Defining staffing levels for children and young people’s services

RCN standards for clinical professionals and service managers
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Throughout this document, the term ‘children and young people’ is used to refer to infants (neonates), children, and young people up to the age of 18 or the point at which an individual’s transition to adult health care is completed.

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Executive summary

The political and policy backdrop for public sector services across all four countries of the UK is increasingly marked by uncertainty and complexity. Children and young people have a right to be cared for by nurses who have the right knowledge and skills to meet their needs.

There have been numerous public inquiries that have highlighted key issues related to the impact of inadequate nurse staffing levels or an inappropriate mix of skills. Most recently the Francis Inquiry highlighted the need for staffing levels to be appropriate and for all staff to be properly educated, trained and regulated to meet the needs of patients. The RCN has repeatedly called for improved staffing levels across all service areas.

The intensity of workload within all services and across all settings continues to increase as a result of medical advances, changes in primary care out-of-hours provision and increased public expectation of services. In many areas this has resulted in increased attendance at emergency care departments, with more children requiring periods of assessment, observation and short stay, in acute settings. Evidence indicates that many could be managed in the community if there were sufficient community children’s nurses (CCNs) to provide care and support at home. The lack of consistent and adequate availability of CCN teams across the country is a key factor inhibiting care at home or closer to home, particularly for those children with minor acute illnesses and long-term conditions, as well as those needing continuing care and end of life care support.

The standards contained in this document apply to all areas in which babies, children and young people receive care, as well as across all types of services and provision commissioned by the NHS including the acute and community, as well as third sector and independent sector providers. The standards are the minimum essential requirements for all providers of services for babies, children and young people.

Individual children’s nurses, managers and health care providers must take responsibility to ensure safe staffing levels and skill-mix. Workforce plans should be reviewed on an annual basis and more frequently in response to any known service pressures such as increased clinical acuity and seasonal activity. Senior nurses are advised to audit against the standards within this document and to highlight deficiencies or variation to their senior management teams and the organisation’s board. A full risk assessment should be undertaken and escalation to senior management or executive team level in all cases where staffing and skill-mix deficiencies continue and are deemed unacceptable against the standards.

The Francis Inquiry recently recommended that boards must take greater notice of nurse staffing levels and seek the view of nurse directors about the potential impact of any proposed major change, including changes to nurse staffing or facilities, which could affect the fundamental standards and quality of patient care (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013).

Workforce planning considerations, patient acuity and workload measures are highlighted. It should be noted that from April 2013 the use of Nursing and Midwifery Workforce Programme tools incorporating professional judgement are mandatory for the NHS in Scotland.
Introduction

Children's services are becoming increasingly complex, encompassing general and specialist care provision across an age spectrum that extends from neonates to adolescents and young adults. Services are designed to meet children and young people's surgical, medical and mental health care needs. Additionally, an increase of higher dependency nursing care is delivered within hospital wards and a greater amount of acute, complex care and continuing care is being provided in community and primary care settings. As a result RCN members have consistently raised the importance of identifying the safe minimum staffing levels and skill-mix across all of these settings as a priority.

As the number of young people with complex and long-term health care needs grows, the need for adolescent and young adult services is increasingly important, alongside age appropriate care and dedicated facilities designed to meet their specific needs (Children and Young People's Health Outcomes Forum, 2012).

This RCN guidance, which was first produced in 2003 as a result of a Delphi study, has been revised to encompass additional areas of children's and young people's services, drawing upon evidence, best practice and the professional judgement of a wide range of practitioners and children's nurse leaders. The revision was further informed by a background report that includes an evidence and analysis review (Williams, 2012).
The policy and professional context of care provision

Recent policy initiatives and legislative changes will have a significant impact on how future services will be organised and delivered in all four countries of the UK. The broader multi-disciplinary team, as well as inter-agency workforce strategies in the four countries will also have important implications for the development of the nursing workforce, future skill-mix and staffing levels. Policy directives on integrated service provision combined with a growing emphasis and focus on care at home or closer to home will also necessitate changes in how nurses are prepared for their roles and the delivery of services (Willis Commission, 2012).

The blurring of the boundaries between different professional roles is undoubtedly increasing as a result of the European Working Time Directive. Some roles – such as nurse practitioner, nurse specialist and nurse consultant – are developing to undertake tasks once viewed as the remit of doctors, while assistant practitioner and technician roles are developing to meet local service needs (RCN, 2012d).

Senior nurses are advised to audit against the standards within this document and to highlight deficiencies or variation to their senior management teams and organisation’s board. A full risk assessment should be undertaken and escalation to senior management or executive team level in all cases where staffing and skill-mix deficiencies continue and are deemed unacceptable against the standards.

All nurses are bound by the NMC Code of professional conduct (NMC, 2008) to promote and protect the rights and best interests of their patients. This includes ensuring that staffing levels and skill-mix are appropriate to meet their needs. Meanwhile, the Children’s National Service Framework (England) (DH, 2003a) for example emphasised that children and young people should receive high quality, evidence-based care that is appropriate to meet their specific needs and delivered by staff who have the right knowledge base, expertise and skills. The Bristol Royal Infirmary inquiry report (Kennedy, 2001) clarified that children and young people should always be cared for by health care professionals who hold a recognised qualification in caring for children. Subsequent reports have continued to highlight the importance of staff having the right knowledge and skills to meet the needs of children and young people, and in 2012 the RCN published core competences for nurses caring for children and young people (RCN, 2012b).

The Children and Young People’s Outcomes Forum (2012) also reinforced the importance of having the staff with the right knowledge, skill and competence across the child/young person’s care pathway.

Children and young people are frequent users of all types of health care compared to adults (DH, 2003a); in any one year, one-in-15 children/young people are admitted to hospital. The majority of admissions continue to be unplanned, with changes in patterns of service provision and care delivery affecting staffing and skill-mix requirements. In 2002 the Delphi study undertaken by the RCN Paediatric Nurse Managers’ Forum found that:

- it is generally acknowledged that those children and young people admitted to hospital today are more acutely ill and require greater nursing intervention
- shorter lengths of stay, increasing throughput and bed occupancy place greater pressure on nursing resources
- nurses’ roles are expanding to encompass many aspects of care and treatment undertaken by other professional groups
- the provision of education and support to parents/carers to facilitate partnership in care and/or preparation for care at home is intensifying
- marked seasonal variations no longer exist in most children’s wards and departments
- there is an increase in the number of nursing students and others requiring supervision and support in clinical environments on top of clinical care requirements.

