A background report on nurse staffing in children’s and young people’s health care

A review and analysis of the evidence, commissioned by the Royal College of Nursing

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January 2012
Preface

This background report was commissioned by the Royal College of Nursing to contribute to the updating of the RCN publication: *Defining staffing levels for children and young people’s services: RCN guidance for clinical professionals and service managers*, first published in 2003 and updated in 2012/2013.

The report provides a review of available literature relating to staffing child health services from across the UK and evidence from discussion with senior children’s nurses working across a range of general and specialist services in England. Analysis of this evidence has highlighted gaps in the literature and led to a number of recommendations to be included in future guidance.
Staffing levels for children’s services

Introduction

Children’s services are complex, incorporating the full range of health care services for infants and children from the neonatal age group to young adults up to 19 years of age (DH, 2004, Kennedy, 2010). This age group reflects a period of rapid biological and psycho-social growth and development and requires the skills of health care staff who understand this development and the impact that ill health has on individual children across this age range. Services provided include neonatal services, specialist and tertiary services, mental health, community and local district hospital services as well as emergency, surgical and critical care services. With increasing throughput and bed occupancy in hospital settings and an increasing number of children being provided with care at home, staff are required to have knowledge of child development and common childhood illnesses as well as specialist knowledge relating to their specific field of practice.

Health care is provided in a context of increasing demand and expectations from children, families and the public and budgetary restrictions from the government and commissioners. In addition, the ageing health care workforce and increasing provision of care in community settings, places additional pressures on health care managers to plan ahead, be creative and make workforce planning a priority to ensure availability of the right number of staff with the appropriate skills for the future. Nurses comprise the largest part of the health care workforce and there is now a growing body of evidence to show that a lack of nurses, both in terms of numbers and knowledge and skills, has a negative impact on the quality of care provided to patients (Healthcare Commission, 2007, RCN, 2010, Commission on the Future of Nursing and Midwifery 2010, Vlachioti et al., 2011, Wilson et al., 2011).

Current professional guidance relating to nurse staffing levels in children’s and young people’s services was first published by the RCN in 2003 (RCN, 2003). This provides guidance on the nurse: patient ratios based on specific contexts of care such as general children’s wards and specialist service settings. This guidance has been used to support government and professional guidance relating to specialist services for children and young people (NICE, 2005, Jones et al., 2011). This analysis builds on the 2003 guidance to explore current core principles in relation to staffing children’s services, outline recent guidance in relation to specialist services and discuss work undertaken around workforce planning and the use of workload acuity and dependency scoring systems.

This review acknowledges the extensive review of government policy, research and professional guidance found in the RCN Guidance on safe nurse staffing levels in the UK (RCN, 2010). There is no intention to repeat this work, but to apply the principles from this guidance to nurse staffing in children’s and young people’s health care.

This work draws on:

- literature published in relation to children’s services since 2003
- discussion with senior children’s nurses working in a variety of children’s services, particularly those where no or limited specific staffing guidance currently exists.
Core standards in staffing children’s and young people’s services

There are a number of core standards relating to staffing children’s services which are widely cited and formed a key part of the current guidance (RCN, 2003a) and the position statement for the Children and Young People’s Field of Practice (RCN, 2003b). These are widely accepted as the standard to be achieved when staffing children’s services (NICE, 2005, Jones et al., 2011, verbal evidence from senior children’s nurses) and should become essential standards for staffing children’s health services. These include numbers of staff to be included within the bedside establishment, adjustments to nursing numbers required to cover annual leave, sickness and training, the ratio of qualified to unqualified staff and the training required by non-nursing staff (Table 1).

These standards will be explored further with specific children’s nursing specialties, as they have been applied differently depending on the degree of development of staffing guidelines within each specific specialty. However, there are two standards which are not dependent on local specialties but on wider hospital guidance and practice:

- the adjustment to baseline establishment required for leave and training
- use of a dependency or acuity scoring tool.

Whilst undertaking this literature review, a number of senior nurses from across children’s specialties were approached to discuss current progress with the development of staffing guidance, especially in relation to those areas of children’s and young people’s health care where guidance is not yet in place. These senior nurses represented specialists and managers from a number of specialities across child health, including:

- district and tertiary children’s services
- children’s surgery, ambulatory care and mixed/surgical and medical wards
- hospital and community children’s oncology services
- community services
- PICU/HDU
- peri-operative care
- workforce planning.

It became apparent from these discussions that the allowance for training and leave within nursing establishments varies across services and was reported to be between 19.5 and 22 per cent above the baseline staffing requirements. Whilst there was a desire to achieve 25 per cent (RCN 2003a, RCN 2010b), to maintain quality and safety during periods of increased demand or reduction in workforce, the current financial constraints were cited as a reason that this is not being achieved when planning the nursing workforce. The evidence underpinning the recommendation of 25 per cent allowance (RCN 2003a, RCN 2010b) is not always clear from the literature, but there is evidence available to support this figure. The Association for Perioperative Practice (AfPP) stated that 25 per cent ‘should not be regarded as overgenerous’ as annual leave accounts for 17 per cent of this following the introduction of Agenda for Change (AfPP, 2008, p22), whilst the Paediatric Intensive Care Society (PICS) quotes 15 per cent for annual leave. In addition PICS calculated an additional 11
per cent to cover study leave (statutory and mandatory training at 2.5 days/year), sickness and special leave and 16 per cent if maternity leave is included. This makes 31 per cent uplift if maternity leave is included (PICS 2010). Therefore a 25 per cent allowance above baseline staffing requirements is a realistic figure to allow for regular leave and study leave, but not for maternity leave.

Where staffing guidance is well developed and endorsed by national organisations, such as in the case of oncology (NICE 2005), paediatric intensive care units (PICU) (PICS, 2010) and neonatal services (DH 2009), there appears to be more consistency in application of the core standards. Oncology and children’s intensive care guidance refers to the RCN staffing guidance (RCN, 2003a) for use to determine baseline establishments (NICE 2005, PICS, 2010), whilst the neonatal toolkit identifies the evidence underpinning each of the staffing recommendations (DH, 2009) and the PICU guidance provides detailed calculations for the staff required (PICS, 2010). These provide the supporting evidence to enable service managers to justify staffing numbers to commissioners. However, this evidence is not as readily available for other services and may account for the differences in nursing establishments.

