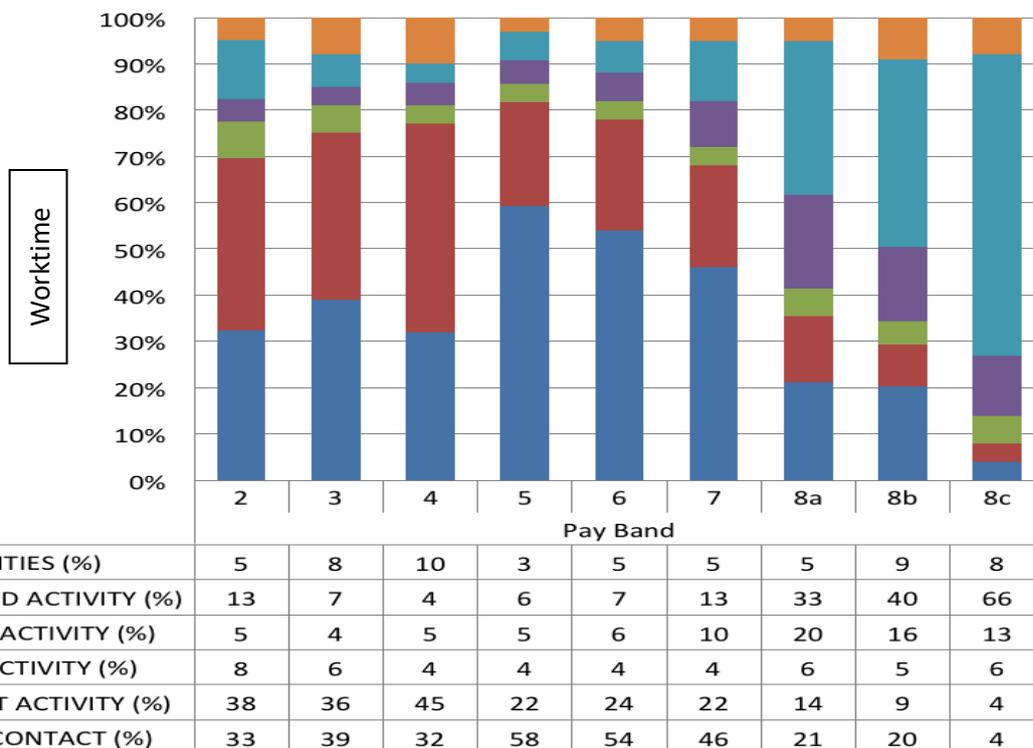
1. Dietetic Activities

Overall, on average, dietitians spend 72% of their time carrying out patient focused activities or 'care contact time'. This leaves 28% of work time for other activities. This is across all settings, adult and paediatric work and across all pay bands.



