

Executive summary CSM semi-structured interviews

This report summarises the results of a set of semi-structured interviews about staff experiences of the Common Staffing Method (CSM). Our aim was to explore the experiences of a range of staff groups that use the CSM. Our objectives were to determine:

- 1) if the CSM was perceived to be effective or not
- 2) awareness and understanding of the CSM
- 3) if the CSM was acceptable to staff
- 4) barriers and facilitators to the utilisation of CSM, across different Boards and among professions

Appendix One features our methods while Appendix Two contains the Interview schedule.

Staff with a wide range of professional backgrounds were recruited:

- Senior Charge Nurses
- Chief Nurses
- Health Visitor Team Leads
- Nurse Specialist
- Lead Nurses
- Nurse Team Leads
- Practice Development
- an Implementation Programme Manager

Nine were from a rural environment, seven from an urban environment, and eight from a hybrid environment. Participants were from four Health Boards. Island Boards were under-represented – we were only able to recruit from one. We were unable to recruit anyone from The State Hospital. The following themes and key messages arose from this work.

Perceived effectiveness and funding

To determine the level of effectiveness of the CSM would require a different method to interviews. Therefore, we asked participants for their perception of how effective the process is.

The CSM was perceived as a means for ensuring safety and governance on the wards by taking account of recurrent and severe risks and taking account of that in real-time staffing. It can do so by making a case for increasing funding and staffing levels.

“We got permission to over recruit by 10 Whole Time Equivalent (WTE) across all my areas and then I allocated them to the areas of highest need, and that's continued for this year. So... we've still got the 10 and we've allocated it to different areas this time based on the CSM.” [Chief Nurse 4 Hybrid]

The assessment of staffing level risks was seen as both essential and practical. The following illustrates a change in practice that would reduce risk, done as a result of CSM.

“CSM highlights our risk management; it highlights we're training our staff... It's also really good for our teams because we sit down with them and say so you've highlighted this as a risk here, do you have a risk assessment for this? But if there's only one Registered Nurse on, they need risk assessment to cover themselves if anything does happen. But we always make sure now since legislation, we've got a Senior Nurse on call.” [Senior Nurse Manager 1 Hybrid]

Staff recognised the need for all elements of the CSM to be addressed if a request for increased staffing were to be sanctioned. However, some were not convinced that the CSM could increase funding and staffing levels, which impacted on their submitting such a request to finance.

“I've got 64 clinical areas. If I'm asking for 20 staff in 60 areas, that's 1200 staff. I'm never going to get that. So, it's unrealistic from that expectation... You're kind of thinking, ‘well, no, we can't put this into via finance and via the Senior Leadership Team for assurance and locally authorising it, because we're never going to get it.’” [Chief Nurse 3 Urban]

Some staff felt “disillusioned” towards the CSM because they had expected that having submitted a report based on the CSM, their manager would read and sign it off, when they actually did not. Similarly, others spoke of feeling “disheartened” because they received no increase in staffing.

“It could have been great, but when you get all these things and there's no resource to back it up, then it's I think it could become disheartening if it was the first time it happened to you... I don't think the local teams at any Health Board are that flushed with money that they can deliver what's been asked for... We have had a fraction of what we asked for.” [Chief Nurse 3 Urban]

The primary benefit of the CSM was perceived to be increased staffing, measured by whole time equivalent (WTE). A particular example was the CSM being a tool for evidencing work capacity, leading to increased WTE saving on Agency Costs. A similar point was made which highlighted a further practicality:

“That whole process then triggered a review of our funded establishments because it was evident through our use of the CSM outputs that our inpatient areas were significantly under resourced and that we were using high numbers of Agency and supplementary staff to try and mitigate some of that. We used the Common Staffing Methodology output to inform calculations to try and unpick where our gaps were. Most of our funded establishments no longer had the 22 ½% timeout allowance within them and we were able to demonstrate and evidence that gap.” [Chief Nurse 1 Urban]

The illusion of funding was consequently likened to a “*Catch 22*” situation. For a definition of *Catch-22* visit the [Merriam-Webster](#) website.

