HospiceUK

Safe and effective staffing for palliative care inpatient services:

an improvement resource

September 2025

Acknowledgements

This resource was developed by Hospice UK and authored by Ann Casey MBE, RN, FRCN based on the safe, sustainable and productive staffing guidance produced by the National Quality Board in 2016.

We are very grateful to the following organisations for supporting the Hospice Workforce Resilience programme, without whom this resource would not have been possible:

Julia Rausing Trust

National Open Garden Scheme

Masonic Charitable Foundation

We would like to give particular thanks to the members of our professional reference group for their generosity in giving their time, advice and support to this project:

Jane Turner (Chair), Chief Nursing Officer, Sue Ryder

Anita Hayes, Clinical Quality Lead, Hospice UK

Gemma Aspinall, Chief Care Officer, Northern Ireland Hospice

Emma Dixon, Director of Clinical & Digital Services and SIRO, St Ann's Hospice (now Moya Cole Hospice)

Ross Fletcher, Director of Clinical Services and Governance/ Deputy CEO, Barnsley Hospice

Ericka Lipscombe, Director of Care, Naomi House and Jacksplace (hospices for children and young adults)

Mandy Murray, Head of Clinical Services, St Columba's Hospice Care

Suzy O'Callaghan, Director of Clinical Services, St Wilfrid's Hospice (Chichester)

Cate Oliver, Director of People and Organisational Development, North Devon Hospice

Louise Pennington, Lead Nurse Palliative Care, University Hospitals Dorset NHS Foundation Trust

Ann Rhys, Clinical Director, Hospiscare

Sara Robins, Clinical Services Director / Deputy CEO, Arthur Rank Hospice Charity

Janet Simkins, HR Director, St Joseph's Hospice

Melanie Taylor, Evidence Lead, Hospice UK.

HospiceUK

About Hospice UK

Hospice care eases the physical and emotional pain of death and dying. Letting people focus on living, right until the end.

But too many people miss out on this essential care. Hospice UK fights for hospice care for all who need it, for now and forever.

How to cite this document

Casey A. Safe and effective staffing for palliative care inpatient services: an improvement resource. London: Hospice UK; 2025

Contact us

For more information about our workforce programmes, contact: clinical@hospiceuk.org

Publication review Next planned review date: Sept 2026.

Disclaimer

Contents

Figures

Tables

About this resource

Note that this publication does not include specific guidance for community palliative care settings.

A set of case studies to illustrate principles and practice of safe and effective staffing accompanies this resource. For further information, contact: clinical@hospiceuk.org

This document forms part of a pack of documents to help hospices, local commissioners, national health bodies and government departments with the planning, commissioning, and contracting of palliative and end of life care services for their populations from the independent hospice sector. See page 32 for further details about these documents.

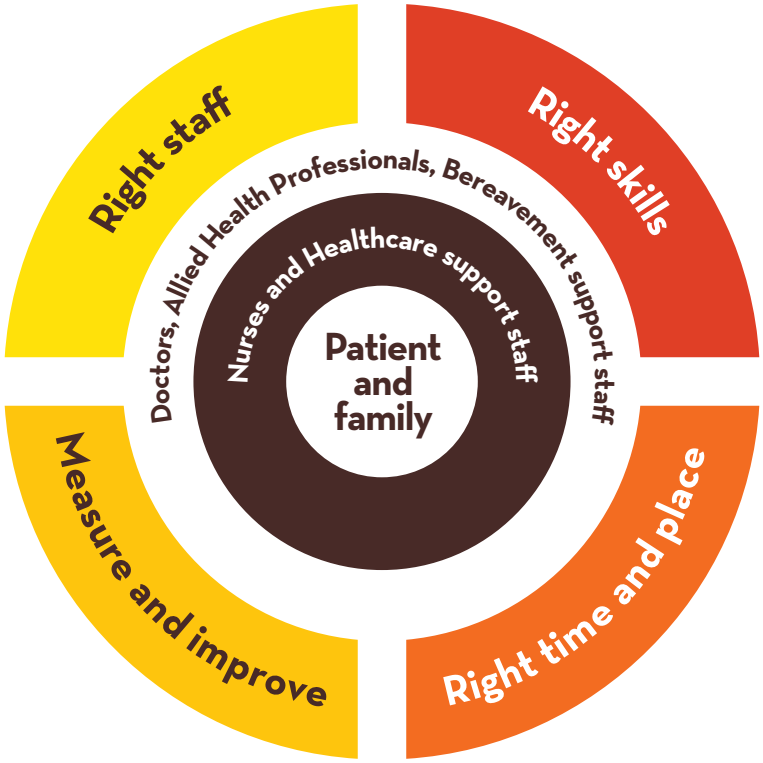
Summary

The National Quality Board (NQB) published guidance in 2016 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'[1], outlining its expectations and framework within which decisions on safe and sustainable staffing should be made to deliver safe, effective, caring, responsive and well-led care.

The scope of this safe and effective staffing improvement resource is to provide hospice leaders and clinical staff with guiding principles on planning, monitoring, and demonstrating their staffing requirements efficiently. This will help improve the quality of care and support productive discussions with commissioners and funding stakeholders.

The resource is based on previous work by the NHS and other hospices, together with an evidence review of the literature tailored specifically to the unique needs of the hospice sector. It covers staffing considerations for both adult and children's hospice inpatient services. In line with the recommendations of Sir Robert Francis (2013)[2], this document places the patient and their families at the centre of all safer staffing domains that contribute collectively to ensuring safer staffing is prioritised – see Figure. 1.

Figure 1. The domains of the safer staffing principles in hospices



Based upon the expectations set out by the National Quality Board in: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. NQB; 2016

1 National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. NQB; 2016
2 Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary (HC 947). The Stationery Office; 2013.

This resource includes all professions and support roles that contribute to safe and effective care for palliative care patients and their families. However, the core focus is on nursing and healthcare support staff due to the essential 24/7 need for these roles, as demonstrated in Figure 1 above.

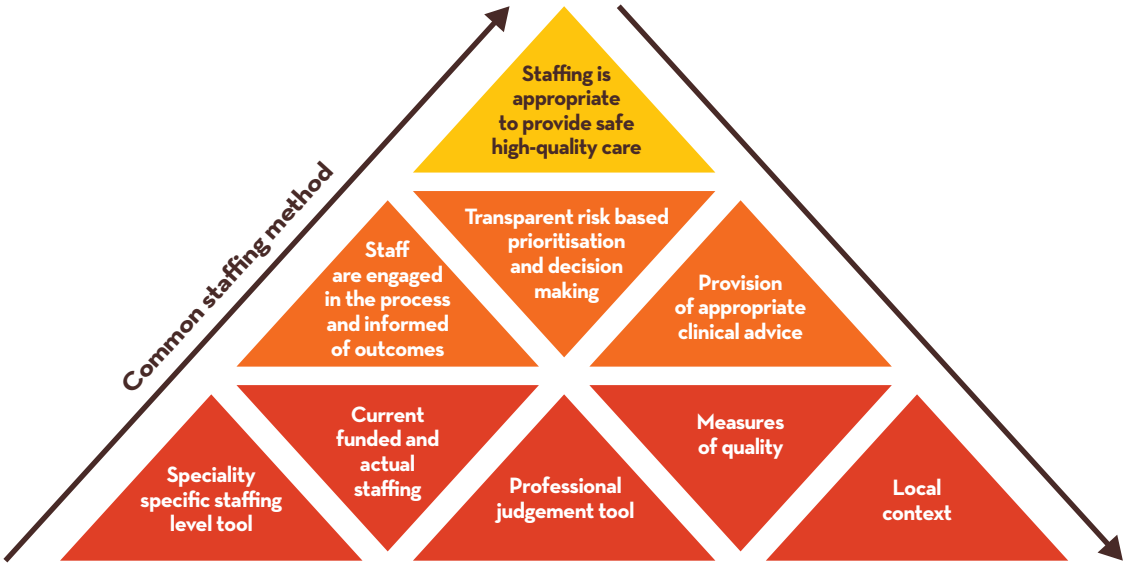
The resource supports the executive leadership team in their decision-making in relation to reviewing, monitoring and resetting staffing establishments in hospice settings across all UK nations. Where the hospice provider is delivering NHS England commissioned care, the executive leadership team must be cognisant of the requirements under Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014[3] which expects providers to deploy enough suitably qualified competent and experienced staff to enable them to meet all other regulatory requirements. Following the principles set out in this resource will enable teams to evidence how they are meeting Regulation 18. Despite having staffing legislation in NHS Wales, this does not apply to hospices and in common with Northern Ireland, Scotland and England, Wales follows the triangulated approach to reviewing, monitoring and resetting staffing levels on an annual basis. This is to ensure the right staff with the right skills are in the right place at the right time. In Scotland, hospices are not governed by NHS Scotland's safe staffing legislation and therefore are not required to use their tools and do not have access to them. It is, however, the responsibility of commissioners of services to ensure that the healthcare provider reviews current process and documentation relating to the securing of healthcare from other providers to ensure this has regard to the guiding principles and provides assurance that appropriate staffing arrangements are in place. The elements required specifically to meet NHS Scotland's safe staffing legislation (see the middle row in the middle section of Figure 2 below) are;

- Staff are engaged in the process and informed of outcomes.
- There is transparent risk-based prioritisation and decision-making.
- The provision of appropriate clinical advice.