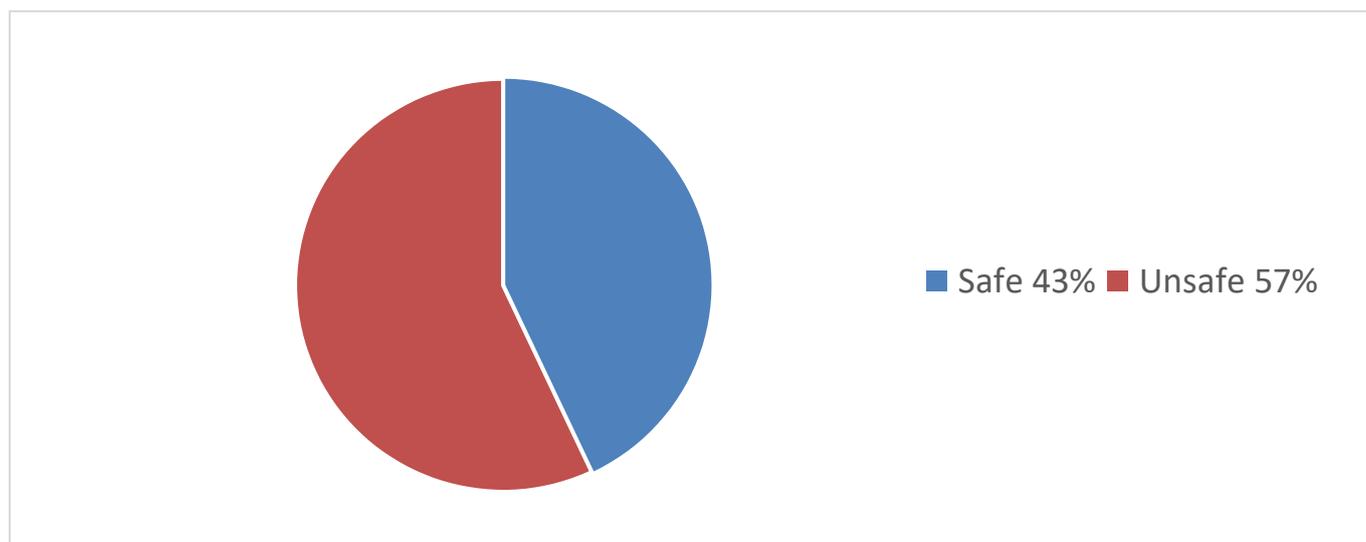
2. Dietetic Activities and Pay Band

Work time spent in patient focused activities (or 'care contact time') increases as banding progresses for unqualified dietetic staff and peaks at band 5 (the entry level for newly qualified dietitians). A band 5 dietitian can expect to spend 80% of their working week carrying out patient focused activities. As banding increases through the qualified grades, 'care contact time' reduces significantly, this is in favour of service focused activities (with many of those employed in band 8 roles having very little 'hands on capacity' with patients).