When discussing nursing establishments with a range of nurses, it became apparent that dependency and acuity scoring tools were not currently widely used to determine baseline establishments or required changes to establishments. The reasons given for this were that the tools available were not suitable for small wards of less than 30 beds or non-ward based settings. However, there is considerable work being undertaken in the development and use of these tools, which will be explored later in this paper.

Table 1: Core standards to be applied in services providing health care for children and young people (adapted from RCN, 2003a, RCN, 2011a)

| 1. | The shift supervisor will be supernumerary to ensure effective management, training and supervision of staff |
| 2. | Nurse specialists and practitioners will not be included in the bedside establishment, except where required to maintain skills |
| 3. | At least one nurse per shift will be trained in APLS/PILS depending on the service needs |
| 4. | There will be a minimum ratio of 70:30% registered to unregistered staff |
| 5. | A 25% increase to the baseline 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 inpatient areas |
| 7. | Nurses working with CYP should be trained in children’s nursing with additional training for specialist services or roles |
| 8. | 70% nurses should have the specific training required for the speciality |
| 9. | Support roles should be used to ensure that nurses are used effectively |
| 10. | Unregistered staff such as health care assistants and nursery nurses must have completed a course of training specific to the setting 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. | Dependency scoring should be completed to provide an evidence base for adjustments in staffing levels |
| 13. | Quality indicators should be monitored to ensure high quality care is provided and maintained |
| 14. | Where services are provided to children, there should be access to a senior children’s nurse for advice at all times |
There is evidence from senior nurses that the ratios of registered to unregistered staff in many children’s services are greater than 70:30 per cent. Discussion with senior nurses suggests that few specialist children’s areas are using unregistered staff for clinical work. Senior children’s nurses would like to see guidance relating to this ratio change to 80:20 per cent for tertiary services as the work that can currently be undertaken by unregistered staff is limited. However, 70:30 per cent is a minimum ratio and specialist areas such as some oncology units, do not employ unregistered staff due to the nature of the work, which requires high levels of nursing intervention. There is a lack of evidence about the actual ratios of registered to unregistered staff in general children’s wards in district general hospitals, where ratios of staff may be nearer or below 70:30 per cent. In 8.3 per cent (23) of 275 hospitals cited in the latest NCEPOD report into children’s surgery, there were no children’s nurses employed on some wards, including those in private hospitals, university teaching hospitals, district general hospitals and single specialty hospitals in England, Wales & Northern Ireland (www.ncepod.org.uk/2011).

A review of literature from the USA, Australia and Europe, including the UK, between 2000 and 2010, recommends ratios of 70 per cent specialist nurses and 30 per cent non-specialist nurses. However, it recommends the same basic children’s nurse to patient ratios as the RCN 2003 guidance, increasing to one children’s nurse to 2 or 3 patients where medical interventions are increased (Vlachioti et al., 2011, RCN, 2003a).

A number of these core standards have been further developed in the recent RCN guidance ‘Health care service standards for neonates, children and young people’ (RCN, 2011a). Section five of this guidance provides the supporting rationale and evidence underpinning the recommendations about staffing levels and skill mix. In view of this evidence, it is recommended that the core standards listed in Table 1 form minimum requirements for future children’s services staffing, with the development of the recommendations relating to dependency scoring and data collection.

### Staffing specialist children’s services

#### General children’s wards

In hospital children’s services, there is evidence that inpatient nurse staffing is based on the RCN guidance: Defining staffing levels for children and young people’s services: RCN guidance for clinical professionals and service managers (RCN, 2003a). Current evidence from senior children’s nurses cites these guidelines as the accepted standard for workforce planning in children’s services. A recent literature review of child health services, undertaken for Public Health Wales, cited the RCN guidance for workforce planning, emphasising the need to review staffing when circumstances change, such as a service reconfiguration or increase in incidents (Jones et al., 2011).

Whilst these guidelines are currently used in practice, there are some areas where they may no longer be sufficient for current staffing needs. Evidence suggests that:

- the guidance may be insufficient for both children’s wards in a general hospital and for general children’s wards in a tertiary centre, as the patient acuity is reported to be increasing and length of stay falling
- the increasing acuity of patients and reduced length of stay means that workload at night is often similar to the daytime. Therefore, for children over two years of age a ratio of 1:4
nurses to patients may be required as a minimum throughout the 24-hour period in all inpatient settings.

In addition, the experience of senior children’s nurses indicates that the use of dependency and acuity tools is limited. This makes it difficult for nurses to provide informed evidence underpinning nursing requirements. It is important that the individual needs of the children should be assessed using a dependency tool to determine the level of care required and thus estimate workload for a clinical area or team.

Senior nurses have reported current review of the bandings in children’s services, with the need to justify the need for band 6 nurses rather than band 5. This is particularly true of district general hospital services where children’s inpatient services might be small with low bed occupancy. However, these services require appropriately trained staff, with the knowledge and experience to meet the needs of children with both medical and surgical problems. Therefore, future guidance should include specific reference to DGH children’s services, where knowledge and experience of a wide range of child health issues and high dependency skills are required.

The Children’s National Service Framework (NSF) (DH 2003, 2004) did not deal with staffing and skill mix issues in relation to child health services, which was seen as an area lacking in this guidance (Brice 2007). However, it did state the need for staff with the appropriate knowledge and skills and made recommendations that health care staff are trained in the care of children regardless of the setting in which the care is provided (DH 2003). Future guidance should include recommendations about knowledge and experience and skill mix, especially in relation to nurses taking responsibility for the daily management of children’s services across all settings. Managers should be experienced in and knowledgeable about the needs of children and their families in order to represent children’s services at a senior management level.