This means that providers must follow the common staffing methodology, ensuring leaders of provider organisations:

- Use all available evidence within the context in which the care is being delivered.
- Ensure clinician input / advice is sought and encompassed.
- Ensures that any associated risks with staffing are identified and mitigated as far as possible when calculating the staffing needs, together with robust escalation processes.

Figure 2. Common staffing methodology, NHS Scotland



Source: Scottish Government. Common staffing method [Chapter 11]. Health and Care (Staffing) (Scotland) Act 2019: statutory guidance. 2024 [Internet] Edinburgh: Scottish Government [cited 02 Sept 2025] Reproduced with permission.

3 Care Quality Commission. Regulations for service providers and managers. Regulation 18: Staffing. [Updated 16 May 2025] [Internet] CQC. [2025]. Reproduced with permission.

Following the safer staffing principles set out in this guidance will enable executive leaders and senior staff to follow the triangulated approach to ensure the right staffing establishments are identified to meet patient needs using an evidence- based approach, that staff with the right skills and education are employed / in post, and that they are deployed effectively and efficiently to meet the needs of patients whilst prioritising safety for patients, families and staff. The guidance supports systematic approaches to monitoring patient and staff outcomes so that care staffing and their outputs are continuously improved, ensuring sustainable resourcing.

NHS England has developed an eLearning resource to support the development of the fundamental skills in safe and effective staffing[4]. It comprises six modules:

1. Essentials of safer staffing.
2. Safer staffing and quality of care.
3. Impact of policy on workforce and safer staffing.
4. Right place and the right time.
5. Safer staffing governance.
6. Safer staffing in maternity settings (for midwifery staffing only).

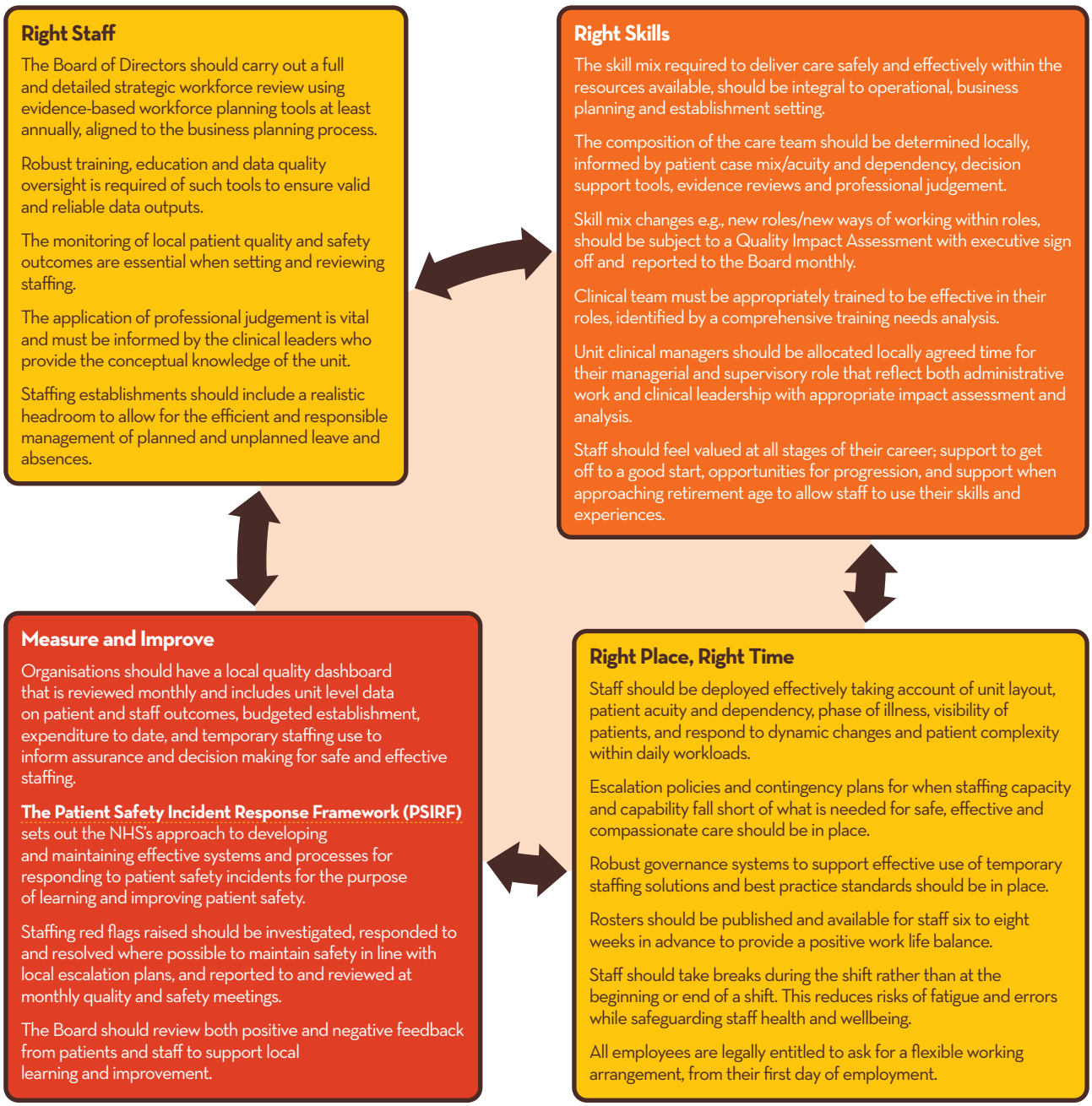
The sessions are short (each taking approximately 30 minutes to complete) and may be 'dipped into' for reference. Certificates are available for each session completed and for the overall programme. The modules are available to staff across voluntary sector hospices. Completing the programme will greatly enhance staff in their professional judgement application and support their decision making. Each session includes reference links to further resources should learners choose to check their understanding throughout the programme.

The improvement resource presented here is designed to support staffing in palliative care services within independent hospice inpatient units, as well as those within NHS hospitals for adult and children's units. Figure 3 summarises the key principles which are expanded upon in the main resource.

4 eLearning for healthcare. Fundamentals of safer staffing. [Internet] NHS England.

Key principles

Figure 3: Summary list of key principles



Based upon the expectations set out by the National Quality Board in: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. NQB; 2016

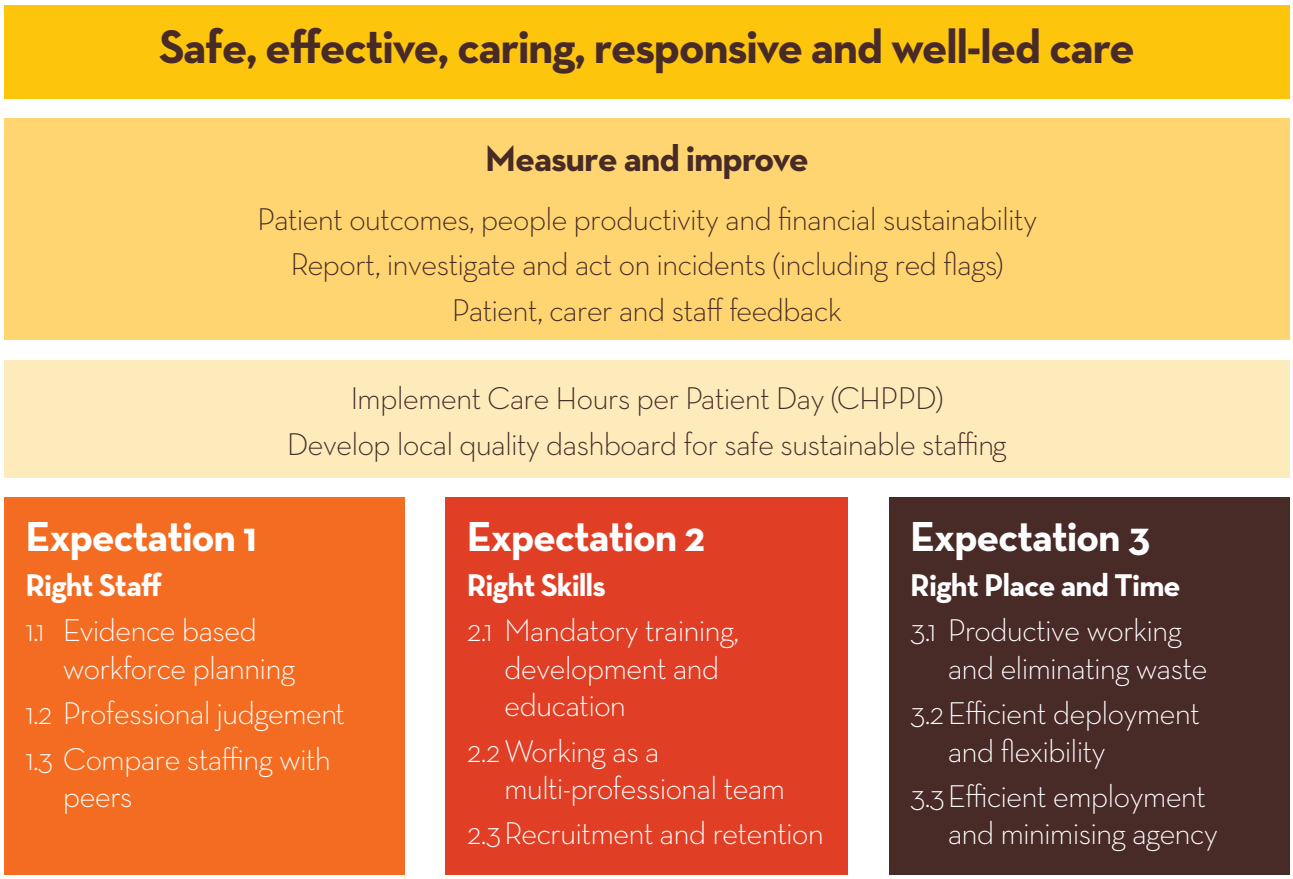
The Key Principles are available as a standalone document, which can be used as an aide memoire to this resource.