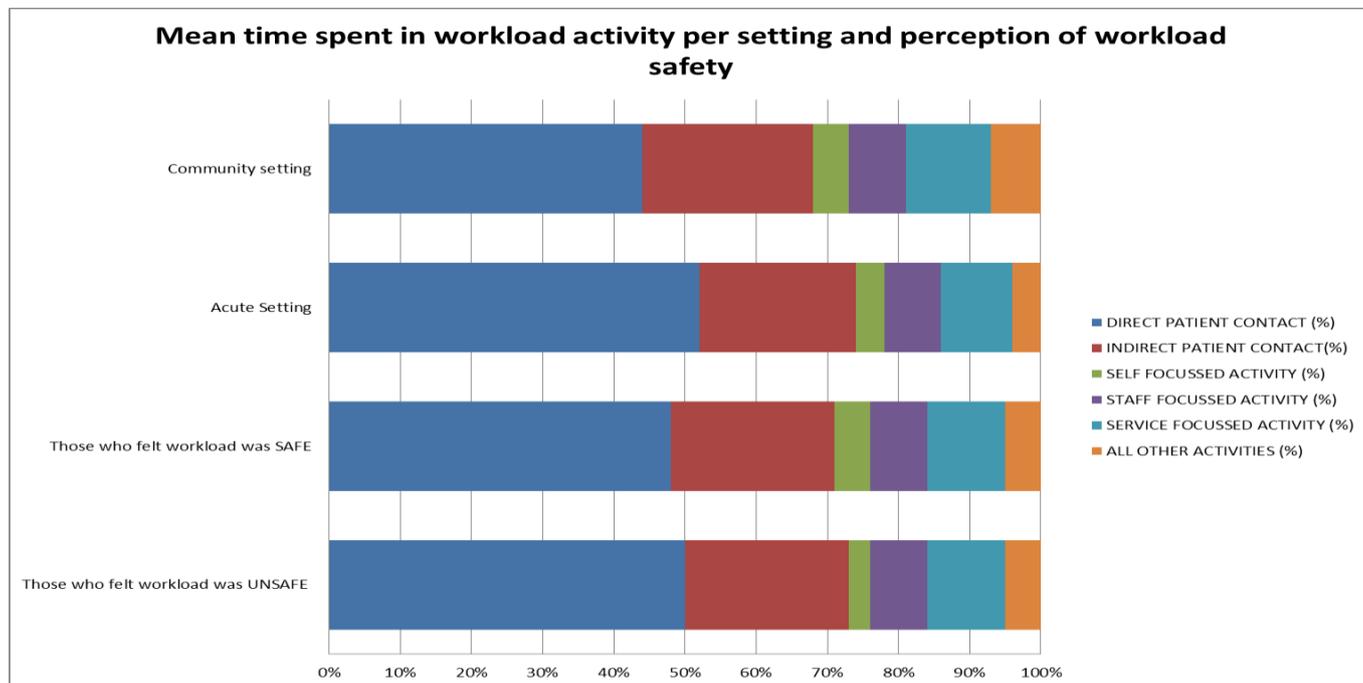
3. Workforce Perceptions of Safety

57% of the NHS dietetic workforce feel their caseload is safe but of these, 60% work over and above their contracted hours (overtime). Of the 43% of dietitians and support workers who feel their workload was unsafe, 9 out of 10 work over and above their contracted hours, with only 3 out of these 9 being paid for the additional hours. The main reason for working additional hours was cited as carrying out indirect patient activities.



4. Dietetic Activities and Safety

In the acute setting, care contact time takes up a higher percentage of the working week of a dietitian compared to the community setting where more time is spent on service focused and other activities. Overall, there is little difference in the percentage of time spent in patient related activities between clinicians who feel that their workload is safe and those who feel their workload is unsafe. However, the percentage of work time spent on self-focused activity was noticeably lower amongst those who felt their workload was unsafe.



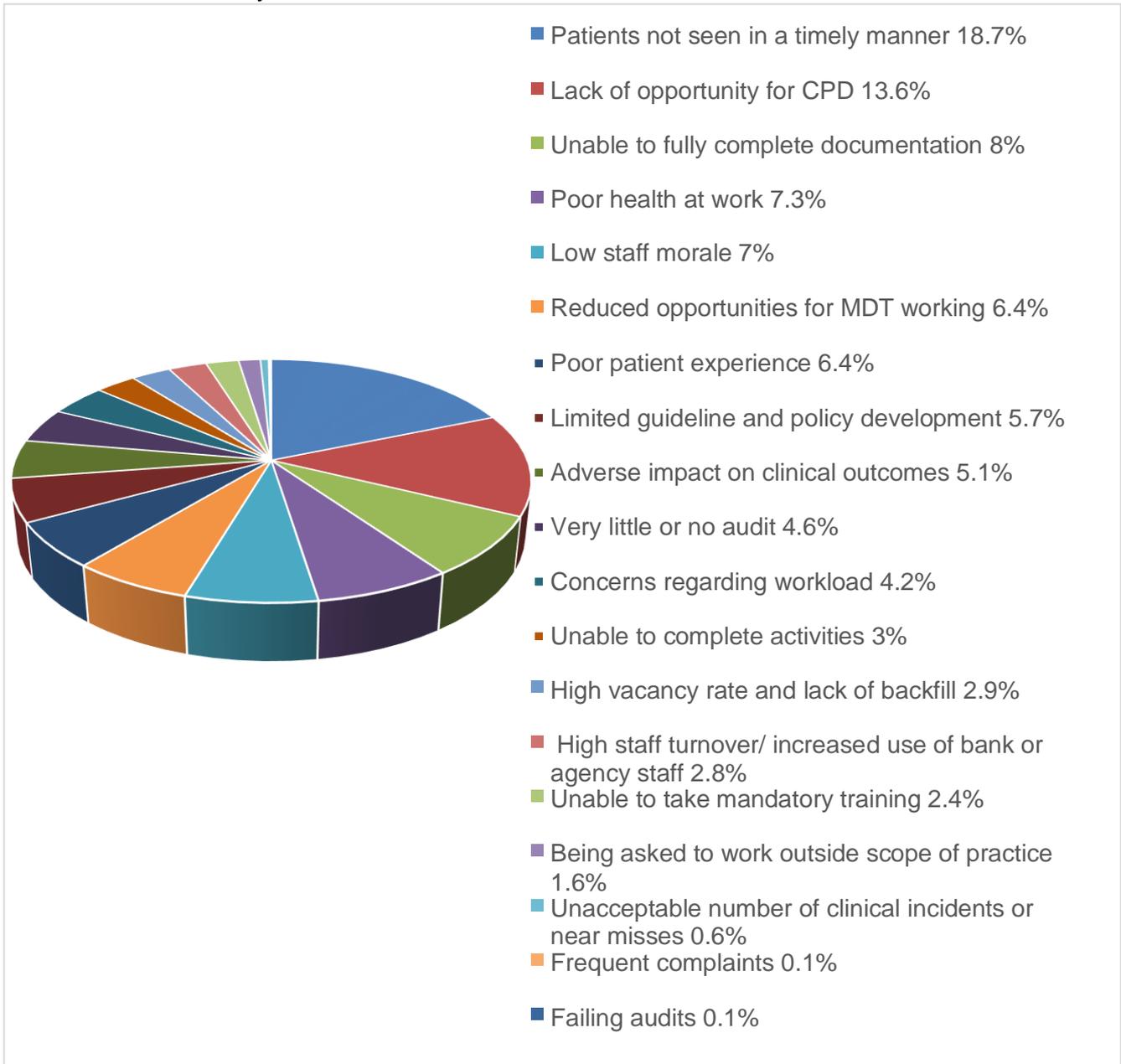
RECOMMENDATION: Across a dietetic department, the average percentage of work time allocated to care contact time should not exceed 75% as this has been shown to be a level at which clinicians are likely to feel safe when practicing.