“Effectively, we're recruiting against vacancies we don't have, but we're then held to account for spend that we don't have money for. Beggars belief. We can't close the beds. But we can't staff

because we don't have money... Here's an area that you have got open because you've told me I have to open it, but you give me no money for it." [Chief Nurse 3 Urban]

Awareness and understanding

Some staff felt that the benefits of the CSM were not clear. Others misunderstood the information, incorrectly believing that by completing their CSM, they would automatically get more staff. Some appeared to lack awareness of HIS webpages dedicated to CSM, while others said that they struggled to navigate the HIS pages to find specific information.

"I know that we've got a lot of resources on our Internet site. Some of them may or may not be HIS resources and I don't know how much of the template that we use is based on HIS resources. ... I just know I just used the template that was provided to me by [Health Board]." [Chief Nurse 4 Hybrid]

Compliance and engagement

Experienced staff spoke of finding the CSM acceptable, expressing confidence in engaging with it, especially through repeated use. Several recognised the importance of being compliant in relation to the Health and Care (Staffing) (Scotland) Act 2019 legislation, and that finding it hard to take the time to complete it was not a justifiable reason for non-compliance. Legislation was thus perceived to provide assurance that both staff and patients were protected:

"How can anybody really argue with the fact that we want to make patient care safe, effective, high quality, person-centred as an ethos for the work that you're doing? The legislation also protects staff. It supports staff well-being... I try to talk around it and talk about the benefits rather than just saying it's legislation and the carrot and stick... Yeah, you're busy, but it's not just a tick box exercise unless you make it such." [Senior Nurse 1 Rural]

Improving engagement with the CSM was a challenge for some staff, but it was felt that staff were now able to see the benefits, based on robust decisions being made based on the CSM. Despite this, some staff spoke about struggling to act in accordance with the legislation. A member of staff provided an example of a low level of compliance in their setting.

"When we ran our workload tools, I only had 50% of my team despite being mandatory. And obviously I know it's a legal requirement on [Health Board], but only 50% of my team actually completed the tools. So, from my point of view, no. Using the tools didn't enable me to write a robust report using accurate data because the data was not accurate." [Health Visitor and School Nurse Team Leader 3 Hybrid]

Having sufficient time to use the CSM in the appropriate timelines to maximise its impact was felt to be particularly demanding.

"The Senior Charge Nurses actually uploading the information to the electronic systems, Nurse Managers then supporting the Senior Charge Nurses to review their outputs and complete their CSM templates. And then my time in just reviewing that process and doing that loop closure, that's a definite challenge, not insurmountable, but there is, you know, competing priorities and because of that you know it's quite often the things like that feedback process that fall down the ladder of

priority a little bit. So, the timeliness and being able to conclude to the process is difficult.” [Chief Nurse 1 Urban]

A member of staff was critical of engaging with the CSM in its current form and suggested it was better to rely on Professional Judgment instead.

“When I speak to Chief Nurse colleagues and Associate Chief Nurse colleagues, we all think the same. But every year we have to put all this data into this online platform and spits out a number we don't recognise and guess what the default set is. We go back to Professional Judgement and apply.” [Chief Nurse 3 Urban]

The wide variety of systems and tools (including *Datix*, *Illuminate* and *TURAS*) that housed information necessary for completing the process were described as a barrier to easy completion and reporting. Some staff said that they struggled to remember how to engage with the CSM when there were lengthy gaps between doing tool runs. In particular there was a feeling that the tools were too broad for some of the clinical areas, skewing dependency data.