While much of the above is still true today, the intensity of workload within all services and across all settings has increased yet further as a result of medical advances and changes in primary care out-of-hours provision. In many areas this has resulted in increased attendance at emergency care departments, with more children requiring periods of assessment, observation and short stay in acute settings.
Indeed, evidence indicates that over a third of short stay admissions in infants are for minor illnesses that could have been managed in the community (Saxena et al., 2009), with almost 75 per cent of all children’s asthma admissions able to be prevented with better primary care (Asthma UK, 2007).

From a community perspective, over the last 50 years community children’s nursing (CCN) services have developed based on local need and are delivered in a number of ways. However, despite the growth in services and the fact that in 1997 the House of Commons Health Select Committee identified that, ‘all children requiring nursing should have access to a community children’s nursing service, staffed by qualified children’s nurses supplemented by those in training, in whatever setting in the community they are being nursed’, services are still developed in an ad-hoc way and are dependent on local leadership and support rather than a national strategy.

The lack of consistent and adequate availability of CCN teams across the country is a key factor inhibiting care at home or closer to home, particularly for those children with minor acute illnesses and long-term conditions, as well as those who are dependent on technology, for example requiring 24-hour invasive ventilation or needing continuing care and end of life care support. Essentially, children requiring provision for end of life care should receive 24-hour community children’s nursing care wherever and whenever this is required. Unfortunately in many parts of the country this is not available and countless children die in hospital settings, rather than at home (DH, 2007, Scottish Government, 2012).

Over recent years the numbers of registered learning disability (LD) nurses working within specialist learning disability children’s services has risen (DH/DCSF, 2008, Gates, 2011). These nurses have particular roles in supporting children at home, in a range of community settings including school, and within hospital settings as appropriate. Registered LD nurses work with the child, families and multi-disciplinary/agency team to support the child and their family meet their physical, intellectual, emotional, and social needs. Part of the LD nurse’s role is to increase awareness and understanding of the possible impact of the child’s learning disability upon their overall needs, explore different ways to communicate effectively with the child, and develop flexible approaches to best meet the individual child’s needs.

The 2012 report Strengthening the commitment: the report of the UK modernising learning disabilities nursing review highlights areas for development and input from LD nurses, and identified a need for increased input in the key area of transitioning young people from children’s to adult services. The report acknowledges the increase in numbers of children and young people with complex physical health care needs and confirms the valuable role that LD nurses play in community children’s services.
Nurse staffing and the quality of care

Health care delivery to children and young people has changed dramatically over recent years thanks to a drive to reduce waiting times and lengthy inpatient stays, improve access, accelerate the delivery of services, and actively encourage the involvement of children and their parents in care. Advances in technology and medical interventions mean that children with a life limiting and life threatening illness can require both complex and routine care provision for lengthy periods of time throughout their lives.

The landscape for children’s services today is one of uncertainty, with financial constraints meaning that staffing levels have again become a matter for debate and cause for concern. Regulation and inspection bodies highlight concerns about staffing shortages and media headlines report unsatisfactory practice. Young people, parents and carers now have high and realistic expectations of the care they wish to receive from nurses and other health care professionals.

The current regulatory environment includes the Nursing and Midwifery Council (NMC) which regulates every nurse in the UK. In England, sufficient staffing is one of the six essential standards all health care providers must meet to comply with the requirements of the Care Quality Commission (CQC) which was established in 2009. Infants, children and young people have the right to be cared for by sufficient numbers of staff with the right qualifications, skills and experience, and all staff must receive appropriate training and supervision to meet the professional standards that allow them to practice (CQC, 2010a, 2011a). The Regulation and Quality Improvement Authority (www.rqia.org.uk) and the Health Inspectorate Wales (www.hiw.org.uk) provide similar regulatory governance of care provision in the respective countries of the UK, and in Scotland the Safer Patient Programme has a key role in making services safer for children and improving outcomes. More information is available at www.scottishpatientsafetyprogramme.scot.nhs.uk.

The aim of regulation is to reduce risk to children, but what are the safe or sufficient staffing levels that will reduce risk in children’s health services? The list on page 9 outlines the minimum expected standards for the staffing of children’s health services to provide safe care delivery (RCN, 2003; RCN, 2011a).

Individual children’s nurses, managers and health care providers must take responsibility to ensure safe staffing levels. To assist this process children’s nurses are required to keep up-to-date records, report adverse events, incidents, errors and near misses, and know the arrangements for reporting where the service falls below the standard for quality and safety (CQC, 2011b).

Nurse managers must ensure that needs analysis and risk assessments are in place to determine sufficient staffing levels, and that they are able to respond to changing ward/department circumstances to cover sickness, emergencies and vacancies using good quality data from quality and outcome streams and human resource departments (CQC, 2010b; RCN, 2010a). Tools for staffing, patient acuity and patient mix are available, some of which are listed by the Department of Health (2011) under its Get staffing right web resource, which can now be found at www.webarchive.nationalarchives.gov.uk. Energise for Excellence and other bodies are cited at the end of this publication in the section on workforce planning.

Improved quality of care has been associated with higher numbers of registered nurses to patients. American studies have for many years written about improved outcomes with higher registered nurse to patient ratios (Needleman et al., 2002; Heinz, 2004; Kane, 2007; Aiken et al., 2008).

Patient death, cardiac arrest, nosocomial infection and the development of pressure sores are reported to be directly related to poor nurse-to-patient ratios (Kaulshal et al., 2001; Needleman et al., 2002). In children, Stratton (2005 and cited by Lacey et al., 2008) found a link between five indicators of quality care and nurse staffing: medication administration errors, central line infection, blood stream infection, intravenous infiltrates and parent/family complaints. Although there has been no similar work performed in children’s areas with which to compare findings in the UK, Rafferty et al. (2007) suggest that hospitals with better nurse-to-patient ratios have better outcomes and that staffing levels in NHS hospitals have the same impact on factors affecting nurse retention and patient outcomes as have been found in the USA.
Core standards to be applied in services providing health care for children and young people

1. The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff. See the RCN’s resources on supervisory ward sisters or team leaders at www.rcn.org.uk/publications

2. Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff.