Background

This resource is based on the National Quality Board's[1] expectations that ensure safe, effective, caring, responsive and well-led care on a sustainable basis, with the employment of the right staff with the right skills in the right place at the right time (see Figure 4). In line with the overarching National Quality Board guidance, leaders of organisations are responsible and accountable for ensuring their patients receive quality, safe, dignified and compassionate care.

This improvement resource sets out key principles of safer staffing practice. It is designed to be used by everyone involved in clinical establishment setting, approval and deployment – from clinical practitioners and leaders through to the executive leadership team. The principles outline a systematic approach to identifying the organisational, managerial and local factors that support safe staffing in adult and children's palliative care inpatient services. It brings together the current academic evidence base and incorporates the standards set out by the National Quality Board, using a triangulated approach to determine staffing requirements rather than making judgements solely on numbers or ratios of staff to patients.

Figure 4: The National Quality Board's expectations for safe, sustainable and productive staffing (2016)



Source: National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. NQB; 2016

It is also important to recognise how an organisation's People Directorate, along with professional organisations and unions can support this work. A partnership approach using staff forums is important in developing and monitoring workforce policies and practices, and in influencing the organisational culture, addressing a working environment that is diverse and inclusive.

About hospice care

Hospices provide care at different stages of a person's illness, not just at the end of life. They provide palliative care, specialist palliative care and end of life care for people with a life-limiting or terminal condition. This holistic approach aims to improve quality of life and support people to live well until they die. Hospice care includes support for physical needs, such as pain management and stabilising a person's condition, as well as meeting their emotional, psychological and spiritual needs. The range of services that hospices provide typically include living well services, clinically-led outpatient and other community based care, along with inpatient services.

There are also bereavement support, befriending and compassionate neighbour initiatives which are mainly delivered by volunteers. Support for those important to a patient including family members and others in caring roles is a key part of hospices' work.

Education and research are foundational elements of hospice care and hospice education teams provide significant value to local health systems by enhancing the knowledge and skills of health and social care professionals across the system in providing quality palliative and end of life care. Indeed, regular training in palliative and end of life care to upskill patient-facing healthcare staff is recommended in order to build understanding of the importance of recognising the need for, and early introduction of palliative care[5, 6].

Hospices also play a crucial role as key community assets by providing compassionate palliative and end of life care, which enhances the quality of life for patients and those important to them. They contribute significantly to social capital by fostering a sense of community, support, connectedness and solidarity. In connecting communities, many hospices model the Asset Based Community Development approach[7] to identify what is important to a community and bring people together to share their strengths and take appropriate action. This includes supporting the development of death literacy[8] within local communities[9, 10, 11].

Hospice care for children and young people

Hospices play a crucial role in supporting children and young people who have been diagnosed with a life-limiting condition, and those people important to them. The need for this care is on the rise[12, 13, 14]. The provision of short breaks is an important aspect of care for children and young people.

The hospice workforce

The hospice workforce is comprised of a multidisciplinary team of professionals including volunteers. The team typically includes nurses, healthcare support workers/assistants, medical staff, social workers, allied health professionals, chaplains, bereavement support staff and family support therapists. The primary focus is on enhancing quality of life, managing symptoms, and providing compassionate care.

Hospice inpatient units are staffed 24 hours a day, seven days a week. Staff are employed either part-time or full-time, working a varied shift system of long or short days and nights, and many follow the terms and conditions as set out in the NHS Agenda for Change structure.

5 The National Confidential Enquiry into Patient Outcome and Death. Planning for the end: A review of the quality of care provided to adult patients towards the end of life. London: NCEPOD; 2024

6 Commission on Palliative and End-of-Life Care. Palliative and end-of-life care: opportunities for England. Vol. 1. Commission on Palliative and End-of-Life Care; 2025

7 Nurture Development. About ABCD. [Internet] [2018] [cited 02 Sept 2025]

8 Death literacy has been described as 'the knowledge and skills that people need to make it possible to gain access to, understand, and make informed choices about end of life and death care options'. Graham-Wisener L, Toner P, Leonard R, et al. 34 Death literacy in the UK– benchmarking levels of death literacy and validating a new measure. BMJ Support Palliat Care. 2022;12:A14

9 Tapping House. Compassionate communities. [Internet] [cited 02 Sept 2025]

10 Treetops Hospice. Compassionate communities project. [online] [cited 02 Sept 2025]

11 St Mary's Hospice. https://www.stmaryshospice.org.uk/compassionate-communities/ [Internet] [cited 02 Sept 2025]

12 Fraser LK, Gibson-Smith D, Jarvis S, Norman P, Parslow R. 'Make Every Child Count' Estimating current and future prevalence of children and young people with life-limiting conditions in the United Kingdom: final report February 2020.

13 Public Health Scotland. Children in Scotland requiring Palliative Care (ChiSP) 3. Edinburgh: Children's Hospices Across Scotland; 2020

14 Fraser L, Bedendo A, Jarvis S. Children with a life-limiting or life-threatening condition in Wales: trends in prevalence and complexity: final report May 2023.

The support of volunteers in palliative care is invaluable. Their roles support the provision of emotional support, companionship, and practical assistance. This assistance not only supports healthcare professionals but also enriches the lives of those they assist. Volunteers' dedication and empathy help create a nurturing environment that values the importance of human connection and dignity in the final stages of life.

The hospice workforce, like many in other large sectors and industries, is facing numerous challenges and the '10 Year Health Plan for England'[15] represents an opportunity to shape health and care services that can adapt to the future. In this changing landscape we know we cannot rely on the traditional solutions to some of our major workforce pressures and we need to think differently moving forward.

The 10 Year Health Plan[15] signals an intention to move the focus from hospital to community care. Neighbourhood health services will aim to bring together local patient-centred teams. This approach is already in place in hospices which have adopted the Asset Based Community Development approach[7] to identify what is important to a community and bring people together to share their strengths and take appropriate action. The 10 Year Plan[15] supports the use of non NHS capacity where it is available as well as closer partnership working across shared system/provider boundaries. There is an ambition to ensure all NHS staff have access to career coaching and developmental opportunities including the development of advanced practice models and increasing the numbers of nurse consultant posts. Alongside this there will be a focus on improving staff's attendance at work. All of these ambitions and aims are important today and for the future of staffing in palliative care services and these aspirations are supported within this resource.

15 Great Britain. Parliament. Fit for the future: the 10 year health plan for England. London: Stationery Office. 2025.

Academic review

The thinking and conceptualisation of this piece of work was informed by a series of literature reviews conducted by a qualified librarian on safe staffing in palliative and end of life care settings. This knowledge was further supported by a supplementary piece of work to map examples of patient acuity tools, along with commentaries on their use across different specialties, and within end of life care.

Restricted to information published in the English language, the literature searches were conducted in 2021 and 2024, using established clinical and medical databases (British Nursing Database, CINAHL, Cochrane Library and PubMed). The library databases maintained by the King's Fund and the Royal College of Nursing were also interrogated. Further manual searches of journals such as BMJ Supportive & Palliative Care, and Palliative Medicine identified conference proceedings of interest.

Both activity strands focused upon approaches and studies from countries with comparable systems and resourcing to the UK.

Right staff

There must be sufficient and appropriate staffing capacity and capability on palliative care inpatient units (IPU) to provide safe, high-quality and cost-effective care to patients at all times. Staffing decisions must be aligned to business planning processes so that quality care can be provided now and on a sustainable basis.

The nursing establishment is defined as the number of registered nurses, nursing associates, assistant practitioners and healthcare support workers /assistants (HCSW/A) who are required to work within a particular IPU or team. The IPU establishment may include allied healthcare professionals (AHPs), bereavement support staff and other support staff such as administrative staff or housekeepers, dependent on the model of care being delivered.

Evidence-based strategic workforce planning

In line with National Quality Board[16] and Developing workforce safeguards guidance[17], executive leadership teams should carry out a full and detailed strategic workforce review at least annually, aligned to the business planning process to provide assurance that staffing is safe, effective and sustainable. In addition, a mid-year review using an evidence-based workforce planning tool should be undertaken and reported considering the context of multi-professional staffing, triangulated with professional judgement and a review of quality outcomes for patients, their families and staff. Outside of these timeframes, if there are operational, structural or process changes, or concerns about patient or staff safety, a reassessment of the workforce establishment / model may be triggered.