**Ambulatory care, day care and outpatient departments**

There is considerable variation in service size and configuration of day care services, which makes identifying specific recommendations for staffing difficult, as the needs of patients with cancer differ from those attending general children’s medical or surgical clinics or day care facilities. Therefore, the reason for attendance, the treatment required and the size and configuration of the service, will all affect the volume of attendees and the number and skill mix of staff required. For example, where general practitioners use children’s day care services as phlebotomy services, these skills should be included when planning the staffing profile.

An unpublished survey by the RCN Children’s and Young People’s Cancer Nurses Forum community clearly demonstrated the differences in size and configuration of children’s day care services, with some being stand-alone services and others incorporated into wards and outpatient departments. Similarly, the staffing of these services varied from mixed dedicated and ward staff, to a dedicated team of nurses led by Band 7s. Some services included clinician’s assistants, play specialists, clinic assistants/health care workers and nurse practitioners. In some cases the nurse practitioners are providing nurse led services, including prescribing, clinics and management of the service. In view of the developments in practice in this area and the provision of more services on a day case basis, there is a need to undertake work to determine the ideal skill mix for day care services based on the...
The RCN Children’s and Young People’s Cancer Nurses Forum community is currently looking at the required staffing levels for clinics and day care services, reviewing the Hurst tool and the need for increased nursing input into oncology outpatients, where more complex interventions are being provided. It will be important to review the outcomes of this work to establish whether recommendations can be made across all similar services or whether individual services should undertake workforce planning based on assessment of the local needs.

The National Service Framework (DH, 2003) stipulated that children’s nurses should be available to care for children undergoing day surgery. This was supported by the RCN information sheet on children’s day surgery (RCN, 2004), which recommended a minimum of two children’s nurses, as with other care settings. It also makes recommendations about the education and skills required by nurses working in children’s day care services. These include skills in communicating with families, recognition of the sick child and pain management. However, it makes no recommendations about the overall skill mix required in a day surgery service, depending on the type of service and configuration in relation to outpatients and ward areas. More work is required in this area, as day care and ambulatory units can exist without children’s inpatient facilities (Evans 2008) and the skills and experience of day care and outpatient staff need to be sufficient to deal with any child admitted.

Discussion with senior nurses suggests that outpatient facilities are largely staffed by health care assistants with access to a children’s nurse where required. It is important that these staff have completed a competency training programme with regular updates to ensure competence is maintained. There is also a requirement for access to a senior children’s nurse (RCN, 2004), as one may not always be available on site in an independent or district general hospital. Clear policies and procedures are required to ensure nursing staff know how to access the relevant professional.

**Emergency care (A&E, minor injuries units (MIU)/urgent care centres (UCC), observation/assessment units)**

Emergency care for children is often provided by registered adult nurses despite the fact that between 25 and 30 per cent of all emergency department attendances are children and young people (RCPCH/RCN, 2010). The Royal College of Paediatrics and Child Health (RCPCH) and the RCN joint paper outlines methods of developing children’s nurses in emergency nursing skills and adult nurses in the care of children and also provides competencies for nurses working in children’s emergency services at bands 5, 6 and 7. Grant and Crouch (2011) have reviewed the issues relating to staffing children’s emergency services and who is best placed to do this. They suggest further debate to ensure the emergency care workforce have the knowledge and skills required to care for children across the age range (Grant and Crouch, 2011). There is a clearly a need for professional guidance about the education and skill mix requirements in children’s emergency settings, including the role of the paediatric emergency nurse practitioner (PENP) (Evans, 2008).

The NPSA Review of patient safety for children and young people (NPSA 2009) identified a lack of recognition of the sick child as a key issue to be resolved to reduce safety incidents. The Department of Health listed six generic skills required by all staff dealing with acutely and critically ill children including nurse practitioners (DH, 2006) (Table 2). The PENP is trained to assess children and could provide education to other staff to recognise the sick child, as well as provide more timely interventions, reducing waiting times and providing health education (Evans, 2008). Evans outlines
the benefits of an integrated emergency service with close working between children’s assessment and emergency services, as well as children’s surgical and in-patient facilities. This highlights the need for individual services to review the number of children attending the different environments and establish a nursing and multidisciplinary team to meet the requirements of the children using the services.

Table 2: Generic skills required by all staff caring for the critically ill child (DH, 2006 p 3)

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**High dependency care**

Children’s high dependency (HD) care is provided in both district general hospitals and tertiary children’s services, but the development of dedicated HD units has been slow. Doman and colleagues (2004) suggest that HD care is commonly delivered on general children’s wards (Doman et al., 2004). Their study highlighted six issues relating to the provision of HD care in district general hospitals, including the need for dedicated units and the associated staffing requirements. Haines (2005) identified similar concerns in a children’s hospital where there was a regional PICU, but no HDU, putting pressure on ward staff, who may not have the required knowledge and skills to manage HD patients. Rushforth and colleagues demonstrated from data collection over 12 months, in 36 wards in 14 hospitals (10 trusts) across Yorkshire, that 72 per cent of HD care is provided in tertiary specialist wards and PICUs, with the remaining 28 per cent taking place in district general and major acute general hospitals (Rushforth et al., 2011).

One of the difficulties identified by Rushforth in relation to identifying children requiring HD care was the lack of a clear definition of HD care (Rushforth et al., 2011). Whilst the DH had produced a list of ‘disorders’ requiring high dependency care, they had not clearly defined this category of care (DH 2002). In addition, the DH does not collect information about children’s high dependency bed usage alongside critical care bed data, which might help quantify need nationally (www.dh.gov.uk). In view of this, Rushforth and colleagues developed a children’s high dependency care assessment tool which was piloted, refined and used to determine the HD activity across the 10 hospital trusts. In view of the number of patients reviewed using this tool, this makes it an effective tool to justify HD nursing requirements on a daily basis.