Staff who spoke positively were aware of the need for compliance with the process to be able to generate a favourable outcome but recognised the reality of current financial constraints. While the lack of compliance was recognised, it was not necessarily tolerated. A member of staff acknowledged that he would not accept someone saying that they had not used the CSM as required. Instead, they said that they would be matter-of-fact in their challenge:

“If it's just a case of can't be bothered not doing it, I don't believe in it. That's a different story. That's a different conversation. Well, I can understand you might feel that way. Doesn't matter. You have to do it. It's part of the legislation. So, it's not a negotiation here. It's one of the very few negotiations that I wouldn't have.” [Chief Nurse 3 Urban].

Acuity, capacity and priority, and settings as barriers to using the CSM

Some staff felt staffing level tools, in particular Community tools, did not take reliable account of patient acuity, and had a subjective element based on who completed them and when they were completed.

“There's the level one to four of acuity or complexity and I guess that's open to the interpretation of the staff member who's completing the tool. You know two individuals could base a complexity of a patient completely different.” [Nurse Team Lead 2 Hybrid]

The greatest barrier to application of the CSM might be the capacity of staff and the priority they give to the process. Capacity relates to the number of staff required to run a ward safely and ties in with caseload, and the amount of work that staff are faced with. Capacity can therefore negate the ability to do a tool run.

Strong feelings were raised around prioritising patients over the CSM. For example, there was a perception that the CSM was another task distracting from direct patient care. Some recognised benefits to be gained from the CSM, but that the benefits were difficult to achieve because of the responsibilities for caring for patients. Several participants made strong arguments for prioritising the

CSM processes, but some felt that there may be a choice between prioritising patient care or CSM processes. Overall, some staff felt conflicted between putting the patient first and making the effort to gather evidence to justify changes to their staffing levels.

“I've been asked, ‘Will I get sacked if I don't complete it? I've got XYZ with my clients and my patients and I've got job protection, I've got a report due, I've got records that need written, and I've also got this tool?’ So um, something has to give with conversations around diary management, but I know that can be a touchy subject, not just with my team, but that can be a touchy subject in terms of having those conversations sensitively.” [Health Visitor and School Nurse Team Leader 3 Hybrid]

When considering priorities, some felt that the process to fulfil the demands of good governance, was taking away from Nursing duties, and so they did not see a direct benefit to them from its use.

“But the whole process of doing it is pure bureaucracy. It's paperwork, it's data, it's not nursing, it's not caregiving, it's administration which I get Nursing will involve administration, but not to that degree.” Chief Nurse 3 (Urban)

Safe staffing levels are environment dependent. For example, it was noted that the tools are less reliable in a community setting:

“I think the tool is very biased towards acute services, and community is an entirely different beast. They (our patients) are not captive in a bed for a kick off. They roam free. They have an opinion on whether they'll be in or not, you know, and hard to reach families will actively evade us as well. So, it is much harder to be to apply the tool I would say in community settings.” [Health Visitor Team Lead 2 Rural]

Some suggested that rural small teams would be particularly vulnerable to short staffing. Another issue raised was the challenge of Agency staffing and recruitment to Island Boards. Because the particular Island did not have any Nursing Agencies, Registered Nurses who might live in one of the mainland cities, would come onto the island, provide cover for a fortnight, and go home.

The layout of the wards was seen to affect staffing needs, and therefore it is important to know if the CSM accurately captures that:

“This building is 130 years old, delivering 21st century healthcare in 19th century real estate. When you walk out to some of your wards, it literally goes in a V shape. You can walk straight ahead, or you can turn right. And depending on where you are down those corridors, you can have single rooms. So, for 24 patients, you could have two legs of 12. Now you would need more nurses to go the two legs of 12 than you would if you had one Nightingale ward of 24 because they then become more visible. So, somebody's becoming unwell, the person up there can't see them. But for the extra staff who could maybe man both at the same time... and that's what you put in these tools, but don't always get tangible outcome. You'll get feedback, but you won't get tangible outcomes.” [Chief Nurse 3 Urban]

Facilitators to using the CSM

Facilitators reflected cultural change, and normalisation. Aspects of cultural change included the discourse around what “safe” means; and the perception of tangible culture change arising from implementation of the CSM. Supporting staff was seen as vital, with ‘Local Champions’ being an

important means to engage hearts and minds, as well as sustaining the process by helping the workload tool run, provide training, and answer questions. These tended to be Senior Charge Nurses, Nurse Managers, Finance Managers or Nurse Directors.