3. At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need.

4. There will be a minimum of 70:30 per cent registered to unregistered staff (although the precise ratio will vary throughout clinical areas. For example, it is expected that there will be a higher proportion of registered nurses in areas such as children's intensive care, specialist, and in many cases general children's units).

5. A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave.

6. There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas.

7. Nurses working with children and young people (CYP) should be trained in children's nursing with additional training for specialist services or roles.¹

8. Seventy per cent of nurses should have the specific training required for the speciality, for example, children's intensive care, children's oncology, children's neurosurgery.

9. Support roles should be used to ensure that registered nurses are used effectively.

10. Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks.

11. The number of students on a shift should not exceed that agreed with the university for individual clinical areas.

12. Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels.

13. Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.

14. Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period. A senior qualified children's nurse is a nurse that holds a children's nursing qualification, also has a master's degree in an appropriate health/social care related subject, with a minimum of five years' full time experience in uninterrupted clinical practice. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification.

15. All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day.

16. Children, young people and young adults must receive age-appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs.

Adapted from RCN 2003a and RCN 2011a

¹ Registered nurses who have completed learning disability and mental health nurse education programmes will have attained additional knowledge and skills by completing a recognised child-focused post-registration education programme to work with children and young people.
Neonatal services

The nurse staffing levels required for neonatal services are clearly defined in the Neonatal toolkit published by the Department of Health (England) in 2009. This defines three levels of care and the associated registered nurse: infant ratios required for each level:

**Special care**
1:4 registered nurse: infant
(this group will include babies requiring treatment for jaundice and extremely premature infants requiring tube feeding)*

**High dependency care**
1:2 registered nurse: infant
(this includes babies requiring nasal continuous positive airway pressure (CPAP) or intravenous nutrition or observation and treatment for convulsions)*

**Intensive care**
1:1 registered nurse: infant
(this group includes babies born with congenital anomalies requiring surgery, or babies requiring respiratory and other system support due to extreme prematurity); there are times when this ratio will be increased to 2:1 registered nurses: infant, such as in neonatal extracorporeal membrane oxygenation (ECMO)*.

When planning the establishment for each unit, consideration needs to be given to the skill mix and available education programmes, such as the post-registration neonatal courses, the foundation degree and specific neonatal life support programmes. Clear guidance is given within the toolkit as follows:

In neonatal intensive care units (NICU) and high dependency units (HDU) 80 per cent nursing capacity should be registered nurses and in special care 70 per cent of nursing capacity should be registered nurses. In addition, 70 per cent of these nurses should hold a post-registration neonatal nursing qualification. Where unregistered staff are employed, such as nursery nurses or assistant practitioners, these staff should have undertaken relevant training to a minimum level of NVQ3 or foundation degree and should work under the direct supervision of a registered nurse.

Due to the high number of staff required in neonatal units, the dependency of infants will require review on a regular basis (a minimum of once per shift) to ensure effective use of staff and to maximise capacity within each unit, ensuring that each baby receives the right care from the right person with the right knowledge, skills and competence.

Workforce plans should be reviewed on an annual basis to ensure that neonatal capacity can meet the requirements of projected increases in births in the local geographical area. In Scotland there is a mandatory workload planning tool across neonatal services (see page 22).

* The British Association of Perinatal Medicine revised and updated the detail related to the levels of care – see British Association of Perinatal Medicine (2011) Categories of care at www.bapm.org/publications
Designated children’s intensive care and children’s high dependency services

The optimal nurse staffing levels for paediatric intensive care units (PICUs) have been defined and refined over a period of 15 years by both the Royal College of Nursing and the UK’s Paediatric Intensive Care Society which published its latest version of the standards in 2010 (PICS, 2010). These have defined levels of care and related registered nursing requirements which are now widely used during workforce planning:

Level 1: 0.5:1 registered nurse: patient (children requiring close supervision and monitoring following surgery or with single system problems).

Level 2: 1:1 registered nurse: patient (this includes children requiring intubation and ventilation).

Level 3: 1.5:1 registered nurse: patient (this includes ventilated children on vasoactive drugs or with multiple system problems).

Level 4: 2:1 registered nurse: patient (this includes children requiring ECMO or renal replacement therapies).

In all categories, the ratio will increase by one level if the child is nursed in a cubicle.

The PICS has stated that establishments should be calculated on 6.7 to 7.01 nurses per bed, depending on whether an allowance for maternity leave is included in this calculation. This figure includes the 25 per cent addition recommended for training, sickness and annual leave.

Due to the high number of staff required in PICUs, the dependency of children will require review on a regular basis (a minimum of once per shift) to ensure effective use of staff and maximise capacity within each unit. Where the unit provides an integrated retrieval service, retrieval nurses must not be factored into the bedside nursing requirements.

High dependency care

The nursing requirements for infants and children in NICU and PICU requiring high dependency care have been defined above. However, high dependency care is often provided outside of the intensive care unit in both specialist wards in tertiary hospitals and general wards in district general hospitals. The expertise and support for staff in these settings varies considerably, necessitating staffing for high dependency care to be based on local requirements as well as national guidance. While use of a children’s high dependency care assessment tool (Rushforth et al., 2012) can assist the assessment of staffing requirements for high dependency care, the following registered nurse-to-patient ratios should be applied regardless of the setting:

- 0.5:1 registered nurse: patient for children requiring close supervision and monitoring following surgery, those requiring close observation for mental health problems or with single system problems.

- 1:1 registered nurse: patient, where the child is nursed in a cubicle, has mental health problems requiring close supervision, or where the condition of the child deteriorates and requires intensive care. This higher ratio will also be required during the admission process until the child is fully admitted and stable.

In a designated children’s high dependency unit (HDU) the nurse in charge must hold a children’s intensive care qualification (note: further work is to be undertaken in conjunction with the Paediatric Intensive Care Society to identify core knowledge, skills and competence to be attained, recognising that at a local level educational provision will be commissioned to meet local needs).

All nurses working in high dependency settings should have training in high dependency nursing and use of an early warning score to assist in the recognition of the deteriorating child. Workforce planning should be undertaken to ensure nurse staffing is sufficient to meet the requirements of children requiring high dependency care, whether there is a designated HDU or where high dependency care is provided on the wards.
General children’s wards and departments

The optimal nurse staffing levels for general children’s wards have often been based on the RCN’s guidance *Defining staffing levels for children and young people’s services: RCN guidance for clinical professionals and service managers* (first edition) (RCN, 2003a). However, in more recent years both the acuity of the patient and the reduction in length of stay combined with the inception of paediatric assessment units (PAUs) and/or clinical decisions units (CDUs) indicate the need to review staffing levels at a minimum of once a year and more frequently in response to any known service pressures such as increased clinical acuity and seasonal activity.