It is estimated that between 5 and 15 per cent of all general paediatric DGH admissions require high dependency care (DH, 2001), making this a significant proportion of the work in any children’s service. Datt and Robinson (2007) provided a comprehensive overview of the development of a children’s high dependency service in a busy district general hospital, where one of the core issues was developing and supporting sufficient nursing staff to provide this service. This paper provides a good example of how policy and guidance was used to underpin service development and justify future developments.
The DH recommends that all hospitals providing emergency care to children should have a high dependency facility with available children’s nurses (DH, 2002, 2006). The DH recommends a ratio of 1:2 nurse to patient ratio (DH, 2002), which is supported by the Paediatric Intensive Care Society (PICS, 2010). Additionally, the DH recommends one nurse per patient when stabilising the child and that trusts should not expect their staff to work outside their competence by ensuring that adequately trained staff are available at all times (DH, 2006). Therefore, whether high dependency care is provided in a general or specialist centre, consideration needs to be given to staff training and competence assessment, as well as the numbers of staff required to provide this service.

From the available literature a minimum ratio of one children’s nurse for two patients is required, with capacity to provide for periods of 1:1 care for new admissions or children that deteriorate and require PICU admission or transfer. All staff should have the skills to recognise the deteriorating child and provide initial resuscitation and should undertake a course in children’s high dependency care. However, it is recommended that the lead nurse has completed children’s intensive care education and training and that there is a local network to ensure good communication and support from the regional PICU (DH, 2006).

Operating departments
There is currently no specific guidance regarding nursing numbers when staffing children’s theatre suites, except for the RCN recommendation to include one children’s nurse in the department (RCN 2011a). However, the Association for Perioperative Practice provides a formula for workforce planning in perioperative settings, which could be applied to any perioperative setting, including children’s theatres. This provides the following staffing requirement per theatre for elective surgery:

- two scrub nurses (one could be a trained health care assistant)
- one circulating nurse
- one anaesthetic assistant
- one recovery nurse per patient.

Where an emergency theatre is staffed, the staff must have a broader skill set and good knowledge and more staff may be available (AfPP, 2008).

In addition, where more than one theatre is in use an additional senior nurse is required to coordinate activity and staff are required to transfer children between the theatre and wards (AfPP 2008).

Further work is required in perioperative care to determine whether these staffing numbers are sufficient to meet the needs of children in the perioperative setting. However, they provide an informed basis for workforce planning at the current time, as they have been produced using a clearly calculated formula by staff with knowledge and experience of operating department nursing. However, it is recommended that there are a minimum of two children’s trained nurses available during children’s lists to cover anaesthetics, theatres and recovery, as per the core standards. This is particularly important in DGH settings, where the number of children’s nurses working elsewhere in the hospital will be smaller than in a tertiary centre. Therefore, theatres should employ children’s
nurses for the lists where children are involved. All other staff should have knowledge and skills specific to children’s nursing including resuscitation, safeguarding and the role of the family.

Specialist hospital services
There is a range of guidance available relating to specialist children’s nursing services, including children’s oncology and cardiac nursing. However, little of this evidence is specific about the number of nurses required. In the case of oncology and cardiac guidance, readers are referred to the RCN staffing guidance of 2003 (NICE, 2005; NHS Specialised Services, 2011). This specifies the following, using oncology as an example:

- thirty three per cent of patients require 1:2 ratio of nurses to patients (HD care)
- the remainder require one nurse to three patients
- a shift supervisor and nurse practitioners/specialists are additional to the bedside establishment.

Evidence from discussion with senior and specialist nurses suggests that these figures may now be insufficient with a higher number of children in specialist hospital wards falling into the HD category, in some cases up to 50 per cent. This information is not always supported by evidence gained from using workload and dependency tools, but is often based on professional judgement and feedback from staff. Due to the requirement for a nurse to patient ratio of 1:2 for children falling into the HD category, there is a need for objective workload measurement to support professional judgement, especially where staffing requirements are increasing in specialist services. Therefore, it is recommended that further workload measurement is required in specialist services over a period of time (minimum four weeks) to demonstrate the need for higher nurse: patient ratios where acuity is high. Tools such as Paediatric Acuity and Nursing Dependency Assessment (PANDA) tool may prove useful in this setting (www.institute.nhs.uk/building_capability/high_impact_actions_submissions/paediatric-acuity-and-nursing-dependancy-assessment-panda-tool).

The recent guidance relating to children’s and young people’s cardiac nursing (RCN 2011) provides significant detail about the competencies required by the different grades and specialist roles within cardiac nursing, without providing guidance about the number of the individual roles required across networks or based on population served. This information is essential to workforce planning, and therefore work needs to be undertaken by individual specialist networks using the tools and guidance discussed below.

Neonatal services
In neonatal services, staffing levels have varied between units for many years. The British Association of Perinatal Medicine (BAPM) outlined levels of care with associated staffing levels in 2001 (BAPM, 2001) as follows:

- **Intensive care:** 1:1 nurse to patient ratio (2:1:1, RCN 2011a)
- **High dependency:** 1:2 nurse to patient ratio
- **Special care:** 1:4 nurse to patient ratio
However, these were not universally adopted. The report of the neonatal intensive care services review group (DH, 2003) found large variations in nurse staffing levels across the country and recommended clearly defining the specific levels of care and establishing staffing levels for these. Subsequently, further evidence has confirmed the continued variation in nursing numbers and thus, available cots, in neonatal units (Bliss, 2007). The RCN position statement published in 2008 (RCN, 2008) endorsed the staffing levels recommended by BAPM (BAPM, 2001), which have been reinforced in the third edition of the BAPM standards (BAPM, 2010). The rationale for these staffing levels is based on both professional judgement and research exploring the relationship between nursing workload and care time with outcomes in neonatal care (Hamilton et al., 2007, Milligan et al., 2008). These recommendations were incorporated into the Department of Health publication: *Toolkit for High Quality Neonatal Services* (DH, 2009).

In addition to the bedside nurses the toolkit provides recommendations for additional staff to the bedside numbers, including the evidence base for these (DH, 2009):

- a lead nurse/midwife responsible for leadership and management
- in HDU/ITU a minimum of 80 per cent registered nurses
- a minimum 70 per cent nurses hold a post-registration qualification in neonatal nursing
- a minimum of two nurses at any time, with one holding a supervisory role
- a supernumerary shift co-ordinator
- a lead nurse/midwife for surgical neonates
- a lead neonatal surgical nurse/midwife to co-ordinate admission, discharge and transfer of babies requiring surgery, including communication with families and community teams.