Some staff suggested that the CSM was normalised for Nurses who had been using it for a large part of their time in the was embedded in the processes that they follow.

Staff described the ability of the CSM to identify the pressure points within the service, and to make others aware of the challenges some professional groups may face if understaffed. The clarity around the timescales involved in completing tasks that the CSM can bring, appeared to have reduced some of the unrealistic expectations and pressure placed on staff:

“I suppose it's made other disciplines aware of some of the challenges that certain disciplines might face if they are understaffed. It's brought a greater awareness to the team as a whole around some of the challenges that we face when we find ourselves in those circumstances. It's definitely taken some of the pressure off staff in terms of time scales in which certain tasks need to be completed.” [Nurse Team Lead 1 Urban]

Appendix One: Methods

Study design

Semi-structured interviews.

Participant eligibility criteria

We sought NHS staff across the following types of NHS Boards:

- island Board
- large Board
- mid-size Board
- special Board

Sampling

We sought to recruit staff experienced in interacting with the CSM, therefore we adopted purposive sampling based on the following professions:

- Board decision makers
- Senior Management Team (reflecting a broad range of disciplines and job types)
- Clinical managers
- Team Leads/Senior charge Nurses/Midwives

Running the interviews:

Participants were approached to take part in a recorded interview via Teams that would last 45-60 minutes. They were provided with verbal and written information about the study and had adequate time to decide whether or not they consent to be interviewed. For the purpose of a final report and journal article, identifying information (e.g. a participant's name), was anonymised. People were identified only by their profession and the type of environment they worked in (Urban, rural, or hybrid), to enable a better context re who said what.

Recordings were saved at a secure location online and stored only until a transcript of the talk has been made. Access to the recordings was by the primary HSR alone. Two second HSRs independently reviewed a sample of anonymised transcripts to check the quality of the analysis. All transcripts were run through NVivo, a computer software package, for the purpose of coding and analysing the qualitative data. A largely inductive approach to data analysis was taken to achieve comprehensive theory-building, see for example Locke (2007)¹.

¹ Locke, E.A., 2007. The case for inductive theory building. *Journal of management*, 33(6), pp.867-890.

Appendix Two: Interview schedule

1. Awareness and understanding
 - a) How engaged are you in applying the Common Staffing Method?
 - If engaged, please explain your role in the process,
 - If not engaged: please explain why not,
 - How are you being supported at applying the CSM within your clinical area?
 - b) Have you noticed any impact/improvement as a result of CSM being used within your clinical area?
 - c) Does your Board have Governance processes in place to support CSM?
 - How do these processes feel to you?
2. Acceptability
 - a) How confident are you at applying the CSM as an individual.
 - If you do not feel confident, why not?
 - Do you understand how the CSM is being applied within your clinical area/organisation?
 - Have you utilised any HIS resource to support your understanding of CSM, or are you aware of existing HIS resources?
 - b) How much effort does it take to engage with CSM?
 - If you have little capacity, how able are you to engage with CSM?
3. Barriers and facilitators
 - a) What has been a barrier to your application of the CSM?
 - Do you consider all of the elements of the triangle?
 - How do you apply each section of the CSM?
 - How have you worked round this?
 - b) What has facilitated your use of the CSM?
 - What would help you to ensure you can apply all elements of CSM?
 - How/why has this been impactful?
4. Perceived effectiveness
 - a) Can you provide evidence/examples to indicate if/to what extent CSM has achieved safer staffing levels?
 - b) In your experience, do you think CSM is an effective tool for achieving safer staffing levels?