The standard for a general inpatient ward should reflect the age of the child as well as acuity. Hospitals should therefore use a proven methodology to assess acuity of patient care that clearly reflects the needs of children, not adults.

The changing health environment, with the reduction in length of stay, increasingly indicates that the bedside care of children has little difference between day and night (Rushforth, 2008). The following standards provide an indicative baseline ratio of registered and unregistered nurses to children and young people, taking into account the distinct care requirements linked to age and development. Additional unregistered staff may be required during the day to meet the demands of the inpatient areas such as: theatre runs, ward rounds and elective admissions, as well as to provide support to family members.

**Standard for:**
Bedside, deliverable hands-on care
Children < 2 years of age 1:3 registered nurse:child, day and night.
Children > 2 years of age 1:4 registered nurse:child, day and night.

When setting baseline establishments the average age of patient population should be considered, as where there are high numbers of children under two years, an increased registered nurse: patient ratio is required (see section 3, core standards).

The ward staffing complement must also have a supervisory ward sister/charge nurse and unregistered staff, who are not included in the above baseline bedside establishment. The following standards should be applied for all general inpatient wards as a minimum:

- one Band 7 ward sister/charge nurse
- one ward receptionist +/- admin support for sister
- minimum of one health play specialist
- one housekeeper
- +/- one hostess.

Skill mix should be balanced to meet the needs of the service and dependency/acuity of the children and young people requiring nursing care.

Children and young people should be cared for by staff who have the right knowledge, skills, expertise and competence to meet their needs.

In addition to the Band 7 ward sister/charge nurse, a competent, experienced Band 6 is required throughout the 24-hour period to provide the necessary support to the nursing team. This will provide an experienced nurse to advise on clinical nursing issues relating to children across the organisation 24-hours a day.
Specialist children’s wards and departments

Guidance for specialist wards (such as oncology, cardiac, neurosurgery) has previously been referred to in the 2003 RCN guidance. At least a third of patients on specialist wards should be classed as requiring high dependency care, although in some ward areas this may be as high as 50 per cent (RCN, 2003).

The standards for specialist wards must be supported by a suitable acuity tool. In many specialist units a number of children will meet the criteria for high dependency care (HDU). The relevant standards must be followed (for example, 1:2 registered nurse:child). The minimum standard for other children being 1:3 registered nurse:child.

When setting baseline establishments the average age of patient population should be considered, as where there are high numbers of children under two years, an increased registered nurse:patient ratio is required (see section 3, core standards).

The ward should also reflect the structure as described for the general ward or department for other staff including a supervisory ward sister/charge nurse.

Seventy per cent of nursing staff should be trained in the specialty, with a minimum of one nurse who has completed this additional specialist training on duty throughout the 24-hour period.

A practice educator is required to ensure the continuing education of nursing staff, working in specialist areas to maintain high standards. Each service will set local requirements for practice educator numbers, based on:

- number of students
- number of newly qualified staff
- the range of specialities and complexity of patient needs
- how mandatory, clinical skills development and specialist updating are delivered and assessed in the organisation.
Ambulatory care: emergency departments, outpatient departments, assessment units, minor injury units, day care and day surgery

Ambulatory care includes emergency and outpatient departments, assessment and minor injuries units and day care facilities. Increasing numbers of children are seen in these areas and discharged home or to community care. The environment and skills of the staff must be appropriate to the needs of children. Therefore, all staff should be trained in:

- paediatric life support – a basic life support course with yearly update (such as the paediatric intermediate life support course or EPLS course) will be suitable for staff in departments such as outpatients but in emergency departments, assessment units, and day surgery and medical day care facilities, one member of staff should be trained in advanced paediatric life support (APLS) at all times (RCS, 2007)
- safeguarding children to level 3 as defined by the intercollegiate framework
- effective communication with children and parents,
- pain management
- recognition of the sick child.

Emergency departments

All registered nurses within a separate and dedicated children’s emergency department must be registered children’s nurses.

A minimum of two such nurses on each shift must also possess recognisable post-registration trauma and emergency training (RCS, 2007; RCN and RCPCH, 2010; RCPCH, 2012).

There must be at least one nurse with valid APLS/EPLS skills on duty at all times (DH, 2004; DH, 2006).

In DGH mixed emergency departments, a minimum of one registered children’s nurse with trauma experience and valid EPLS/APLS training must be available at all times (RCN and RCPCH, 2010; RCPCH, 2012). All other registered nurses caring for children must attain and maintain the minimum knowledge, skills and competence outlined above (RCN and RCPCH, 2010).

Outpatient departments

Providing a quality service for children, outpatient departments must be integrated with inpatient services, ambulatory care and community care for children and young people. Requirements and recommendations include:

- outpatient departments must ensure skilled staff are available for care (Dodd, 2001)
- outpatient clinics run by children’s specialist nurses or therapists improve the quality of care provided, particularly if more effective use of telephone and e-mail communications is afforded (Dodd, 2001)
- where e-health technologies are used, all staff will require training in their use (The Scottish Government, 2005)
- a minimum of one registered children’s nurse must be available at all times to assist, supervise, support and chaperone children (DH, 1991; RCN, 2011).
Assessment units

Assessment units play an increasing part of everyday care within hospitals, due to the increasing numbers of children attending emergency departments and the overall length of hospital stay for children decreasing, with many children remaining an inpatient for less than 24 hours (DH, 2006/7).

Staff with the right knowledge, skills and competences must be available to meet the needs of the children and young people attending assessment units irrespective of the model of provision. As with other in-patient services, there must be a minimum of two registered children’s nurses available throughout the opening hours. A minimum of one nurse must possess valid APLS skills at all times. Where nurse-led services are provided, these should include a minimum of one children’s advanced nurse practitioner throughout opening hours.

Minor injury units

Children requiring assessment and treatment at a minor injuries unit may present with mild pyrexial illnesses, minor cuts and bruises, minor gastrointestinal disturbances or respiratory illnesses, bites and stings. As a minimum all children must be assessed by a registered nurse with appropriate training (ideally a registered children’s nurse). All nurses who are not registered children’s nurses must have the knowledge, skills and competence outlined in the section on ambulatory care. Mechanisms must be in place to ensure ready access to professional children’s nursing leadership within the service.