Where neonatal nurse practitioners are employed within neonatal units, these should also be considered in addition to the bedside establishment, as they often work on the medical rota alongside the registrars and junior doctors, bridging the gap between nursing and medicine.

Due to the growing evidence base for the above staffing levels in neonatal services, these numbers and ratios should become the universal standard for staffing neonatal services from local special care units to tertiary level 3 services. The RCN guidance on health care service standards for neonates, children and young people, published this year endorsed these ratios stating that nursing establishments should be based on the level of care required by each baby and suggesting that those infants requiring the highest levels of intensive care may require two nurses to manage the care (RCN, 2011a).

**Children’s intensive care**

The evidence for the bedside nursing requirements in children’s intensive care has been developing since the first edition of the PICS standards published in 1991 (PICS, 1991). The fourth edition of the PICS standards endorse the 25 per cent uplift recommended by the RCN (PICS, 2010), but states that there are additional considerations for PICU giving a total uplift of 31 per cent. The workforce planning guidance incorporates the uplift required for annual leave, bank holidays, training, maternity and sick leave into the bedside nursing numbers and also includes allowance for a nurse-in-charge and runners. This gives a total requirement of 7.06 WTE per bed (PICS 2010, appendix 13, page 44). Whilst the research evidence for this figure is unclear contributors to this guidance...
included representation from the Royal Colleges of Nursing, Anaesthetics and Paediatrics and Child Health, as well as a commissioner and the DH.

In addition to the bedside establishment, the following posts are identified as outside the bedside establishment:

- senior nurse/matrons
- research and audit staff/data clerks
- education staff
- nurse consultants
- health care assistants
- housekeepers.

Whilst the PICS standards make no clear specification that retrieval nurses are additional to the bedside establishment, the standard for ‘retrieval and transfer of the most critically ill child’ states that ‘the Retrieval Service should operate without compromising the care of the children in the paediatric intensive care unit’ and that there should be a retrieval nurse rota (PICS, 2010 p34 – 40). This allows for the difference between stand-alone and integrated retrieval service models which are both in operation across the UK.

Where the retrieval service operates outside the PICU, the nursing staff are available for retrieval as required to the limit of the nursing numbers. Where the service is integrated into PICU, the nurse may have clinical duties until required for retrieval, but need to be available to the retrieval service. However, where retrieval nurse practitioners are employed, they operate in a role traditionally undertaken by a PICU doctor and thus should be considered additional to the bedside nursing capacity when employed in this role (Herring, 2010).

Work is currently being undertaken by the RCN Children’s Intensive Care Nurse Managers Community to benchmark staffing across the country to determine whether the PICS staffing standard is being achieved. Early indications suggest that most units are achieving the previous standard of 6.4 WTE/bed including unqualified staff, but not the 2010 standard. The reasons for this vary across the country from competition for staff in London where there is more than one unit to a shortage of suitably qualified nurses and an aging workforce in other areas of the country. Therefore, the nurse managers are looking at issues relating to retention of staff and the role of the associate practitioner (AP) in relation to future workforce planning. A pilot of the associate role suggests that an associate and a registered nurse can look after two stable intensive care patients. The nurse is responsible for both patients but delegates tasks to a trained and competent AP and evaluates the outcomes of these tasks (evidence from discussion with RCN Children’s Intensive Care Nurse Managers Community Chair).

There is also evidence of exploring further the role of the health care assistant in children’s intensive care, but this comes with a note of caution to ensure that roles are developed in a structured way to ensure effective use of staff and their skills (King and Crawford, 2009). Development of the HCA through a structured pathway to assistant practitioner, may be an effective career pathway to nursing for those people unable to access a nursing degree when they leave school.
In view of the evidence and widespread agreement for the PICS standards, it is recommended that these be endorsed with consideration for how staffing levels will be maintained in this labour intensive area in the future. Alternative models should be reviewed carefully to ensure that nurses are undertaking essential nursing duties.

**Community children’s nursing teams**

The Children’s NSF recommended developing care for children close to home (DH 2004b). However, the research evidence relating to this has been limited, which might reflect the development of differing models of service provision across the country (RCN, 2009a) with wide variations in the numbers of nurses employed (RCN 2009b). The numbers of children requiring care in the community is increasing, due to initiatives such as admissions avoidance, but there has been no significant decrease in hospital bed numbers to reallocate funding. Recruitment to existing community children’s nursing posts is reported by senior nurses as difficult due to a lack of funding and current funding priorities are addressing preventative services with additional money provided to increase the number of Health Visiting posts. However, future reconfiguration of children’s services, recommended by the Royal College of Paediatrics and Child Health (RCPCH), will reduce the number of 24 hour children’s hospital services and increase community services (RCPCH, 2009). This will free up the number of children’s nurses available to community services, although the RCPCH has stated the need for an increase in the numbers of qualified children’s nurses in order to meet the needs of recommended service reconfigurations (RCPCH, 2009).

A study undertaken by the Social Policy Research Unit at York University aimed to discover the evidence for provision of care closer to home including the range of provision across England, the implications for the planners, providers and users of these services and the cost effectiveness of existing models (Parker et al., 2011). Using a range of methods including survey of providers, feedback from families and case studies, the researchers identified three types or ‘clusters’ of service:

- hospital-based services providing specialist care
- community-based services providing generic care
- therapy-based services.

These have been supported to some extent by an international literature review undertaken by the Scottish Government into the needs of children with complex needs (Law J, McCann D, O’May F, Smart C and Buchan J., 2009). This work recognises the first two models or types and suggests the third is based on family centred care. They go on to suggest that this possibly reflects the continuum of medical intervention, which reduces as the child moves from acute care model to family based model.