For the average band 5 dietitian (who generally would spend less time on service focused activity) a figure of up to 85% is likely to be acceptable. For band 7 and 8 staff, up to 65% and 40% respectively is likely to be safe.

5. Safety Concerns

As previously mentioned, safety (within this document) is defined by clinician perception rather than verified entities that have been measured. Dietitians are experts in their own work domain and are likely to be best suited to detect and evaluate events that contribute to patient safety which would be difficult for an outsider to observe.

The most frequently occurring concerns that dietitians have regarding workload safety are patients not being seen in a timely manner, having lack of opportunity for CPD and being unable to complete documentation fully. These three concerns accounted for over 40 percent of all the concerns declared in the 2015 member survey on workload.



Caseload Statistics*

*These figures are based on data from a BDA commissioned project in 2015, as such these figures act as a starting point for safe caseload statistics. A project report accompanies this document and the project is likely to be repeated in 2018 to add further authority to these figures.

The BDA often receives enquiries from members wishing to know how many patients they should be expected to see safely per week, often the question is asked at a time when caseload demands are increasing. Sometimes the question arises due to threats to existing service provisions or more favourably due to opportunities for new services to be developed.

1. Patient Contacts

The following table shows the average number of contacts per whole time equivalent (W.T.E) per week as reported in the 2015 workload survey and categorised by setting and whether the workload was perceived to be safe or unsafe. Those that undertake overtime increase their capacity to see patients in a manner deemed safe.

The average number of patient contacts by dietetic staff per W.T.E per week									
	Clinician reported data								Manager reported Data
	Acute				Community				
Overtime (>37.5 hours paid & unpaid)	✓		✓		✓		✓		✓
No overtime (37.5 hours)	✓		✓		✓		✓		✓
Safe	✓	✓			✓	✓			✓
Unsafe			✓	✓			✓	✓	
New	10	11	13	15	8	8	12	8	
Follow-up	26	27	29	32	14	18	18	25.2	
TOTAL	36	38	42	47	22	26	30	31	32

RECOMMENDATION: The **safe** number of patient contacts (new and follow up) in the acute setting per W.T.E per week is likely to be 36**. To allow for 20% absence, over a year this figure would average out as 29 per week and equates to an average of **1498 contacts per dietitian per year**. The average number of contacts per year of an **unsafe caseload is 1747**.

RECOMMENDATION: The **safe** number of patient contacts (new and follow up) in the community setting per W.T.E per week is likely to be 22**. To allow for 20% absence, over a year this figure would average out as **18 per week and equates to 915 contacts per dietitian per year**. The average number of contacts per year of an **unsafe caseload is 1248**.

*PLEASE NOTE: in the 2015 edition of this guidance, data presented on safe contacts had not taken into consideration those that do overtime and those that do not. Previously figures reported were: the number of contacts deemed to be safe in the acute setting (per W.T.E per week) were 37 contacts and in the community were 24.7 per week.