Decision making to ensure safe and effective staffing for all multiprofessional groups must follow a logical process. Although registered nurses, nursing associates and healthcare support workers provide a significant proportion of patient-centred care within IPUs, due to their 24/7 presence, other groups to consider include:

- Clinical Nurse Specialists / Nurse Consultants.
- Bereavement support staff.
- Spiritual care staff.
- Medical staff.
- Allied health professionals.
- Advanced clinical practitioners.
- Paramedics.
- Pharmacists.

A transparent governance structure, including IPU to executive leadership team reporting of all multiprofessional staffing requirements, should be in place for determining staffing numbers and skill mix, and monitoring its effectiveness.

16 National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. NQB; 2016

17 NHS Improvement. Developing workforce safeguards: supporting providers to deliver high quality care through safe and effective staffing. London: NHS I; 2018.

Hospice executive leadership teams should be assured that the following key elements of planning are followed:

- Use of a systematic, evidence-based approach to determine the number and skill mix of staff required.
- Exercising professional judgement to meet specific local needs, but ensuring this does not duplicate elements included within any evidence-based staffing tool used.
- Reviewing the patient quality and safety outcomes for the IPU.
- Reviewing staff and workforce metrics.
- Taking account of national guidelines, bearing in mind they may be based on professional consensus.

Evidence-based workforce planning tools

Workforce planning tools that are utilised to support staffing establishments should be agreed and adopted by the hospice executive leadership team for implementation in practice. Robust training, education and data quality oversight are required for such tools to ensure valid and reliable data outputs. Workforce planning tools and how they are used can vary.

Being cognisant of the variation in workforce planning tools, executive leadership teams should ensure that there is:

- An evidence base for the tool's use in the palliative care specialty that has been subject to academic review.
- No local manipulation of the identified staffing resource from the evidence-based figures embedded in such tools, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived using the tool.
- Independent and systematic validation of such tools is applied consistently across the organisation and as directed by the tool's evidence base.
- Adherence to the guidance on the number of datasets and content required for setting unit establishments.
- Transparency of the results and agreed routes for decision-making.
- The relevant staff trained to use such tool.
- An agreed allowance for planned and unplanned leave (headroom as outlined later).
- Following of good procurement practice.
- Consideration of the occupancy and turnover within the IPU, which may be factored into such tools already.
- Consideration of the limitations of such tools, for example, small units, low occupancy and low patient acuity / dependency may not recommend sufficient staffing resource to provide the minimum numbers to meet staffing regulations across the IPU over the 24/7 period.

Professional judgement

When undertaking workforce planning a triangulated approach is encouraged; using an evidence-based staffing tool, in conjunction with clinical quality and safety indicators and professional judgement. The application of professional judgement is vital and in particular must be informed by the leads of each of the services as they have the expert clinical and conceptual knowledge of the areas.

A Professional Judgement Framework[18] has been designed to guide application of 'professional judgement' when considering the results of staffing reviews and the establishment recommendations. It is intended to provide a number of 'prompts' that might help sense-check the results of staffing reviews and help to provide confidence in the results, or else flag circumstances where a decision might be used to recommend a variation from the calculated figures.

18 Saville C, Griffiths P, Casey A, Chable R, Chapman H, Radford M, et al. Professional judgement framework: a guide to applying professional judgement in nurse staffing reviews. University of Southampton; 2023. doi: 10.5258/SOTON/P1102

Professional judgement is an essential element of staffing decisions. In exercising professional judgement, professional code or standards of conduct should be adhered to, such as the Nursing & Midwifery Council[19] (NMC) or Health and Care Professions Council[20] (HCPC).

Professional judgement may consider some of the following but not limited to:

- **Inpatient unit layout and visibility (single bedrooms)** The configuration of inpatient units and the visibility of patients affect the nursing time to deliver care and this can be reflected in staffing establishments through professional judgement. In some units there will be significantly more distance between patients than in others. In addition, a large number of single bedrooms within inpatient units may be considered as part of the safe staffing review. The availability of technology and equipment to support staff in these unit layout designs may also be a factor for consideration. This should be reported to the executive leadership team to support the rationalisation of final staffing requirements and recommendations.
- **Shift patterns** The type of shifts (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. Consideration should be given to a mixture of shift patterns to accommodate flexible working requests, occupational health recommendations and to support staff wellbeing. These should be monitored to understand the impact and effect on staff and patient outcomes.
- **Skill mix** The split of registered and unregistered clinical staff needs to be considered locally with regards the number of nurses and nursing associates and balanced with the numbers of healthcare support workers, taking into consideration the spread of acuity and dependency of the patients. Allied health professionals (AHPs), and other non-clinical staffing complements must be reviewed and monitored regularly due to the interdependency. If any changes are made to the spilt of registered and unregistered staffing resource, or changes to the interdependent roles such as bereavement support staff or AHPs, a full quality impact assessment (QIA) must be completed, monitored and reported to the executive leadership team. This is also required if new roles are introduced into the clinical area. The presence / absence of administrative support staff such as ward clerks may directly impact the nurses' workload at particular times.
- **Local factors** In the absence of a robust evidence-based workforce planning tool to match the vagaries of your particular IPU, it is important to apply professional judgement to staffing requirements. Some units operate a flexible approach to bed utilisation e.g., open / close beds as demanded and in these situations the staffing capacity must always be assessed and readjusted based on the overall care needs of the patients, i.e. acuity and dependency. However, some decision support tools may already cover these and therefore it is essential to understand the evidence underpinning the workforce planning tool used to avoid duplication.

Comparing staffing levels with peers or benchmarking

Benchmarking / peer comparisons can promote professional discussion and challenge around staffing, performance and outcomes. However, it is difficult to directly compare and contrast individual units, especially externally as the configuration of the IPU and its locality may not be the same. If examined you should aim to choose services with similar occupancy, configuration, locality, and case mix. While you should exercise caution in comparing staffing with peers, it can act as a 'sense check ', particularly on assumptions, red flags, staff and patient outcomes and professional judgements. You should take account of local factors, e.g., Phase of illness and performance status plus Integrated Palliative care Outcome Scale (IPOS)[21] as per the Outcome Assessment and Complexity Collaborative (OACC) suite of measures, patient acuity and dependency, as well as differences in the accuracy and completeness of data collection. Consider a network approach to share perspectives on safer staffing across palliative care services.

19 Nursing & Midwifery Council. The Code: professional standards of practice and behaviour for nurses, midwives and nursing associates. London: NMC; 2018.
20 Health and Care Professions Council. Standards of conduct, performance and ethics. Rev ed. [London]: HCPC; 2024.
21 Cicely Saunders Institute. Palliative care Outcome Scale. [Internet] [cited 02 Sept 2025]

Quality and safety outcomes

The monitoring of local patient quality and safety outcomes are essential when setting and reviewing staffing. As there are no national reportable measures collated, some local data may need to be collected at service level, such as place of death and / or admissions to hospital in the last 90 days of life as per the palliative and end of life care profiles statistics for England published by the Office for Health Improvement and Disparities[22].

The IPU clinical and service managers should be involved in the design of a local quality dashboard in order to access quality and safety information to inform staffing decisions. Such data including nurse sensitive indicators are referred to later in this guidance.

Allowing for headroom

Staffing establishments should include a realistic headroom (often called uplift) to allow for the efficient and responsible management of planned and unplanned leave and absences. Underestimation may result in an establishment that cannot meet day-to-day staffing requirements and over-reliance on unexpected and unfunded temporary staffing solutions.

Such types of planned and unplanned leave are:

- Annual leave in line with employment terms and conditions with long service enhancements.
- Study leave, and educational requirements in line with training needs analysis by headcount, competency frameworks and local requirements for statutory, mandatory and role-specific skills. Higher proportions of part-time staff will increase headroom requirements.
- Parenting leave; some organisations operate a central funding pool for parenting leave (calculated at unit level and then managed centrally).
- Sickness absence; this should be based on the organisation's target level of sickness / absence (e.g., 3% to 4%) and aligned to plans to implement improvements to support staff to be well and at work.
- Other unplanned leave such as compassionate leave.

Whilst the Royal College of Nursing has made a recommendation in their updated consensus guidance[23] of adding a minimum of 27% headroom to establishments, it does not provide either the breakdown of this or the evidence to support the figure. The Dash review[24] in its first recommendation calls for a revamp of the National Quality Board, and this body should then ensure that any unfunded mandates are not imposed on providers without due diligence. It is, therefore, important that the headroom provision applied is realistic and reviewed at least annually based on local data and intelligence. Service leaders supported by their executive leadership team should recruit into their full headroom allowance to ensure sufficient planned provision of substantive staffing levels to cover the IPU. Failure to recruit to the full headroom, can lead to increased reliance on temporary staffing and negatively impact patient outcomes as well as staff health and wellbeing.

Table 1 gives an example of how headroom can be calculated and may support local decision-making. Please note that the percentages used here are illustrative examples only and **not** based on any guidance or evidence. As such they should be adapted for local decision making.