Parker and colleagues (2011) identified the value of these services to families and suggested that there were cost benefits, although there was no detail relating to this. In addition, they listed five key factors in the development of services:

- commissioners and providers require effective relationships
- improved data in relation to activity, workload and costs
• provision of effective support to families
• adequate capacity to ensure the quality of the service
• support of practitioners working in isolated settings

However, they did not make any recommendations about staffing numbers based on the models identified (Parker et al., 2011). One of the reasons for this may be due to the complex nature of community children’s nursing (CCN) and the complexity of care required by a large number of children being discharged from hospital and the lack of funding and structured development of these services (RCN, 2009a). The Scottish Government (2011) did not make recommendations regarding nursing workforce numbers due to the complexity of services provided and different models of care provision. However, they did recommend workforce modelling or planning to ensure that the workforce was matched to the local needs to enhance the quality of life for the child and family. This is sound advice for a service provided over differing geographical and demographic areas with different models of provision in existence.

Discussion with community children’s nurses (CCNs) has identified a number of issues which should be considered when planning the workforce. The composition of CCN teams will determine the numbers of nurses required and the flexibility of the service. Where services are made up of specialist nurses, there is often a focus on a particular client group, whereas general community children’s nurses will manage a wider patient population. Early CCN teams were set up with physiotherapists and social workers as well as nurses, however, there was no requirement for nurses to have a community children’s nursing qualification. Nurses were recruited from district nursing teams or other children’s services. The requirement to have a specific qualification varies across the country and services and in some areas, unregistered staff are employed to provide phlebotomy services or provide continuing or respite care to children. However, it is important that staff have the knowledge and skills to work with families in the home. Therefore, a community children’s nursing course is required, especially where staff are working in geographically isolated areas. In Wales a new, flexible model of education has been adopted to allow nurses to undertake a short course or complete a full academic programme in community children’s nursing (RCN, 2009b). This is being introduced in some areas of England and may contribute to increased recruitment of appropriately trained nurses and greater flexibility of service provision. The introduction of an all graduate profession and NMC standards for pre-registration nursing education (NMC, 2011) will ensure that nurses undertaking training on courses validated after September 2011 will be able to work with children requiring their field of practice, in any setting. The aim is that future education will produce nurses who are flexible and educated to meet the changing needs of health care provision. However, in the interim managers must continue to ensure that their workforce has the knowledge and skills required to care for children’s needs. It is likely that nurses with both specialist and generic community nursing skills will be required to work across primary care teams.

There is currently limited guidance regarding workforce planning for CCN teams. The RCN recommends 20 whole time equivalent CCNs for a child population of 50,000 (RCN 2009a) giving a ratio of 1:2,500 child population. In addition, the RCN has further recommended that all CCN teams are led by a children’s nurse who has completed an appropriate education programme and that teams comprise a minimum of 70 per cent registered nurses, of which 25 per cent should hold a
recognised community children’s nursing qualification. However, the number of nurses required can vary considerably depending on the geographical area covered, complexity of patients and education needs of children and families. Where community palliative care is required, the needs of distressed families can involve considerable nursing time, impacting on other families if there is little flexibility in the service.

There are some recommendations regarding specialist posts within the community such as the specialist nurse for children with diabetes, where the recommendation is for one nurse for up to 70 cases. This figure would be reduced if there is increased travelling required in rural areas, high poverty or social deprivation levels, children with complex issues or where the nurse has management responsibilities (RCN, 2006). The recommendations for paediatric oncology outreach nurses (POON) is five per principle treatment centre (NICE, 2005), but the source of funding will impact on the type of service provided by these nurses. This can range from a 24-hour advisory service to a key worker role which could include both training to staff in other centres and direct care to children.

The available evidence suggests that due to the varied nature of the service it is difficult to make recommendations which will work for all services. However, the RCN guidance provides a starting point for workforce planning which should additionally consider local service models and needs. In addition, the RCN has made recommendations for a clear strategy to address the inequitable provision across the UK, to provide a 24 hour service and a clear structure for both pre and post-registration training (RCN, 2009a). For such a complex service, there is a need for creative workforce planning due to the ageing workforce, increasing demand and complexity of the health needs of the children and young people.

Specialist and advanced practice roles
There has been a rapid development of both specialist and advanced practice roles in the last two decades with proven benefits for the quality of care in children’s services (NICE, 2005, Herring, 2010, NHS Specialised Services, 2011). However, senior nurses reported that many of these roles are currently being reviewed, as they are costly and the benefits will have to be shown if the roles are to remain. Many nurse specialists are reported to be currently providing clinical shifts as part of bedside establishment. Recommendations from the RCPCH (2011) advocate an increase in the number of advanced children’s nurse practitioners (ACNP) in order to ensure that all children are seen by a paediatric consultant or middle grade or an advanced practice children’s nurse. This points to a need for caution when considering cutting advanced practice posts for financial reasons and illustrates the need for a clear structure for role development and framework for evaluation incorporating the principles of quality and safety (CQC, 2010). This will help ensure ACNPs can meet the needs of children’s services in the future. Among the range of services that nurse specialists and practitioners are currently providing are:

- pre-op assessment and non-surgical investigations in day care services
- discharge pathways in a variety of settings
- triage prior to seeing a doctor in accident and emergency
- replacing junior doctors in day care, critical care retrieval (Herring, 2010) and neonatal care (BAPM, 2010)
• work between hospital and community settings and across tertiary and secondary care in outreach and liaison roles (NHS Specialised Services, 2011).

A clear structure for development and wider evaluation of these roles is required to provide evidence regarding the quality and effectiveness of services provided through these roles (DH 2008). Large studies, across a range of services or geographical areas, would provide more robust evidence for the retention and further development of these roles. The value of highly experienced, knowledgeable nurses, with a focus on the holistic needs of patients, has been widely reported in the nursing press and recommendations for development of these roles are now incorporated into guidance for developing services (DH, 2008, NHS Specialised Services, 2011, www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer/Energiseforexcellence, www.advancedpractice.scot.nhs.uk, Welsh Assembly, 2006). However, in the current climate, there needs to be clearer evidence for the cost effectiveness of these roles.