**20% absence allows for (annual leave/study leave/bank holidays/average rate sick leave).

2. New to Follow-up Ratios

In a full 37.5 hour working week with no absences, the average acute dietitian who spends 75% of their time in care contact time and who sees the average of 36 patients per week, would spend 47 minutes per patient contact (see definition of patient contact on page 4). Similarly for the average community dietitian, the expected number of minutes per patient contact is 61. These are crude figures which will vary, depending on a number of factors including but not limited to: whether the patient contact is a new or follow-up; the level of patient's nutritional complexity; and the amount of support available from dietetic assistants.

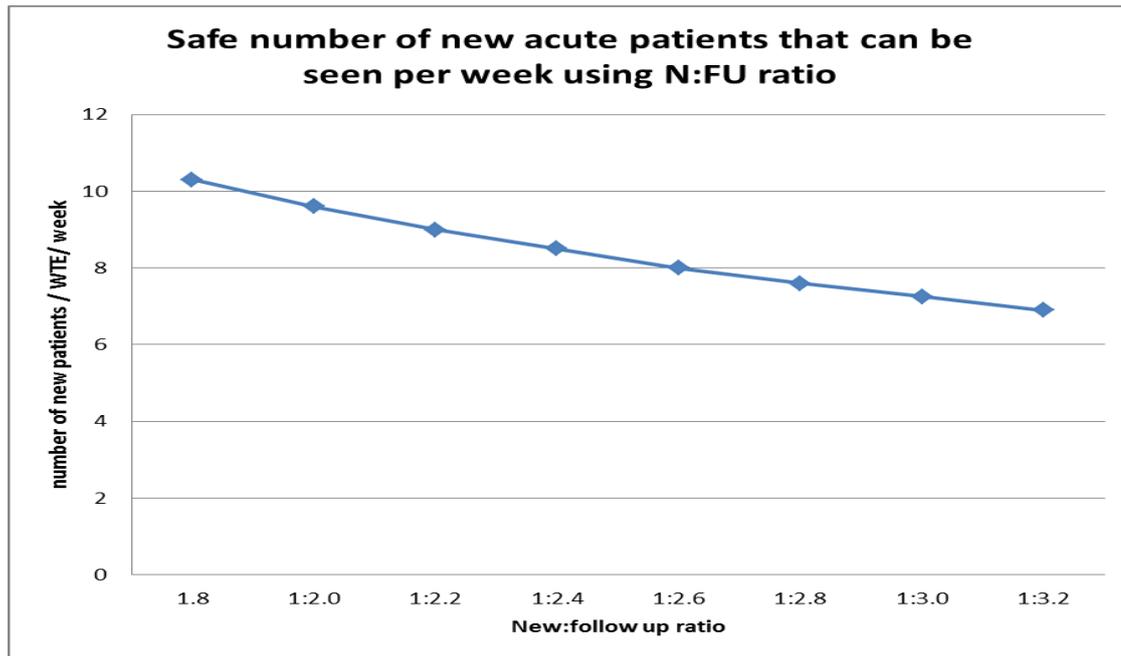
The new contact to follow-up contact ratio (N:FU) is a type of performance measure and can be a useful tool for comparing clinical decision making across comparable case mix of patients. There is no ideal N:FU ratio and the BDA does not endorse this ratio as a performance measure against which targets should be set. As a general rule of thumb, new contacts take longer than follow-up contacts and therefore this ratio has an effect on capacity.

The table below shows safe average patient contacts reported per clinician (all grades) per full 37.5hr working week (i.e. not averaged out over a year to allow for absence) and the corresponding N:FU ratio:

Average N:FU ratios					
Setting	Perception of workload	New patient contacts per W.T.E per week	Follow up patient contacts per W.T.E per week	Total patient contacts per W.T.E per week	New- to-follow up ratio
Acute	Safe	10	26	36	2.60
Community	Safe	8	14	22	1.75

When assessing capacity of a dietetic team consisting of dietitians and assistants, the N:FU ratio can be considered to estimate the safe number of new patients that could be seen by the team within a given period of time.