22 Office for Health Improvement and Disparities. Palliative and end of life care profile December 2023 update: Statistical commentary. [Internet] [Updated 17 Sept 2024] Gov.UK. [cited 02 Sept 2025]

23 Royal College of Nursing. Nursing workforce standards. [Internet] 2025. RCN. [cited 02 Sept 2025]

24 Dash P, Department of Health and Social Care. Review of patient safety across the health and care landscape. London: DHSC. 2025.

Table 1: Example considerations in setting headroom

Element	Example %	Rationale
Annual leave	13.5%	This is the average annual leave across the workforce, in line with Agenda for Change and should take account of local patterns and length of service.
Sickness / absence	4%	This is a target to ensure processes that promote staff wellness are in place which allow staff to attend work as planned.
Study leave	4%	This includes mandatory and core / job-specific training and learning activities.
Parenting leave	1%	In some organisations this is managed centrally. It includes maternity, paternity and adoption leave, and is driven by local workforce demography.
Other leave	0.5%	This includes carers' leave, compassionate leave, etc.
Total	23%	The total percentage added to the calculated establishment to ensure deployment of appropriate staffing for the unit.

Appendix 1 (see page 30 – 'Calculating your headroom' – provides detailed guidance on how to complete the calculation of headroom using a bottom-up approach.)

Information required to support establishment reviews

To support the triangulated approach where data from evidence-based tools, outcome measures for patients and staff, alongside professional judgement is used, see the data sets in Table 2 below.

Table 2: Data sets to support the triangulated process of safer staffing reviews

Patient related	Staff related	Process / system related
Patient acuity and dependency data	Workforce metrics such as turnover, sickness absence, vacancy, reasons for leaving	Educational requirements
Occupancy* of IPU	Staff survey results	Staffing red flags
Patient survey / experience results	Care hours per patient days (CHPPD) / staffing fill rates	Rostering KPIs / metrics
Clinical indicators such as falls, pressure ulcers, medication omissions	Temporary staff utilisation and reasons Occupational injury	Integrated Palliative care Outcome Scale (IPOS) Karnofsky Performance Scale (KPS)
Complaints and compliances		

*Exercise caution as occupancy may be included within the evidence-based workforce planning tool utilised.

Right skills

Decision-makers should give appropriate consideration to the right skills required to deliver services as safely, efficiently and effectively as possible. Clinical leaders and managers should be supported to deliver quality, efficient services, and staffing should reflect the multiprofessional team approach. Clinical leaders should use the workforce's competencies to the full, introducing and supporting the development of new roles where they identify a need or skills gap in line with national policy / best practice. Attention should be paid to the needs of the workforce, recognising that skill sets change over time, particularly as supply routes expand in line with the new ways of training and education and recruitment sources.

Our ability as professionals to adapt and innovate is vital to achieving quality care in the right place and at the right time. By ensuring we utilise the most up-to-date intelligence and insights, we can shape a workforce that is fit for purpose for the next decade and beyond, as well as demonstrate positive outcomes and experience for our patients and their families. To optimise the workforce efficiently and effectively, local determinants should inform the skills required across all IPUs, recognising that colleagues today have different expectations of their employers than previously. Flexibility, working differently, and roles crossing organisational boundaries are now essential if we are to retain the talent we have in healthcare across the United Kingdom.

Thinking about how services can be designed for the future, and talking and listening to staff, patients and families can enable organisations to develop models that are more likely to be sustainable.

Multiprofessional teams

IPUs require a multiprofessional team approach. As nurses are the workforce more consistently rostered to work 24/7, the following should be considered when determining who is best placed to safely meet patients' care needs. To utilise the workforce efficiently and effectively, it is important to identify the skills needed to deliver the care required and to deploy the right staff to deliver that care.

While AHPs are not typically rostered within an inpatient staffing establishment and may work as part of a peripatetic team, they are part of the core team and vital to the delivery of care.

Nursing, medical, AHPs, bereavement support staff and spiritual carers have key roles in directly influencing the quality of care that patients and their families receive and the decisions made around all aspects of an individual's admission, treatment, discharge / death (see page 13 – Evidence-based strategic workforce planning). The skills across the professions are wide and varied in the palliative care setting but some core elements are:

- Highly developed clinical reasoning.
- Rapid but effective decision-making.
- Patient / family focused goal setting.
- End of life planning / future care planning.
- Personalised end of life care.
- Complex symptom management.

Skill mix

The skill mix and staffing required to deliver services safely and effectively within the resources available should be regularly reviewed and should be integral to an organisation's operational and business planning and establishment setting. The composition of the care team on each IPU should be designed to ensure they are appropriate to meeting the needs of the patient group cared for in this unit. The appropriate mix of nursing workforce, which may include registered nurses, nursing associates and healthcare support workers (HCSWs), should be determined locally, informed by patient case mix / acuity and dependency, decision support tools, evidence reviews and professional judgement. In addition, shift by shift skill mix and staffing decisions are required. Specific roles may more appropriately meet the needs of specific patient groups at particular times of the day or across the seven-day service, for example physiotherapy / occupational therapy. Conversely, the absence of administrative support staff such as ward clerks and bereavement support workers may increase nurses' workload at particular times.

A range of clinical nurse specialist and advanced nurse / clinical practitioners, AHPs, doctors and spiritual care professionals provide expert advice, intervention and support to IPU teams. It is important therefore when considering the 'right skills' to meet patient and families' needs, as well as the staff allocated / rostered to each IPU[25], to take a wider view of access to the relevant expertise across the organisation / local healthcare providers. The inclusion of support staff such as ward clerks and housekeepers are vital to assist in effective functioning of IPUs. Skill mix changes that modify funded establishments to develop new roles or new ways of working within existing roles – for example, nursing associates or apprenticeship frameworks – should be based on a comprehensive assessment, including a full Quality Impact Assessment (QIA) and executive sign-off. Risks should be recorded on local and corporate risk registers as well as the QIA, to enable regular monitoring. Organisations should have measures that are routinely assessed against Key Performance Indicators (KPIs) to ensure safety and effectiveness.

Unplanned gaps in skill mix need to be managed effectively to reduce the impact on care quality and safety. Organisations should have regular touchpoints to review staffing throughout the working day to help identify, mitigate, and escalate gaps in skill mix. Clinical leaders should consider how local escalation processes support both larger clinical sites, and also smaller / peripheral / isolated sites with a smaller critical mass of staff. Escalation processes should take into consideration the professional judgment of local clinical leaders. The use of in-house bank staff or peripatetic teams of registered nurses and HCSWs to support short notice, unplanned gaps in skill mix provides greater continuity of care.

Some organisations operate a subject matter 'champion' model whereby members of the IPU team assume a lead role for a particular area of practice: for example, nutrition or tissue viability. It is important that these members of staff have the relevant education, training and dedicated time to function safely and effectively in these roles.

Staff training, development and education

All members of the clinical team must be appropriately trained to be effective in their roles. The senior nurse / clinical team leader is responsible for assessing the training requirements of individual team members. A comprehensive training needs analysis identifies opportunities for upskilling staff to address gaps in patient care. These should be completed annually or more frequently if the model of care is changed and a plan developed to meet them using available resources as part of the locally agreed headroom (see 'Allowing for headroom' section on page 16). This assessment enables opportunities to be identified to upskill staff to address gaps in expertise in the delivery of patient / family care. Education and training needs and competency assessment can be met through, for example, local skills training and assessment, eLearning, seminars, shadowing, clinical placement exchanges and rotation programmes. Compliance with performance reviews and mandatory / skills training should be incorporated into the local quality dashboard.

25 Payne S, Harding A, Williams T, Ling J, Ostgathe C. Revised recommendations on standards and norms for palliative care in Europe from the European Association for Palliative Care (EAPC): A Delphi study. Palliat Med. 2022; 36(4):680-697. doi: 10.1177/02692163221074547. Epub 2022 Feb 3.

Consideration should be given to the specific learning and development needs of the newly-registered workforce. The Nursing Midwifery Council (NMC) sets out the principles for preceptorship[26]. Local conversations with staff, accredited education institutions (AEIs) and clinical leaders can help inform this. Career progression pathways should be clear for all clinical staff, but particularly those newly-registered staff, including internationally-educated colleagues. Organisations may wish to consider the provision of senior workforce across the 24-hour period to maximise support for clinical colleagues and ensure all staff have been appropriately assessed. In addition, clinical leaders may be supported by clinical / practice education teams. Many organisations are benefitting from the role of legacy mentors who are experienced nurses, usually in late career, who can provide coaching, mentoring and pastoral support to nursing staff at the start of their careers or who are newly appointed into the palliative care sector.

Whilst education and training may be directed to specialist palliative care qualifications enabling advanced and enhanced levels of clinical practice, clinical leaders are advised to pay equal attention to the learning and development of clinical staff within general areas of practice to enhance retention and career progression of those colleagues. This should be identified and planned as part of the annual appraisal process and development of a personal development plan.

Registered professionals require periodic revalidation. Although individuals are responsible for ensuring they revalidate, many organisations have adopted a partnership approach.