In addition, specific considerations which might affect the skill-mix include:
- the degree of integration with other children’s services
- the staffing model (for example, whether the service is nurse or physician led); nurse-led services should be led by children’s advanced nurse practitioners to ensure an appropriate level of knowledge and skill
- use of support staff such as clinicians assistants, play specialists, clinic assistants/health care support workers.

Day surgery

The definition of day surgery in England and Ireland requires the patient to be admitted and discharged on the same day of intended surgery (AAGBI, 2011). According to AAGBI guidelines (2011) term infants over 1 month of age and ex-premature infants of a higher age limit are suitable for day surgery. The following staffing requirements are recommended:
- a minimum of two registered children’s nurses must be available at all times (RCN, 2011)
- at least one such nurse must hold valid APLS/EPLS skills (DH, 2004; RCN, 2004; Royal College of Surgeons of England, 2007)
- staffing levels and skill-mix will depend upon case mix, acuity, workload and whether other children’s services are provided within the organisation
- support workers and health play specialists have a key role within day surgery provision (DH, 2004).

Day care (medical)

There is considerable variation in size and configuration of day care services, which makes it essential to review skill-mix requirements in relation to local need. In view of the developments in practice in this area and the increasing provision of services through day care, there is a need for further work to determine the ideal skill mix for day care services based on the range of services provided. However, nurse staffing in all services should meet the core standards and minimum knowledge and competences outlined above.
Operating theatres and recovery

In the operating theatre nurses with appropriate child skills and competences must be available to support surgeons and anaesthetists. Many hospitals have developed local competencies (National confidential enquiry into peri-operative deaths, 2011). As a minimum, registered nurses and operating department technicians must possess basic paediatric airway and circulatory management skills.

At all times there should be a minimum of one registered children’s nurse on duty in recovery areas. After general, epidural or spinal anaesthesia, children must be recovered in a specifically designed unit, with two children’s nurses for children’s lists to ensure one nurse per patient in the immediate post-operative period. Core skills for all registered nurses, in addition to those outlined in the section on ambulatory care, include the following:

• assessment of physiological observations
• advanced paediatric life support skills/European paediatric life support skills, one member of staff should hold a ‘provider’ qualification
• assessment of fluid balance and management and administration of intravenous infusions
• administration of analgesia, anti-emetics and other drugs by all routes and the use of associated equipment, guided by local protocols (AAGBI, 2002).

In addition, skills and competence are required in effective communication with children, young people and their family, as well as recognition of the sick child.

Community children’s nursing, health visiting and school nursing

Community children’s nursing

As highlighted in the introduction to this document, the range and complexity of care undertaken in community settings has increased over recent years as has the percentage of the 0-18-year-old population which has access to a community children’s nursing service. Services continue to be planned, commissioned and configured in a number of different ways to meet local need.

Over recent years community children’s nursing teams have largely comprised registered children’s nurses, many of whom have undertaken additional education and training such as:

• registered specialist community practitioner (SCPHN), community children’s nurse, school nurse, health visitor and/or
• specialist clinical qualifications such as oncology, palliative care and renal nursing (RCN, 2011).

Pre-registration children’s nursing education has mirrored the changes in health care provision, with many (RN) children programmes now preparing registered children’s nurses with a foundation in the knowledge and skills to work in the community.

Future education is likely to build on this pre-registration foundation, and continuing professional development will be required to enable practitioners to work across traditional boundaries and expand their knowledge and skills for community practice in line with the Knowledge and Skills Framework.
It is envisaged that practitioners will need to demonstrate knowledge and skills attainment in relation to:
- the context of care, interagency and partnership working within complex multi-agency teams
- working as an independent practitioner: lone working, accountability, professional boundaries, safe delegation and empowering families to care
- assessment, decision-making, clinical reasoning and interpersonal skills
- the Common Assessment Framework, key working and the lead professional role to manage care packages
- environmental assessment, risk assessment and family assessment
- safeguarding children and young people
- promoting child and family wellbeing, sociological and psychological perspectives
- caring for children with complex health care needs
- communicating with and caring for young adults, including the transition of young people to adult services
- palliative and end of life care, including symptom management and complementary therapies
- modernising and improving services for children and young people, including commissioning of specialist and community services
- clinical resource management
- nurse prescribing.

(RCN, 2009)

Calculating the dependency of any patient in the community is complex; whilst children and young people often live with their families and have carers around them, it is not always possible for every family/carer to provide the care needed.

The RCN recommends that for an average-sized district with a child population of 50,000, a minimum of 20 whole time equivalent (WTE) community children's nurses are required to provide a holistic community children's nursing service in addition to any individual child specific continuing care investment (RCN, 2009a; 2009b). The community children's nursing service will provide both general and specialist care which includes routine calls for follow up observation and the delivery of specialist care, advice and treatment. The whole time equivalent recommendation includes for example those nurses who have enhanced skills and knowledge in specialist areas of care and expertise in the management of conditions such as childhood epilepsy, diabetes, cystic fibrosis, childhood malignancies and complex health and disabilities. Workforce establishments and working patterns must be able to meet the need for 24-hour end of life care whenever and wherever required.

Health visiting

Health visitors are registered nurses from any of the four branches who undertake further education and training to become specialist community public health nurses (SCPHN) (NMC, 2004 RCN, 2011b). The degree level programme supports practitioners to develop skills in child health, health promotion, public health and education, and is both university and community based with practitioners having to successfully complete both components to gain registration.