Private sector
Bedside children’s nurse staffing levels should equate to those recommended for the similar NHS service, such as theatres or surgical services. Whether care is provided in a private or NHS setting children and families should receive an equivalent standard of care and will be assessed against the Essential standards of quality and safety published by the Care Quality Commission (CQC, 2010). This refers all providers to the ‘schedule of applicable publications’ for each standard against which each organisation will be assessed. This includes both professional and government guidance which providers should demonstrate that they have applied to staffing services.

Currently thirteen private hospitals do not employ children’s nurses in ward areas where children are nursed following surgery (www.ncepod.org.uk/2011) and do not meet the longstanding guidance for children’s services. Future recommendations for staffing children’s services in the independent sector should be included within the guidance for all other services. This will include the requirement for access to a senior children’s nurse for advice and policy development and close collaboration with the local NHS children’s services network.

Additional health care roles in children’s services
Nursery nurses are employed mainly in neonatal units for babies in special care and in the community for children with complex needs or requiring respite care. The Neonatal Toolkit recommends that nursery nurses or assistant practitioners have an accredited training (NVQ 3 or Foundation degree) and work under the direct supervision of a registered nurse or midwife (DH, 2009).

Play therapists are an important resource when caring for children who are ill both in hospital and in the community (NCB, 2004, www.nahps.org.uk, RCN, 2011a). Hospital play specialists (HPS) are not included in the bedside establishment as they provide a role in reducing stress and aiding understanding of children and families in hospital. Many hospitals have a central team with allocation of staff time to children who require preparation for treatment or surgery. It is recommended that there is one HPS to 10 beds, with a team structure that promotes career development (anecdotal evidence). However, there is evidence that health care providers are not meeting these standards to ensure that all children in hospital have access to play facilities (NHS
Health care assistants (HCAs) or clinical support workers (CSWs) are often employed for specific non-clinical roles such as housekeeping and administrative duties, with some being used to feed babies and support families. Where clinical roles are undertaken, a competency development package is used to ensure that unregistered staff, providing clinical care, have the right skills to meet the needs of the specific client group. Where the role of the HCA or CSW is to be developed further to include clinical duties, it is essential that this is undertaken within the framework of a structured programme of education and competence assessment and with supervision from a registered nurse who will be responsible for the tasks delegated (NMC, 2008, RCN, 2008b). The RCN has provided guidance on delegation of tasks to unqualified practitioner, which provides direction on the importance of training, regular competence assessment and accountability (RCN, 2008b). However, there is evidence that HCAs can provide a valuable resource within the clinical team and undertake many non-nursing tasks, such as housekeeping and receptionist or ward clerk duties, which are taking up nursing time as well as providing clinical care under supervision (King & Crawford 2009, Shelley & Coyne, 2009). Hurst (2010) provided evidence that nurses spend less that 50 per cent of their time in bedside care and only 75 per cent of their time in direct and indirect care. With an ageing nursing workforce and increasing demand for health care and development of nursing roles, the role of the HCA should be explored further to identify areas where HCAs could be employed safely to enhance the quality of services to children and families (Shelley and Coyne, 2009, Lane and Barlow, 2011). These roles should be included within local workforce planning activity.

Lane and Barlow (2011) have identified the need to develop the roles of the HCA and assistant practitioner, in order to develop a productive workforce to meet future health needs. Assistant or associate practitioners are also being developed in some areas such as children’s intensive care (King and Crawford, 2009). This follows the introduction of the assistant critical care practitioner role in adult practice, which has been developed within a structured framework of education and competence assessment (DH, 2008b). This role in children’s intensive care is also being developed in a controlled way using a structured programme to develop HCAs to become assistant practitioners in order to address future workforce shortages facing nursing (King and Crawford, 2009). This should enable nurses to concentrate on nursing skills and complement rather than replace nurses. Skills for health have produced core standards for assistant practitioners working in health and social care in order to provide a common framework for the development of this role.

Senior nurses have highlighted a number of projects to develop associate practitioners through a two year diploma programme in health sciences, enabling them to work at Band 4 supporting nurses be undertaking specific delegated tasks. These diploma programmes include courses to enable practitioners to work in children’s services, with plans to introduce them in a controlled way into areas such as adolescent units, day care, outpatient clinics and critical care areas. Where these roles are introduced, it should be within a programme of workforce planning (Buchan and
Seccombe, 2010)) based on the skills required to meet the needs of the children accessing the individual services.

**Evidence based staffing and workforce planning**

The information above demonstrates the lack of clear guidance relating to nurse staffing which is applicable to all of the services providing children’s health care. Children’s services are complex requiring differing 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). Achieving the balance between costs and safe, effective services is an increasing challenge for commissioners and providers of children’s health care (RCN, 2007, Ball and Catton, 2011). Where services are highly reliant on nursing intervention, such as neonatal, PICU and oncology services, professional bodies have developed specific workforce guidance for these services, which provide evidence for commissioners when justifying workforce costs (BAPM, 2010, NICE, 2005, PICS, 2010). However, there is a requirement for robust workforce planning across children’s services.

There is a significant volume of nursing literature relating to workforce planning which identifies the principles and issues to be considered when undertaking workforce planning processes:

- 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.
- Flynn and colleagues (2010) recommended a national approach incorporating patient acuity and workload measures with a range of tools used including professional judgement. They also emphasised the importance of education and effective implementation of the tools.
- Kellagher and colleagues (2010) recommend developing capacity and skills in workforce planning particularly in senior nurses and midwives.
- Knowles (2010) recommended looking at career pathways to improve retention of nurses and sustain the existing workforce.
- Lockhart and colleagues (2010) emphasise 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.
- Smits (2011) emphasises that 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.
- Lane and Barlow (2011) have also 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.
- Ball and Catton (2011) recommend using a variety of tools alongside professional judgement and undertake regular review of the staffing profile using quality and cost effectiveness indicators.
- Patterson (2011) recommended looking at what nurses do and collection of data using the AUKUH tool, as well as being creative and including other professionals.
The RCN 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 provided to undertake this work. It outlines the relevant regulatory frameworks and policy and guidance for each of the countries of the United Kingdom. This is important for nurses to understand, as they must work to the guidance for the context within which they work.