Apprenticeships and 'grow your own'

In addition to the traditional career development framework, organisations should develop opportunities to expand and diversify their workforce. The leadership team needs to consider the alternative routes and development of existing staff by upskilling and career developments such as apprenticeships which are available, e.g., registered nurse degree, nursing associate, physiotherapy and clinical practitioner. Succession planning is vital and all opportunities to secure the future workforce should be considered. Such approaches and opportunities will increase retention and support development opportunities for the workforce.

Leadership and teamwork

The IPU clinical leader's role is critical to ensuring the delivery of safe and effective care, and is responsible for ensuring staffing meets locally agreed levels. This post-holder is also responsible for setting the culture of compassionate care and team working. Unit sisters / charge nurses / team leaders need to be prepared for the role and given ongoing support. It is important to allocate time in the roster for managerial work and for supervision of staff. The extent of supervisory time should be determined locally and needs to reflect both administrative work and clinical leadership with an appropriate impact assessment and analysis. It is essential to recognise that supervisory practice time is not entirely non-clinical office-bound and the following elements should be included:

- Working directly with new staff, providing support, expert clinical guidance.
- Observing care delivery, undertaking key audits for assurance.
- Leading the medical care review rounds.
- Participating in the multidisciplinary team care reviews.
- Working within the clinical establishment to provide leadership, particularly where the skill mix requires this.
- Supporting colleagues to undertake key leadership duties to promote effective succession planning.

26 Nursing & Midwifery Council. Principles for preceptorship. London: NMC; 2020.

Referring to the need for ward leader supervisory time the Mid Staffordshire Inquiry Report[2] (page 106) said:

> *'Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.'*

Effective teamwork requires a clear understanding of the standards and responsibilities of all workforce staff. Crucially there needs to be reliable psychological safety to allow professional challenge and an opportunity to continually improve care for patients, their families and working conditions for staff. The importance of equipping staff with the skills to recognise the need to 'speak up', identify and mitigate discourtesy and acknowledge the need to protect each other against potential moral harm, have become important within modern healthcare working environments. Strengthening culture through active listening, ensuring dialogue with other teams, senior leadership teams and the executive leadership team is an important part of building trust, respect and understanding. Using staff and patient feedback, local intelligence and Hospice UK staff survey results[27] should guide discussion and inform learning and changes to practice and culture.

Recruitment and retention

Recruitment and retention strategies at organisational and IPU level are vital to the overall workforce plan. Clinical leaders can identify or anticipate problems with recruitment and retention by monitoring, managing and planning for:

- Vacancy rates.
- Sickness absence.
- Turnover.
- The team profiles.
- Staff and student survey results.
- Recruitment process.
- Outcomes from retention / exit interviews.
- Career development and staff performance reviews.
- Parenting / other leave.
- Succession planning.

Staff should be recruited using an inclusive, competencies and values-based selection process aligned to the vision, mission, values and behaviours of the hospice, which are often aligned to the NHS Constitution[28], the People's Promise[29] and local policy, to support a culture of quality care and experience.

Factors important in attracting new staff and retaining existing staff are:

- IPU and / or organisational culture including leadership and management support.
- Team dynamics.
- Equality of opportunity, valuing diversity and inclusion of all staff, and embedding anti-racism interventions.

27 Hospice UK. Hospice workforce data collection. [online] [cited 02 Sept 2025]
28 Department of Health and Social Care. The NHS Constitution for England. [Internet] 2012. Gov.UK [cited 02 Sept 2025]
29 NHS England. Our NHS People Promise. [Internet] [cited 02 Sept 2025]

- Flexible working arrangements / shift patterns, including self / team rostering.
- Preceptorship programmes / ongoing education, induction, onboarding, specialist palliative care qualifications and training opportunities.
- Ensuring a safe working environment, e.g., addressing the risk of work-related health and safety risks.
- Health and wellbeing support and pastoral care.
- Taking into account personal circumstances, aspirations, preferences and career stage.
- Clinical workload.
- Geographical location, e.g., ease of travel access and cost of living.

Strategies to improve retention can prove cost-effective because experienced staff are retained while agency and recruitment costs are avoided / reduced.

Leadership, adequate resources, and opportunities for development and progression strongly influence turnover. Organisations should be aware of the staff age profile and experience of their staff and may consider flexible working and legacy mentor roles in retaining staff of retirement age to ensure valuable skills are not lost. Consider the need for succession planning for all leadership roles.

We recommend working closely with staff at a local level to monitor job satisfaction and general working environment, and to identify what influences their decision to leave, so that ways to retain them can be found. These should be reviewed on a regular basis and included in the annual resetting of establishments triangulated process.

Staff health and wellbeing

Staff should feel valued at all stages of their career, this includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experiences.

Health and wellbeing are essential for supporting retention and recruitment of staff. Ensuring the utilisation of Resilience Based Clinical Supervision creates a sustainable compassionate environment impacting emotional wellbeing of all staff reducing staff absence, burnout and stress[30].

30 Hospice UK. Resilience-Based Clinical Supervision support. [Internet] [cited 02 Sept 2025]

Right place, right time

Having the right workforce at the right time to meet the varying demands of patient care requires planning, collaboration, and staff engagement. While there will always be unanticipated peaks in activity, demand is relatively predictable. Staff should be deployed in ways that ensure patients receive the right care, first time, in the right setting, in a sustainable way. This can be achieved through effective management and rostering, with clear escalation processes if concerns arise. This will also include:

- Effective leadership.
- Flexible opportunities for staff working.
- An open and transparent culture to safe staffing.
- Executive leadership team level oversight ensuring floor to executive reporting.

The effective utilisation of the healthcare workforce should consistently be our priority ensuring the existing skilled staff are available to meet patient and family needs. Safe and effective working in IPUs can be supported by:

- Coproduced responsive services enabled by technology.
- Robust staff planning and workforce reviews.
- Assessment of patient care needs i.e., acuity and dependency / Phase of Illness, / Karnofsky Performance scale (KPS).
- Systems and processes to manage effective deployment, such as e-rostering.
- Effective and efficient handover processes.
- Safety huddles and 'rumbles' at regular intervals.
- Flexible working to meet service needs and utilising available resources as effectively as possible.
- Utilising the most appropriately skilled staff member to support patients' needs and clinical care.
- Efficient layout of the unit and working environment.
- Administrative, bereavement and other support staff working within the unit / hospice.

Efficient deployment and flexibility

Having agreed an appropriate staffing establishment for each IPU using an evidence-informed approach, the effective deployment of staff is essential to ensure alignment to patient care requirements. The unit manager needs to take into consideration the unit layout, patient acuity and dependency, phase of illness, visibility of patients, and respond to dynamic changes and patient complexity within daily workloads. The availability of the wider MDT and how they are allocated to and deployed on a shift-by-shift basis to support the unit should be taken into account. Each unit should have a robust escalation process to provide a systematic approach for reporting and responding to risks and red flags to address unexpected unmet workload demand, minimising the reliance on agency staff where possible. All members of the unit team should be encouraged to escalate staffing concerns immediately or report retrospectively if necessary.

Factors to consider when rostering clinical staff include:

- In-charge capability / competence.
- Skill mix.
- Patient acuity and dependency / Phase of Illness / caseload.
- Admission and discharge profile.
- Layout of the unit and number of single bedrooms.
- Training requirements.
- Patient-focused activity, e.g., MDT reviews, case conferences.
- Staff flexible working arrangements and rostering rules.
- Utilisation of the planned portion of the headroom, e.g., percentage of annual leave required to be used in each roster.
- Alignment between budgeted establishment and unit roster templates.

Flexible working

All employees are legally entitled to ask for a flexible working arrangement, from their first day of employment[31].

Having a flexible working arrangement may support the retention of the workforce, reducing vacancy and improving attendance at work rates, and consequently supporting the delivery of quality patient care. Requests should be considered in accordance with the hospice's policy and always consider the needs of the clinical areas, the needs of the team and the individual.

Flexible working arrangements might include:

- Full-time to part-time work.
- Altering the part-time hours worked, for example, from weekends to weekdays.
- Changing working hours to support work / life balance, e.g., school hours or care arrangements.
- Compressed hours.
- Job-sharing.
- Self-rostering, where the shift pattern is drawn up to match staff preferences, as closely as possible.
- Changes to start and finish times.
- Annualised hours, where working time is organised around the number of hours to be worked over a year rather than over a week.

Individuals, managers and teams should work together to explore the flexible working options that are available locally which supports the individual and meets the bespoke needs of the patients and service. Flexible working arrangements should be reviewed on a regular basis to ensure they continue to meet the needs of both the individual and the service while:

- Providing safe, quality care for patients and their families.
- Maintaining the positive work-life balance for colleagues.

Most IPU staff work shift patterns of varying lengths to accommodate patient need and staff preferences. Twelve-hour shift patterns have been shown to impact on patient and staff experience, such as increasing continuity of care, reduced cost, and improved systems' productivity[32]. However, working consecutive 12-hour

31 Advisory, Conciliation and Arbitration Service. Statutory flexible working requests: the right to request. [Internet] 2024. Acas. [cited 02 Sept 2025]

32 Dall'Ora C, Ejebu OZ, Griffiths P. Because they're worth it? A discussion paper on the value of 12-h shifts for hospital nursing. Hum Resour Health. 2022; 20(1):36. doi: 10.1186/s12960-022-00731-2.

shifts or switching from day shifts to night shifts within the same week may be associated with increasing fatigue and therefore unit managers planning the rosters should be cognisant of this. The aim should be to ensure roster shift patterns are organised to address the needs of the unit, taking into account staff health and wellbeing and ensuring adequate rest breaks within shift patterns[33]. The practice of staff moving from day to night shift within the same 24- hour period is discouraged and if a decision is made to utilise this option in an emergency situation, then an incident report should be recorded, outcome measured and reported to the executive leadership team.