There is limited evidence to date to support an RCN position on optimum caseloads for health visitors, particularly where services are evolving in response to changes in health and social care. In his 2009 progress report on the protection of children in England, Lord Laming recommended a maximum caseload of 300 families (or 400 children) per full-time health visitor, with actual numbers being lower depending on caseload complexity and other factors (Laming, 2009). The RCN's 2011 position on health visiting in the early years and Cowley et al's recent review recognised that caseloads should be lower depending on the number of vulnerable families the health visitor has on the caseload.
The key skills for school nurses include:

- leading, delivering and evaluating preventative services and universal public health programmes (as set out in the Healthy Child Programme 5-19) for school-aged children and young people, within both school and community settings
- delivering evidence-based approaches and cost effective programmes or interventions that contribute to children and young people's health and wellbeing; reduction in childhood obesity, reduction in under 18 conception rates, reduction in prevalence of chlamydia and management of mental health disorders (such as depression and conduct disorder), co-ordinating services, referring to other agencies and delegating within the team to maximise resources and utilise the expertise of other skilled professionals
- supporting a seamless transition into school, from primary to secondary school and transition into adulthood
- managing the interaction between health and education so that the child or young person enjoys good health and wellbeing (including emotional health and wellbeing) therefore achieving optimal education
- leading support for children and young people who have complex and/or additional needs including providing or co-ordinating support, education and training for families, carers and school staff
- identifying children and young people in need of early help, and where appropriate providing support to improve their life chances and prevent abuse and neglect; this includes working with children and young people at risk of becoming involved in gangs or youth violence
- contributing as part of a multi-agency team to the response for children, young people and families who have multiple problems.

As the dependency of families has increased health visiting teams have developed to include different professional roles and skills, and registered children's nurses and nursery nurses are often key members of the team.

School nursing

School nurses are registered nurses who have successfully completed a post-registration graduate programme and are registered as a specialist community public health practitioner (NMC, 2004, RCN, 2012c). They work with school-aged children across a variety of settings, and undertake a range of care activities from public health to clinical care tasks, especially for children and young people in special schools.

Good practice would indicate that each family of schools has a named school nurse responsible for co-ordinating the care across both the primary and secondary schools; and that the school nursing service should be a year-round service which incorporates team members of different grades who have a variety of skills and knowledge.

There should be a minimum of one qualified school nurse for each secondary school and its cluster of primary schools. The actual number will vary dependent upon the size and complexity of the school population, the number of vulnerable children, deprivation indices and geography of the patch. Qualified school nurses will be supported by a skill-mixed team that includes a number of registered nurses, nursery nurses and health care support workers.
Children and young people’s mental health

It has long been acknowledged that when providing nursing care to children and young people, acknowledging their mental health care needs is everyone’s responsibility.

School nurses and health visitors have a key role in providing emotional health and wellbeing support, providing mental health services at what is often described as Tier 1 and 2 CAMHS (child and adolescent mental health services) (RCN, 2004).

More specialist CAMHS services provided at Tier 3 and Tier 4 will be provided in both inpatient and community settings and by multi-disciplinary teams including psychiatrists, psychologists and nurses. These nurses may be registered mental health nurses who have completed a recognised child-focused post-registration programme or registered children’s nurses who have undertaken post-registration specialist mental health educational provision.

Where children and young people with mental health problems are admitted to children’s wards, the dependency of these patients can be high and should be considered as part of the overall dependency assessment.

The number of staff on any shift in inpatient children and young people’s mental health units must relate to the number of patients. The Royal College of Psychiatrists (1999) indicates a ratio of 1:3 at night for high-dependency patients and two staff plus additional on call for emergencies for low-dependency patients. Abeles et al. (2007) developed the CAMHS-AID (Child and Adolescent Mental Health Services – Assessment of Inpatient Dependency), a dependency measure specifically for inpatient CAMHS which may be helpful in determining staffing requirements.

Adolescent and young adult units

Young people with long-term conditions are increasingly surviving into adulthood. Consideration must to be given to the expertise required to provide care for these young people across all settings.

The transition to adult services has been identified as a period of time when young people can be lost from health care, due to the failure of transition arrangements (Kennedy, 2010). The National Service Framework (Standard 4) states that ‘all young people have access to age-appropriate services which are responsive to their specific needs as they grow into adulthood’ (DH, 2004a). However, this guidance relates to young people below 19 years of age, but the increasing survival of young people with life-limiting or long-term conditions can make transition to an appropriate team difficult. There is a need, therefore, for further work to determine the best configuration of services to manage young people between the ages of 16 and 25, with life-limiting or long-term conditions.

Staffing requirements for adolescent services are not clearly defined, but there are core principles that should be considered when caring for adolescents and young adults:

- workforce planning should consider the psychosocial needs of adolescents, with the registered workforce consisting of 50 per cent registered children’s nurses and 50 per cent registered adult nurses who have knowledge, skills and competence in child and adolescent mental health and in caring for young people where health is compromised by drugs and alcohol
- transition to a service with appropriate expertise for the individual young person.
Traditionally guidance has referred to young people up to 19 years of age. Individuals become adults above this age. However, cancer services guidance includes young adults up to 25 years of age (NICE, 2005). This service advocates specialist units for adolescents and young people, as the cancers in young adults are more aligned to those seen in children and adolescents than adults. Similarly, congenital heart services (British Cardiac Society, 2002) and hospices (see Teenage Cancer Trust’s palliative and end of life care service evaluation at www.teenagecancertrust.org) have developed models for caring for young adults, where survival rates for certain conditions are increasing.

These issues need to be considered when planning the services and workforce required to meet the needs of this age group.

Independent and private sector provision

The independent and private sector currently provide a range of acute and community services to children and young people. Many of these providers do not currently employ registered children’s nurses to manage the post-operative care of children and do not meet current standards regarding the management of children (NCEPOD, 2011).

The standards in this document relating to the staffing of children’s and young people’s health care services are applicable to all services whether provided by the NHS or independent sector, to ensure that children receive acceptable and equitable standards of care across all types of health care provider. Each section that deals with staffing individual service types such as community or theatres, applies equally to the NHS and to independent sector providers.

Bedside children’s nurse staffing levels should equate to those recommended for the equivalent NHS service, such as theatres or surgical services.

All providers must employ or have access to a senior children’s nurse for advice and policy development, and work in collaboration with the local NHS children’s services network.

In order to ensure that children and young people are cared for by nurses with the right knowledge, skills and expertise, a registered children’s nurse will be employed to care for those children admitted to adult wards and services. In addition, nurses will have 24-hour access to a senior children’s nurse for advice where required (RCN, 2002; RCN, 2011).

Environments used for children undergoing surgery in hospital must be appropriate for the age and development of the individual child. Organisations must ensure care provision separate from adult services and provide suitable play and family facilities, especially where overnight stays are required.
Workforce planning

The RCN recognises the importance of providing NHS and independent sector health care managers and hospital/trust boards with robust data appropriate to the clinical and managerial skills and staffing levels required to provide sustainable quality in children's services provision. This information is essential to influence, and to later determine the agenda to provide a clear focus on services for children and young people within any organisation.