For the Acute setting, the following table gives an indication of the capacity for new patient contacts per W.T.E of all clinical staff now averaged out over the full year (based on a 20% absence rate).



When N:FU ratio is lower, there is capacity for more initial contacts to take place safely. The N:FU ratio is therefore a tool that can contribute to the capacity assessment particularly around patient contacts.

Making Decisions on Staffing – Guiding Principles



How to get the right dietitians, with the right skills, in the right place at the right time

When considering the safe staffing levels, there are five key principles pertinent to all bands of dietetic staff:

- **Focus on patient care**
 - Assessing the needs of individual patients is paramount when making decisions about safe staff requirements. This will vary across workplace setting and specialty.
 - Informed professional judgment should be used to make any final assessment of staff requirements.
- **Accountability for staffing level**
 - The employing organisation should enable staff to take part in programmes that assure the quality of care and standards to maximise effectiveness as well as optimise the productivity of the team.
 - Staff should be involved in developing and maintaining hospital policies and governance about staff requirements, such as escalation policies and contingency plans.
 - There should be collaborative decision making on staff deployment between clinicians and managerial staff.
- **Responsiveness to unplanned changes**
 - The ability to be responsive to unplanned variations in demand or the availability of staff needs to be considered. This would include seasonal shifts in staffing needs.
- **Monitoring the adequacy of staff levels**
 - There should be procedures in place for systematic ongoing monitoring of safety indicators and a review of staff levels at timely intervals such as twice a year or sooner.
- **Promote staff training and education**
 - Provisions should be in place for staff to have the appropriate training necessary to enable them to have the right skills to provide the care required. This will help ensure capability as well as capacity.

Triangulating Methods for Assessing Safe Workload and Staffing in Dietetics

The NQB advocates that the capacity and capability of nursing staff are the main determinants of the quality of care experienced by patients. Without a doubt, the capacity and capability of dietetic staff are the main determinants in the quality of nutritional care experienced by patients, be they patients with specific or complex nutrition and hydration needs or indeed any patient choosing from a hospital menu that the dietetic team have had a hand in developing.

The NQB states that:

“Staffing establishments should take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfill mentorship and supervision roles. Providers of NHS services should make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments.”

It evidently follows that there should be sufficient capacity for dietetic staff to see patients safely (including completing documentation and participating in any other indirect patient related activities) and there should also be sufficient time for education and training to ensure the capability of the workforce (as part of staff, service and self-focused activities).

Statistics on worktime activities and patient contacts from earlier in this guidance and in other documents within this suite provide a useful benchmark when assessing the capacity of a team or individual. Nonetheless a variety of factors contribute towards the safety of a dietetic workload and so it is recommended that a range of data incorporating capacity, capability and safety indicators are triangulated in order to achieve a more reliable calculation of safe workload and staffing.



Figure 1. Triangulating data on staff capacity, staff capability alongside data on safety indicators is the recommended approach to obtaining a reliable assessment of the safety of a dietetic workload or safety of staffing level.

1. Capacity

The following table summarises key information required in order to assess the safety of a dietetic workload from a capacity perspective. There is a range of benchmarking data available via the BDA Head Office and Specialist Groups and via the national NHS Benchmarking Network. NHS Improvement is working on metrics as part of the Carter cohort of work due for publication in March 2017.

Completing a Dietetic Activity Clinician Audit Tool (included in the accompanying toolkit) will provide evidence for some of these considerations.

	Capacity assessment of individual staff member	Capacity assessment of team or department	Supporting resources
Capacity considerations	<p>Percent of time spent in each type of dietetic activity.</p> <p>Commitments to indirect patient related activities such as MDT meetings.</p> <p>Number of patient contacts per WTE per week.</p> <p>Referral rate and rate of patient turnover.</p> <p>Ratio of new to follow up contacts.</p> <p>Patient mix/level of complexity.</p> <p>Referral to treatment time. If overtime is worked – how much per week.</p>	<p>Percent of time spent in each type of dietetic activity per individual/team/pay band.</p> <p>Number of patient contacts per w.t.e per.</p> <p>Referral rate and rate of patient turnover.</p> <p>Ratio of new to follow up contacts.</p> <p>Referral to treatment time for in and out patients.</p> <p>Patient mix/level of complexity.</p> <p>Skill mix.</p> <p>Time required per patient.</p> <p>Service demands in addition to number of referrals e.g. patient helpline.</p> <p>Overall view of capacity and demand.</p> <p>Benchmarking of activity with other similar departments.</p> <p>Look at trends within department over time.</p>	<p>Dietetic Activity Clinician Audit Tool</p> <p>Calculations on pages 10 in this document</p> <p>The BDA's Workload Management (2016)</p> <p>The BDA's Caseload Management Toolkit (2012)</p> <p>www.nhsbenchmarking.nhs.uk</p> <p>Please contact the BDA Head Office for any further updated benchmarking tools or data after the publication of this document.</p>