It is also important to understand that workforce planning takes place at different levels: national; regional and local. Initially, it involves modelling workforce requirements for the future to inform education, which will involve national workforce planning leads, secondly setting establishments across the services provided, which may should involve regional workforce planning leads and the use of tools to provide evidence for staffing needs and finally, rostering and daily review of staffing requirements based on patient dependency and workload requirements (RCN 2010a). However, perhaps one of the most important principles identified within this document and other guidance (Flynn et al., 2010, www.nes.scot.nhs.uk) is the need for triangulation of methods when undertaking workforce planning. This includes:

- professional judgement of experienced nurses
- benchmarking with other services (such as that referred to earlier in relation to children’s oncology and children’s intensive care services)
- the use of tools to measure patient dependency or acuity and nursing workload.

The guidance provides a useful summary of these tools (RCN, 2010a p44-48), but few of these have been developed for children’s nursing and senior nurses have reported that to date few of the tools used have been suitable for children’s services. Discussion with senior nurses suggests that some tools such as the Hurst tool is not suitable for use in small ward areas and ambulatory care. Where wards are larger with more than 30 beds these work more effectively. However, discussion with senior nurses suggests that the Association of UK University Hospitals Trusts (AUKUH) and PANDA tools may overestimate staffing numbers in certain services, for example surgery, but not in others, such as oncology. There is work currently being undertaken to adapt and develop tools suitable for children’s nursing. The range of tools available includes:

- 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 judgement and workload assessment using other tools (unpublished work)
- STEAM (System to Escalate and Monitor) (Healey and Wyatt, 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 which could help determine the baseline establishment required. The tool appears simple to use and provides evidence of staffing risks using a RAG (red, amber, green) rating
• SCAMPS (Scottish Children’s Acuity Measurement in Paediatric Settings) (NMWWPP 2011) is a daily workload measurement tool, with seven levels of care identified. However, levels 2 – 4 equate to HDU and PICU dependency levels, leaving three levels 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.

• PANDA was developed at Great Ormond Street Hospital to measure patient dependency and acuity in ward areas, identifying those patients which fall into the HDU and ward intensive care categories, which may increase nursing workload. The scores are collected twice a day to inform ward staffing. This tool can be accessed via the DH Energising for Excellence website or the NHS Institute website (www.institute.nhs.uk/building_capability/high_impact_actions_submissions/paediatric-acuity-and-nursing-dependancy-assessment-panda-tool).

There are a number of tools available which have been developed for use in specific settings:

• CAMHS-AID 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) has 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) described 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.

Historically workforce planning has often taken place at local level and previous initiatives have not been sustained (RCN, 2007). However, there are now national programmes focusing on workforce planning and development of the associated tools for use by providers. National information and tools required for nurse workforce planning can be found on the following national websites:

www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer/Energiseforexcellence/DH_120761
www.scotland.gov.uk/Topics/Health/NHS-Scotland/BHBC
www.dhsspsni.gov.uk/8615_-_a4_partnership_web.pdf
Conclusion and recommendations

In order to meet the demands of future health care services and to maintain safety and quality, it is necessary for senior children’s nurses to undertake robust workforce planning to ensure that the needs of patients can be met using an appropriate skill mix of staff, within a defined budget. The RCN guidance relating to safe staffing outlines the important principles and should be used when undertaking workforce planning activity. In addition, the information and tools on the national government and Department of Health websites, provide managers with the relevant policy information and local guidance. It is important that managers are using this guidance to underpin workforce planning activities, to demonstrate to commissioners that workforce costs are calculated using accepted tools. Triangulation of methods and integration of workforce planning with financial, strategic and educational planning will provide the most robust evidence and should involve commissioners in the planning process.

Due to the ageing workforce and the changing profile of health care provision, a number of new roles have been developed and are being explored in children’s services, including developing the role of the health care worker and introducing assistant practitioners. It is important that these are developed in a structured way using the guidance available from Skills for Health and the Department of Health. Managers must look at the work nurses do, the patient mix, shift patterns and additional work to be completed and identify the best person to complete this rather than using unregistered staff as a cheap option to nursing staff or nurses to complete work that could be effectively completed by unregistered staff. These roles should complement nursing, freeing nurses up to undertake nursing roles rather than administrative, domestic or other roles. Evaluation and review of these roles and the entire workforce is required on a regular basis to ensure that the skill mix continues to meet the needs of the patients. Where specialist and advanced practitioner roles are developed, a clear structure with evaluation processes are required to ensure that evidence is available to illustrate the benefits of these roles and reduce the removal of these posts when funding is reduced.

It is recommended that future guidelines for nurse staffing in children’s services include the core standards, listed in Table 1, as baseline guidance for all children’s services regardless of the setting or whether they are in the public or private sector. Current regulatory frameworks require all providers to work to national and professional guidance, with assessment of services using the same standards (CQC, 2010). In addition, some modifications are required, including:

- the development of the recommendations relating to dependency scoring and data collection should be strengthened with reference to suitable tools and guidance from the four countries of the UK
• in light of the NMC requirement for nurses to work within their knowledge and skill base, it is recommended that all nurses working in children’s services should have a relevant qualification or be working towards this
• children’s services must be able to influence the application of this guidance and should be able to provide this influence to trust and organisational boards. Therefore, new guidance should include a statement about the need for a senior children’s nurse at senior or trust management level
• caution should be used when using staffing ratios, as 70:30 per cent could be achieved by providing three staff for 30 patients. Therefore, it is important for standards to also provide guidance which include minimum nursing numbers
• future guidance should not differentiate between day and night shifts where patient acuity is similar over the 24-hour period
• the importance of workforce planning processes, including data collection to calculate baseline establishments should be emphasised. This process should involve a variety of tools to triangulate evidence.

The literature on workforce planning is clear about the benefits of these activities. It is important that the processes currently available are not short lived and become part of service planning to ensure that the workforce is available to meet the needs of children and families within a framework of safety and quality.
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Published June 2013
Publication code: 004 369