Rest breaks

Local policies for managing rest periods must meet working-time regulations. 'Workers have the right to one uninterrupted 20 minute rest break during their working day, if they work more than 6 hours a day... The break doesn't have to be paid – it depends on their employment contract'[34].

Staff should take breaks during the shift rather than at the beginning or end of a shift. This reduces risks of fatigue and errors while safeguarding staff health and wellbeing. It is important to remember that access to adequate rest, refreshments and hydration facilities should be provided and time to access them should be allowed. Daily staffing levels must take into consideration the need for break cover to maintain consistent staffing levels throughout each shift across the IPU.

Effective rostering

In order to ensure an agreed and planned approach to staff deployment it is essential to have effective rostering systems in place. This is necessary to ensure that the right staff, with the right skills are in the right place at the right time, to meet patient care needs and family support. Electronic rostering can support flexibility as well as incorporating self or team-based rostering options. Rosters should be published and available for staff six to eight weeks in advance to provide a positive work life balance. This will assist in identifying any gaps in staffing and enable timely appropriate actions to mitigate these. Regular roster and staff planning assurance meetings are recommended, to improve rostering for all workforce groups, where professional review of the roster's effectiveness can be undertaken and improvements made as appropriate. These meetings may have representation consisting of senior clinical and operational staff who are responsible and accountable for overseeing roster management and staff deployment.

Staff responsible for developing and managing rosters must be trained in best practice principles and in the use of the e-roster system where they are in place. The senior nurse and / or shift leader should review daily staffing levels in real-time – staff, skills, patient acuity and dependency, and phase of illness, to support evidence-based decisions on safe and effective staff deployment across the IPUs. Daily operational changes need real-time responses to deploy and redeploy staff in order to remain safe. These must be recorded in the roster system at the earliest opportunity. Best practice guidance for effective e-rostering is available from NHS England's good roster guidance[35] and attainment levels handbook[36].

Electronic rostering may provide a clear oversight of staffing across all services, not only month by month but day to day and even shift to shift. Rosters (electronic or paper based) should always reflect the availability and real time deployment of all staff at any given time and should therefore be updated as soon as changes to staffing arise e.g., sickness. Ensuring only the agreed proportion of staff are on planned leave and appropriate management given to any short-term absence or unplanned leave will enable optimal availability of staff to fulfil a roster. Rostering key performance indicators (KPIs) and other metrics need to be owned at all levels of the organisation, and should be reviewed monthly to ensure adherence to rostering management principles.

33 Flo E, Pallesen S, Moen BE, Waage S, Bjorvatn B. Short rest periods between work shifts predict sleep and health problems in nurses at 1-year follow-up. Occup Environ Med. 2014; 71(8):555-61. doi: 10.1136/oemed-2013-102007. Epub 2014 Jun 11.

34 Gov.UK. Rest breaks at work. [Internet] [n.d.] [cited 02 Sept 2025]

35 NHS England, NHS Improvement. Nursing and midwifery e-rostering: a good practice guide. Rev ed. 2019

36 NHS England, NHS Improvement. E-rostering the clinical workforce. London: NHS England & NHS Improvement; 2020

If the skill mix is changed or redesign of services are made, a full quality impact assessment (QIA) should be completed and monitored on a regular basis to scrutinise any risks to patient or staff safety and wellbeing.

Escalation and oversight

Despite the best planning, there will be times when patient care demands exceed the planned levels of staffing. Escalation policies and contingency plans for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care should be in place. These should be accessible, and all staff should be aware of the steps to take where capacity problems cannot be resolved.

Staffing levels should be reviewed on a shift-by-shift basis in line with local staffing arrangements in and out of hours. IPU clinical leaders should have an agreed workforce mitigation plan allowing consistency when making decisions on any unanticipated staffing shortfalls. In the first instance, these should be highlighted in daily / twice daily staffing huddles and where necessary record incidents or staffing red flags. The rationales for these staffing decisions should be clearly documented and reviewed on a regular basis to ensure consistency of approach and contingency planning for the future management. If longer periods of workforce shortages are anticipated, forecast planning is required to ensure that IPUs are safely staffed.

All hospices should have a process that includes triggers, actions and communication which allows safety risks to be clearly identified and understood from IPU to executive leadership team. This is to ensure that responses and decision-making is at the most appropriate level to manage any safety / staffing concerns. Safety huddles may need to be increased to ensure ongoing communications and to provide opportunities for staff to raise any concerns. Staff debrief and wellbeing should be considered throughout any period of escalation.

Effective employment

It is good practice for a clear workforce plan for all workforce groups to be agreed and signed by the nurse and doctor on the executive leadership team. However, IPU staffing establishments will require capacity to respond to peaks in patient care needs or unanticipated staffing shortages. Capacity may be increased, for example, through agreed overtime, additional hours, temporary staffing utilisation.

Temporary staff are a valued part of the overall workforce, and when correctly trained and inducted into an organisation, can be a useful contingency for covering planned and unplanned staff shortages. Robust governance systems to support effective use and best practice standards are important to have in place. Having a one or two preferred agency enables professional relationships and consistency of supply. The benefits of training shifts where the preferred agency's staff receive training can provide a robust framework for ensuring temporary staff are inducted and enabled to work effectively within the team. Following a staged approach to temporary staffing such as, Bank staff > Agency 1 > Agency 2, may provide a more sustainable and safe solution to workload escalation.

All temporary staff should receive local training, induction and adequate orientation for the area in which they are working. They will require access to any electronic patient systems, including health records systems, medicines administration and security access (as required) for the IPU to which they are deployed. Temporary staffing usage and spend should be reviewed as part of the monthly review of the quality dashboard for safe and sustainable and productive staffing.

Measure and improve

Palliative care organisations should collect organisational and unit level metrics to monitor the impact of staffing levels on the quality of patient care and outcomes, the use of resources and on staff themselves. The aim should be to continuously improve patient outcomes, enhance staff experience and use of resources in a culture of engagement and learning.

Evidence-informed metrics may focus on:

- Patient and staff outcomes (e.g., patient and staff incidents).
- Patient and staff experience (e.g., patient and staff survey, and compliments / complaints).
- Staffing data (e.g., appraisal, retention, vacancy, sickness).
- Process measures (e.g., hand hygiene, documentation standards).
- Training and education (e.g., mandatory training, clinical training).

Learning lessons to improve the quality and safety of patient care is a prime function of the dashboard review.

Measure patient and staff outcomes, people productivity and financial sustainability

Organisations should have a local quality dashboard for safe and sustainable staffing that is reviewed monthly and includes unit level data including the budgeted establishment and expenditure to date, as well as temporary staffing to support decision-making and inform assurance. Wherever possible, it is advised that existing data and metrics are used, though organisations may need to set up new metric reporting locally for new measures as appropriate. Utilising a problem-solving strategy which identifies and allows learning from individuals or groups who are successfully addressing a problem despite facing similar challenges and constraints is a key function of the dashboard review which enables understanding of areas of excellence and supporting the spread to other areas. It is also important to understand how nurse staffing levels influence metrics on a pathway basis, where harm can occur at different stages. Staffing data can usually be directly linked to a unit, while processes carried out on a unit (such as rounding, taking observations or administering medication) can be effectively monitored IPU by IPU. However, patient pathways may include more than one service and linking outcomes directly to a single unit is often not possible. For example, care provision in an acute care provider or community service may result in harm later in a patient's stay. Monitoring a range of information is critical to creating a feedback loop that helps you understand whether staffing is meeting patient care needs effectively. This monitoring enables continuous improvement not only in outcomes, but in using the available resources most effectively.

Organisations should develop locally agreed nurse sensitive indicators as part of their triangulation processes. These can measure structures, e.g., the staffing skill mix, processes, e.g., tissue viability risk assessment or outcomes, e.g., numbers / category of pressure ulcers acquired within the service or staff sickness.

These may include incidents such as pressure ulcers, falls with harm, infection prevention and control incidents. However, the evidence to link specific patient and staff outcomes to nurse staffing levels is not conclusive[37, 38]. Blume et al. undertook an umbrella review of staffing levels and nursing-sensitive patient outcomes, concluding

37 Blume KS, Dietermann K, Kirchner-Heklau U, Winter V, Fleischer S, Kreidl LM, et al. Staffing levels and nursing-sensitive patient outcomes: Umbrella review and qualitative study. Health Serv Res. 2021; 56(5):885-907. doi: 10.1111/1475-6773.13647. Epub 2021 Mar 15.

38 Shin S, Park JH, Bae SH. Nurse staffing and nurse outcomes: A systematic review and meta-analysis. Nurs Outlook. 2018; 66(3):273-282. doi: 10.1016/j.outlook.2017.12.002. Epub 2018 Feb 26.

that evidence for a range of widely considered nurse sensitive indicators such as pressure ulcers, patient falls and urinary tract infections were not strong[37].