2. Capability

The following table summarises the key information required in order to assess the safety of a dietetic workload from a capability perspective.

	Capability assessment of an individual staff member	Capability assessment of a team or department	Supporting resources
Capability considerations	<p>Skill set and experience.</p> <p>Competencies obtained in specific areas of work.</p> <p>Adherence to best practice and latest clinical guidelines.</p> <p>Frequency and outcome of practice supervision and peer review.</p> <p>Record of training and education received (including mandatory training).</p> <p>Audit/service development work completed.</p> <p>Evaluation of training provided to others.</p> <p>Feedback from dietetic peers, AHPs and patients.</p>	<p>Adherence to clinical guidelines and latest evidence base.</p> <p>Outcomes achieved due to dietetic interventions.</p> <p>Patient experience metrics.</p> <p>Outcome and frequency of peer review and practice supervision.</p> <p>Education and training record and ongoing programme of development opportunities.</p>	<p>The BDA's Practice Supervision Guidance</p> <p>The BDA's Practice Supervision Toolkit</p> <p>BDA Resource: Model and Process for Nutrition and Dietetic Practice 2020</p>

3. Safety Indicators

It is recognised that no data can provide absolute certainty about how safe the care of an individual patient was, is or will be, however safety indicators are tools that can be used to highlight potential complications or adverse events.

The NICE Safe Staffing Guidance for Nursing in Acute Wards¹² described ‘safe nursing indicators’ and ‘red flags’ as considerations to indicate unsafe staffing levels. A red flag event warns nurses in charge of shifts that they must act immediately to ensure they have enough staff to meet the needs of patients on that ward. The table below shows suggested dietetic safety indicators that should be monitored so as any risks of complications or adverse events are managed appropriately to ensure patient safety.



Those with an accompanying red flag should alert dietetic managers they may need to take immediate action to ensure that patients are kept safe.

	Patient related indicators	Dietitian or support worker indicators	Staff related indicators	Service related indicators
Safety indicators	Timeliness of patient care (including referral to treatment time). 	Being asked to work outside scope of practice. 	Staff morale.	Performance data. 
	Outcome of dietetic interventions.	Compliance with mandatory training. 	Staff sickness rates.	Adequacy of in date nutrition related guidelines and policies. 
	Patient experience metrics.	Concerns about workload. 	Recruitment and retention rates.	Frequency of clinical incidents and near misses. 
		Health at work including (sickness rate/ stress/ tiredness).	Vacancy rate usage of bank/ agency staff.	Frequency of complaints.
		Attendance at required meetings e.g. directorate/ department/ speciality/team/peers/ Swartz round etc.	Workload concerns raised by staff.	Adherence to adequate auditing schedules.
		Frequency of CPD opportunities including practice supervision, peer review and appraisal.	Level of input to MDT teams (including ward rounds/clinics/ meetings/case conferences).	Results from peer reviews.
		Frequency of completion and standard of activities undertaken e.g. patient documentation, audits, projects.	Frequency of in date staff appraisals.	Benchmarking data.
		Overtime and missed lunch breaks.		



Summary

With many conflicting priorities, adjusting the balance of workload activities to address safety concerns can be a complex task and may require review of service provision and not just an individual or teams' workload management. It is important to think holistically and innovatively when addressing workload issues, taking into account all the triangulating factors, whilst keeping the impact on patient care at the forefront of one's mind, will enable the most informed decisions to be made in the interest of patient safety.

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