It is important to ensure that children's services are clearly recognised within the business planning process and that this, as well as the commissioning of new and developmental services for children and young people, provides the basis and structure for the allocation of funding and appropriate budgets.

The following factors are fundamental in this process.

Sphere of influence

Every hospital/trust will have a senior registered children's nurse whose role it is to be visible and credible in the promotion of services for children and young people (RCN, 2004).

Standard 1

The appointment of a senior* registered children's nurse will influence the commissioning and management of children's and young people's services in each health care organisation locally – for example a health board or trust. This individual will be able to speak eloquently and confidently about the needs of children and young people and through their influence will have credibility with key decision makers.

* By ‘senior’, the RCN means a registered children's nurse with a minimum of five years’ experience post-qualification in the specialty, who can show evidence of continuing professional development and achievement and holds a master's degree (ideally in a health or management associated subject).

Supporting evidence/rationale:

- the RCN endorse the need for a named professional who has children and young people’s health experience and expertise to be responsible for commissioning services at local level (RCN, 2003c; WAG, 2004b)
- senior children's nurses will have knowledge of high quality standards of care for children and will ensure that all children receive it (RCN, 2004b; WAG, 2004b; CQC, 2010a)
- all health organisations will have in place a named individual with responsibility for planning and delivering services for children and young people (Kennedy, 2001; DH, 2004c; WAG, 2004b)
- all health organisations should have a senior children's nurse as an equal partner with the operational service manager, and a lead clinician in the management of children's services (RCN, 2004b; WAG, 2004b).

Standard 2

The senior children's nurse will be a key member of the team in relation to decision-making, business planning and determining the development of new services. The senior children's nurse will have a voice in the allocation of financial resources.

Supporting evidence/rationale:

- all trusts/organisations will have in place a named individual with responsibility for planning and delivering services for children and young people (Kennedy, 2001; DH, 2004)
- all nurses, midwives and health visitors have a contribution to make to the commissioning of health and social care (RCN, 2004b)
- in primary care organisations the role of this individual will drive change through commissioning of services, based on sound local planning that involves stakeholders and local partners, including children and young people (Kennedy, 2001; DH, 2004)
- a senior children's nurse with the relevant background in senior management and with appropriate skills and experience is competent to manage a children's service recognising the special needs and demands of this client group (RCN, 2011)
- a senior children's nurse is pivotal to use their professional knowledge and experience to influence senior staff and managers; this individual will communicate articulately and effectively with other
The senior children’s nurse must have awareness of both the local and national health agendas. They must also understand the importance of aligning these and the standards required by other Royal Colleges and professional bodies.

Recognition of the role of the CNST, NICE, CQC and other equivalent bodies in developing, setting, and monitoring of standards is essential. Mutual appreciation and co-operation are key.

The development of a nationally (and internationally) accepted staffing and skill mix formula

Developing a nationally (and internationally) accepted staffing and skill mix formula to determine nursing establishment and skill mix levels in environments where children and young people are seen and cared for.

**Standard 1**

The development of a nationally (and internationally) accepted, objective and rational formula for staffing and skill mix, to determine specialty-specific nurse-to-patient ratios that underpin the delivery of safe and effective high quality care in all areas where neonates, children and young people are cared for is highly recommended (RCN, 2003).

Supporting evidence/rationale:

- ensuring appropriate staffing levels and skill mix to optimise the standard of care children and young people receive regardless of time and location and provide equity and equality of service provision across the United Kingdom (Kennedy, 2001; RCN, 2001; DH, 2004c; WAG, 2004a, 2004b; DHSSPSNI, (2005); Scottish Executive, 2007)
- the English National Service Framework for children, young people and maternity services (DH, 2004c), the Welsh Assembly Government (2004a) and Scottish Government (Scottish Executive, 2007) emphasise that children and young people should receive appropriate high quality, evidence-based care, developed through clinical governance and delivered by staff that have the right knowledge and skills
- in a report published in 2002 the Auditor General (Scotland) found a lack of workforce planning and integrated planning, and places these factors as central to optimal cost effective nurse staffing levels (RCN, 2011). This subsequently led to the development of Nursing and Midwifery Workload Workforce Programme (NMWWP) tools which assist in defining the whole time equivalents required within a range of clinical settings including neonatal and children’s services. There is a range of tools directly relevant to children and young people. These include professional judgement, community children’s and specialist nurse, community nursing workload assessment in relation to health visiting, as well as neonatal and children’s wards and departments.
• a large scale national study conducted by Rafferty et al. (2007) found that patients and nurses in hospitals with the most favourable staffing levels have better outcomes than those in less favourably staffed hospitals
• care by staff who have received specific training to meet the specific needs of the client group undoubtedly influences the quality of care received (DH, 1991b; Kennedy, 2001; RCN, 2003a; WAG, 2003a; WAG, 2005b)
• professional judgment provides a reliable basis for decisions about ward establishments and skill mix (RCN, 2003b, 2011a, Scottish Government, 2011)).

Several factors influence staffing levels and skill mix. As these factors change, the staffing and skill mix should be reviewed. For example, a change in dependency/acuity levels of patients, or a change in the care delivery model (RCN, 2003a).

Workforce planning, capacity and skills

There is a lack of clear guidance relating to nurse staffing applicable to all services providing health care to children and young people. Children’s services are complex requiring a range of numbers and skills of staff to meet children’s needs. Therefore, the requirement for robust workforce planning is ever more important if nurses are to provide effective care within defined budgets (Scottish Government, 2011).

Where services are highly reliant on nursing intervention – such as neonatal, PICU and oncology services – professional bodies have developed specific workforce guidance, which provide evidence for services planners and commissioners when justifying workforce costs (BAPM, 2010; NICE, 2005; PICS, 2010). Within Scotland, the Nursing and Midwifery Workload and Workforce Planning (NMWWP) programme has developed a range of tools to measure workload to determine staffing levels and to be used in workforce planning for the NHS Scotland nursing and midwifery workforce. From April 2013 the NMWWP tools are mandatory for NHS Scotland (the three tools that were mandated from April are the adult, paediatric [SCAMPS] and neonatal tools). This includes a combination of tools in a triangulation approach to measuring activity, professional judgement and clinical quality indicators.

In circumstances where managers and team leaders identify that the safe minimum expected standards cannot be met, either temporarily or on a projected permanent basis, the issue must be risk assessed and escalated to a senior management or executive level team for further discussion and action.