The impact on staff outcomes should also be considered. Immediate issues may need to be addressed on a shift-by-shift basis but reported and reviewed monthly. A systematic review of nurse staffing and nurse outcomes conducted by Shin et al found that whilst higher patient to nurse ratios related to poorer nurse outcomes such as burnout and higher intent to leave, further studies were required to determine the optimal level and association[38]. In the same review they identified an increase in staff occupational injury i.e., needlestick injury, however, this was not statistically significant. Other staffing metrics that may be considered as part of the safe, effective and productive staffing metrics that are reviewed monthly include staff related red flags, staffing fill rates, retention, vacancies, sickness / absence, use of temporary staff or the loss of educational opportunities.

In the absence of robust evidence for specific nurse and patient outcome metrics aligned to staffing it is recommended that local metrics are identified and trends over time are tracked, reviewed and reported alongside staffing data.

Report, investigate and act upon incidents

The Patient Safety Incident Response Framework (PSIRF)[39] in England sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This framework, focused on how the NHS and providers of NHS contracted care act on patient safety incidents, raises attention about how incidents happen as well as the factors that contribute to them occurring. This approach has been adopted by many hospices and palliative care providers and is an approach supported by Hospice UK, as well as a contractual requirement under the NHS Standard Contract[40] and as such is mandatory for services provided under that contract.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

Regardless of approach to patient safety incident management, providers of care should consider any staff capacity and capability issues identified, and act accordingly. All staff should be encouraged to report any occasion where a suboptimal level of suitably trained or experienced staff led to, or may have contributed to patient harm. Professional judgements regarding patient need and staff resources, including skills, to meet that need will be required. These locally reported incidents should be considered patient safety incidents rather than solely staffing safety incidents, and they should be routinely uploaded to the National Reporting and Learning System or in accordance with the hospice's local policy. All staff should be aware they have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider they may be at risk. There should be policies to support staff who raise concerns. All professional staff have a responsibility to ensure that the interests of the people in their care are protected, taking action if they consider they may be at risk[41,42].

Managers should ensure that incident and quality reports, feedback and learning from incidents are acted on, and any learning shared to improve care. Staff and volunteers should be supported to raise any concerns within

39 NHS England. Patient Safety Incident Response Framework. [Internet] [cited 02 Sept 2025]
40 NHS England. NHS Standard Contract. [Internet] [cited 02 Sept 2025]
41 Nursing & Midwifery Council. Raising concerns: guidance for nurses, midwives and nursing associates. London: NMC; 2019.
42 Health and Care Professions Council. How to raise a concern. London: HCPC; 2025.

a culture where Freedom To Speak Up (FTSU) process means that everyone feels confident they will be listened to when they speak up, and action will be taken. Having a 'one staff concept' which values staff and volunteers equally provides a psychologically safe care environment encouraging a FTSU culture and helping it to flourish[43].

Services should consider how they reflect an environment which supports safe and effective care which may include Resilience Based Clinical Supervision[44] and FTSU reporting, local staff survey and patient feedback.

Staffing red flags

Staffing related red flag occurrences are indicators that are likely to be sensitive to the number of available staff and skill mix[45]. As well as insufficient staffing levels, it may also be associated with inequitable patient allocation, changes to patient acuity and dependency, or the skill and competence level of the available staff on shift. There are a number of NICE (National Institute for Health and Care Excellence) recommended nurse staffing red flags for use in adult inpatient settings and these can be viewed in Appendix 2. Palliative care organisations may develop specific red flags to support local oversight and monitoring. When staffing red flags are raised these should be investigated, responded to and resolved where possible to maintain safety in line with local escalation plans, and reported to and reviewed at monthly quality and safety meetings.

Patient, carer and staff feedback

Palliative care providers are encouraged to undertake surveys that include questions with direct or indirect bearing on staffing, e.g., asking patients if they think there were enough staff to meet their needs, and whether they had to wait for call bells to be answered as well as wider feedback on the overall experience of receiving care. Leaders within these organisations should review both positive and negative feedback to support local learning and improvement.

Patient and carer	Staff
Complaints and compliments	Staff satisfaction surveys
Direct care rounds by the nurse in charge	Exit interviews
Patient stories / focus groups	Recruitment and retention statistics
Local surveys / feedback apps	Sickness levels.
Patient experience walk rounds	Absence levels.

All feedback from patients and staff should be reviewed through formal governance processes, where immediate resolution of matters cannot be achieved. Where concerns are highlighted by patients or staff using any of these methods they must be carefully scrutinised and addressed.

43 NHS England. Freedom to speak up policy for the NHS. [national policy e-book] [Version 2]. 2022.
44 Hospice UK. Resilience-Based Clinical Supervision support. [Internet] [cited 02 Sept 2025]
45 National Institute for Health and Care Excellence. Safe staffing for nursing in adult inpatient wards in acute hospitals. [SG1] NICE; 2014.

Appendix 1:
Calculating your headroom

Headroom is built using a bottom-up approach. This appendix walks you through the steps required in calculating your headroom. For example if the ward requires two members of staff working a 7.5 hour shift pattern on duty 24/7 the following calculation process is required:

	Monday Trained	Tuesday Trained	Wednesday Trained	Thursday Trained	Friday Trained	Saturday Trained	Sunday Trained	Total Shifts	WTE Required
AM	2	2	2	2	2	2	2	14	2.80
PM	2	2	2	2	2	2	2	14	2.80
Night	2	2	2	2	2	2	2	14	3.92
								Total WTE	**9.52**

A total of 9.52 WTE is required. However, this does not account for the time out for annual leave etc., also known as headroom. You will therefore need to add the headroom e.g., 22%

22 x 9.52 = 209.44 / 100 = 2.09. 2.09 is your total headroom.

9.52 + 2.09 = 11.61 WTE* = the total establishment you will require to meet the roster plan.

i.e. 14 shifts x 7.5 hours paid per shift = 105 / 37.5 = 2.8

WTE* – Whole time equivalent

The following table shows the full calculation including the headroom.

	Monday Trained	Tuesday Trained	Wednesday Trained	Thursday Trained	Friday Trained	Saturday Trained	Sunday Trained	Total Shifts	WTE Required
AM	2	2	2	2	2	2	2	14	2.80
PM	2	2	2	2	2	2	2	14	2.80
Night	2	2	2	2	2	2	2	14	3.92
								Total WTE	**9.52**
								+22% (Headroom)	**2.09**
								Total WTE*	**11.61**

2.09 is the total working headroom for this roster and should be recorded at the end of your establishment setting process. Headroom should never be reverse calculated.

*To calculate WTE multiply total number of shifts by the number of paid hours per shift and divide by 37.5 (full time weekly contract hours) i.e. 14 shifts x 7.5 hours paid per shift = 105 / 37.5 = 2.8

Appendix 2:
NICE Nursing red flags

The following provides a list[46] of events that should prompt an immediate response by the registered nurse in charge of the ward. The response may include allocating additional nursing staff to the ward or other appropriate responses.

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patients' visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach.
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Fewer than two registered nurses present on a ward during any shift.

Note: Other red flag events may be agreed locally.

46 National Institute for Health and Care Excellence. Safe staffing for nursing in adult inpatient wards in acute hospitals. [SG1] NICE; 2014.

Further reading and resources

Hospice UK Commissioning pack

NHS Norfolk and Waveney ICB, Hospice UK. Commissioning independent hospices guide. London: Hospice UK; 2025.

Hospice UK. Hospice service models: a practical guide to the principles and resourcing of care for adults and children. London: Hospice UK; 2025

Casey A. Safe and effective staffing for palliative care inpatient services: an improvement resource. London: Hospice UK; 2025

Hospice UK. Hospice costing model toolkit. London: Hospice UK; 2025

Other resources

Ball J. Registered nurse staffing levels for patient safety, care quality and cost effectiveness. 2025 [internet] Royal College of Nursing.

Care Inspectorate.
Safe staffing programme. [internet]

elearning for healthcare.
Fundamentals of safer staffing. [internet] NHS Learning Hub. [A six-module learning programme]

Hospice UK. PopNAT.
An interactive tool that brings together relevant and up to date population data for end of life care across the UK.

King's Fund Library.
Patient safety in the NHS [September 2023] [reading list] [internet] King's Fund.

NHS Improvement.
Developing workforce safeguards: supporting providers to deliver high quality care through safe and effective staffing. London: NHS Improvement; 2018.

National Institute for Health and Care Excellence.
Safe staffing for nursing in adult inpatient wards in acute hospitals. [Safe staffing guideline 1]. NICE; 2014.

National Quality Board.
Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. [London]: [National Quality Board]; 2016.

Nursing & Midwifery Council.
Appropriate staffing in health and care settings. [NMC briefing] London: NMC; 2014, updated 2016. Available from:

Royal College of Nursing Library.
Staffing for safe and effective care. 2025 Jan 13. [internet]

HospiceUK

www.hospiceuk.org

t: 020 7520 8200 @hospiceuk /hospiceuk

Hospice UK, Hospice House, 34 – 44 Britannia Street, London WC1X 9JG