The RCN’s Guidance on safe nurse staffing levels in the UK (RCN, 2010a) supports the above and provides a comprehensive overview of the context, importance and theory of workforce planning as well as the tools available to undertake this work. It outlines the relevant regulatory frameworks, policy and guidance for each of the countries of the United Kingdom. This is key for nurses if they are to work to the guidance for the context within which they work.

Standard 1

There is a requirement for robust workforce planning across children’s services.

Supporting evidence/rationale:
• workforce planning involves assessment of demand for staff and how this will be supplied (RCN, 2007) and the best results are obtained when it is aligned to financial planning and service delivery
• a national approach of incorporating patient acuity and workload measure with a range of tools used, including professional judgment and emphasis on the importance of education and effective implementation of the tools (Flynn et al., 2010)
• Kellagher et al. (2010) recommend developing capacity and skills in workforce planning, particularly in senior nurses and midwives
• observation of career pathways to improve retention of nurses and sustain the existing workforce (Knowles, 2010)
• the importance of robust data collection and evidence-based decision-making in relation to workforce planning; if these are effective then optimising nurse staffing can improve quality and safety and improve staff health. (Lockhart et al., 2010)
• employers and nurse directors must assume responsibility for this work, working with education providers to plan for the future and making decisions about the size and configuration of the workforce and reviewing this regularly (Smits, 2011)
• Lane and Barlow (2011) suggested working across acute and community sectors to ensure that nursing roles are not duplicated and a productive workforce is planned; they state that this requires flexibility and collaboration between professionals
• the use of a variety of tools, professional judgement and quality and cost effectiveness indicators to undertake regular reviews of the staffing profile (Ball and Catton, 2011)
• observing what nurses do and the collection of data using the Association of UK University Hospitals (AUKUH) tool, as in addition to being creative and including other professionals (Patterson, 2011).

Workforce planning and education

Standard 1

A senior nurse from the operational side of service will be involved with the development of programmes of education in order to meet the requirements of the workforce plan.

Supporting evidence/rationale:
Registered nurses will need additional training, education and supervision to demonstrate competence in:
• understanding and upholding the rights of children, young people and their families in all areas of the healthcare system
• acting within country specific legislation and adhering to relevant professional codes and local policy and guidance
• communicating with children and young people to understand their needs, involving them and their parents/carers in decision making and facilitating children to care for themselves as much as they are able or wish to
• assessing children and young people in terms of their clinical needs based upon knowledge of their different levels of physical and emotional maturity and development
• recognising actual and potential physical health and mental health problems and deterioration in health status

• basic paediatric life support and first aid
• safeguarding children and young people, recognising signs and situations that indicate abuse or neglect and know how to act and seek the appropriate help and advice
• recording assessments of care, and effective communication with the child health team, involving child/young person and their parents/carers
• in addition to the above the nurse should have access to a named qualified children’s nurse for advice, support and clinical supervision (RCN, 2003).

All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24-hours a day.

Patient acuity and workload measures

Standard 1

There will be a validated and reliable, relevant patient dependency and acuity tool in use that is flexible and developed for children and young people.

Supporting evidence/rationale:
• The paediatric acuity/dependency tool is based on the Association of UK University Hospitals tool. The adapted tool for paediatrics is currently being piloted across children’s services in England and has been tested by NHS Scotland. It outlines five levels of care, two of which equate to the current guidance regarding HDU and PICU care. The inclusion criteria and ‘guidance on care required’ include categories covering care both within acute and community settings and may therefore be useful across all settings. It appears simple to use, with WTE figures for each level of care allocated to calculate the baseline nursing establishment required by a service. Daily changes may be required based on professional judgment and workload assessment using other tools.
• STEAM (System to Escalate and Monitor) (Wyatt and Healey, 2005) is a tool developed in Wales which will provide a real time risk assessment of workload, but over time provides a picture of dependency in a clinical area that could help determine the baseline establishment required. The tool appears simple to use and provides evidence of staffing risks using a RAG rating.

• SCAMPS (Scottish Children’s Acuity Measurement in Paediatric Settings) (NMWWPP, 2011) is a daily workload measurement tool, with seven levels of care identified. Levels 2–4 equate to HDU and PICU dependency levels, leaving three levels of care at ward level. Scores are collected 12 hourly, using a simple form which includes children admitted and discharged and other work impacting on nursing time such as patient transfers. This provides an overview of workload across the clinical area and enables planning for the next shift and establishment setting when data is captured over a prolonged period.

• Nursing and Midwifery Workforce Workforce Programme Neonatal workload tool (NMWWPP, 2011) has been in use since 2009 and is for neonatal staff to record workload data covering 24 hours a day and 7 days a week. The tool should be used on a consistent daily basis to gather data on daily staffing requirements, the peaks and troughs of workload, inform staff rostering and, over time, to provide information on workload trends. It can also be used on a one-off basis or to assist in short-, medium- and long-term planning.

• PANDA (Paediatric Acuity and Nursing Dependency Assessment) tool was developed by Great Ormond Street Hospital to measure patient dependency and acuity in ward areas, identifying those patients requiring ward care, HDC and PIC, which may increase nursing workload. The scores are collected twice daily to inform ward staffing. This tool can be accessed via the Department of Health’s Energising for Excellence website or the NHS Institute’s website.

• CAMHS-AID (Child and Adolescent Mental Health Services – Assessment of Inpatient Dependency) measures dependency of a child on admission to a service (Abeles et al., 2008). It requires further validation but appears to be effective at assessing dependency levels of new admissions.

• Conisbee (2002) described a tool used in community hospice services to assess the level of dependency based on the needs of the child and family. It allocates a single score between 0-3 which will determine the level of care and skills required to meet the needs.

• Lewis and Pontin (2008) describe a tool, developed from an existing health visiting tool, which measures caseload complexity of community children’s nurses. The data is collected to provide evidence to commissioners of workload across a service. The tool was reported to have been working well over several years.

• The Leeds nursing dependency score (Escolme and James, 2004) is used to assess health dependency in children accessing respite care, to identify those children with the highest levels of care needs. This tool involves parents in the assessment, but has a very specific purpose.

• Use of a paediatric early warning scoring tool can prompt a review of staffing where patient scores change significantly, which could impact on both individual patient requirements and the service as a whole.
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