Executive summary – including resource implications

In January 2014 the Royal Free London NHS Foundation Trust board considered the Government response to the Mid-Staffordshire NHS Foundation Trust Public Inquiry, *Hard Truths – The Journey to Putting Patients First* and the guidance published by the National Quality Board and the Chief Nursing Officer, *How to ensure the right people with the right skills are in the right place at the right time*

Hard Truths sets out the Government’s requirement that from April 2014 and by June 2014 at the latest, NHS trusts will publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools. In March 2014 the CQC and NHS England set out their expectations of what boards should consider and what should be included in board papers.

This paper is the first six monthly report to the board. Each divisional board has considered the staffing review, and the required elements as outlined, relevant to their division and their conclusions and recommendations are included in this paper. Ward sisters/charge nurses and matrons have also applied their professional judgement against the results of the staffing review tool results which have informed the recommendations of the divisional boards.

Action required

The board is requested to:
- consider if the report meets the expectations as set out by Hard Truths, the CQC and NHS England.
- consider if the report provides sufficient assurance that the nurse staffing levels are meeting the needs of patients and providing safe care.

<table>
<thead>
<tr>
<th>Trust strategic priorities and business planning objectives supported by this paper</th>
<th>Board assurance risk number(s)</th>
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</thead>
<tbody>
<tr>
<td>1. Excellent outcomes – to be in the top 10% of our peers on outcomes</td>
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<td>2. Excellent user experience – to be in the top 10% of relevant peers on patient, GP and staff experience</td>
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<td>3. Excellent financial performance – to be in the top 10% of relevant peers on financial performance</td>
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</table>
4. Excellent compliance with our external duties – to meet our external obligations effectively and efficiently

5. A strong organisation for the future – to strengthen the organisation for the future

**CQC outcomes supported by this paper**

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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>Respecting and involving people who use services</td>
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<td>4</td>
<td>Care and welfare of people who use services</td>
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<td>5</td>
<td>Meeting nutritional needs</td>
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<td>Safeguarding people who use services from abuse</td>
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<td>8</td>
<td>Cleanliness and infection control</td>
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<td>Management of medicines</td>
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<td>13</td>
<td>Staffing</td>
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<td>14</td>
<td>Supporting staff</td>
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</tbody>
</table>

**Risks attached to this project/initiative and how these will be managed (assurance)**

**Equality analysis**

- No identified negative impact on equality and diversity

**Report from** Deborah Sanders, Director of Nursing

**Author(s)** Deborah Sanders, Director of Nursing  
Rebecca Longmate, Divisional Director of Nursing, TaSS  
Maura McElligott, Divisional Director of Nursing, SAS  
Julie Meddings, Divisional Director of Nursing, Urgent Care  
Mai Buckley, Director of Midwifery and Gynaecological nursing

**Date** 22 May 2014

**References**


*Hard Truths – The Journey to Putting Patients First*,  
https://www.gov.uk/government/organisations/department-of-health

*How to ensure the right people, with the right skills, are in the right place at the right time*  

*A Promise to Learn – a Commitment to Act, Improving the Safety of Patients in England*  

*Review into the quality and treatment provided by 14 trusts in England: Overview report*  
Introduction

Evidence from an increasing number of studies has shown an association between the level of in-hospital staffing by registered nurses and patient mortality, adverse patient outcomes and other quality measures (Needleman et al, 2011). The Francis report made a broad range of recommendations covering local and national NHS management, governance, quality assurance and staffing. The Keogh review of 14 trusts with higher than expected mortality rates noted a positive correlation between inpatient to staff ratio and a high hospital standardised mortality ratio. The review also showed that staffing levels can vary greatly shift to shift and ward to ward. The report of the National Advisory Group on the Safety of Patients in England, led by Don Berwick, also considered NHS staffing levels.

In January 2014 the Royal Free London NHS Foundation Trust board considered the Government response to the Mid-Staffordshire NHS Foundation Trust Public Inquiry, Hard Truths – The Journey to Putting Patients First and the guidance published by the National Quality Board and the Chief Nursing Officer, How to ensure the right people with the right skills are in the right place at the right time

Hard Truths sets out the Government’s requirement that from April 2014 and by June 2014 at the latest, NHS trusts will publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools.

In March 2014 the CQC and NHS England set out their expectations of what boards should consider and what should be included in board papers. The following points are expected to be covered:

1. demonstration of the use of evidence based tool(s)
2. what allowance has been made in establishments for planned and unplanned leave
3. the difference between current establishment and recommendations following the use of evidence based tool(s)
4. the skill mix ratio before the review and recommendation after the review
5. the difference between the current staff in post and current establishment and details of how this gap in being covered and resourced
6. details of any element of supervisory allowance that is included in establishments’ for the lead sister/charge nurse or equivalent
7. evidence of triangulation between the use of tools and professional judgement and scrutiny
8. details of any plans to finance any additional staff required
9. details of workforce metrics – for example data on vacancies (short and long term), sickness/absence, staff turnover, use of temporary staff solutions (split by bank/agency/extra hours and overtime)
10. information against key quality and outcome measures – for example data on safety thermometer, serious incidents, healthcare associated infections, complaints, patient experience/satisfaction and staff experience/satisfaction

This paper is the first six monthly report to the board. Each divisional board has considered the staffing review, and the required elements as outlined above, relevant to their division and their conclusions and recommendations are included in this paper. Ward sisters/charge nurses and matrons have
also applied their professional judgement against the results of the staffing review tool results which have informed the recommendations of the divisional boards.

**Minimum Staffing levels**

There has been much debate about whether there should be defined nurse staffing ratios in the NHS or whether there should be mandated minimum staffing levels. The published guidance from The National Quality board recognises that there is no ‘one size fits all’ approach to establishing nurse staffing and does not prescribe an approach to doing so, neither does it recommend a minimum staff-to-patient ratio.

The Berwick review made the following statement on staffing levels alongside the recommendation that NICE develop guidance as soon possible based on science and data

‘.. we call managers’ and senior leaders’ attention to existing research on proper staffing, which includes, but is not limited, to conclusions about ratios. For example, recent work suggests that operating a general medical-surgical hospital ward with fewer than one registered nurse per eight patients, plus the nurse in charge, may increase safety risks substantially. This ratio is by no means to be interpreted as an ideal or sufficient standard; indeed, higher acuity doubtless requires more generous staffing. We cite this as only one example of scientifically grounded evidence on staffing that leaders have a duty to understand and consider when they take actions adapted to their local context.’

The Government have tasked the National Institute of Health and Care Excellence (NICE) to produce independent and authoritative evidence based guidance on staff staffing by Summer 2014. NICE have issued draft guidance which is currently being consulted on.

**Setting Staffing Levels**

There are a number of different methods of assessing and review ward staffing levels and it is known that different systems applied to the same care environment can give different answers. The use of evidence based tools is one part of making decisions about the correct levels of staffing which should then be triangulated by staff using their professional judgement and scrutiny.

Currently ward establishments’ are reviewed and set by the ward sisters/charge nurses, matrons and divisional nurse directors working in partnership with finance, workforce and operational managers. The Trust is using the Safer Nursing Care (SNC) tool to help inform decision making on the correct level of staff. The data used in this report was collected in March 2014.

The tool was originally developed in conjunction with the Association of UK University hospitals and has, following a review of the tool commissioned by the Shelford Group, been re-launched. The acuity and dependency of patients in a ward is measured over 20 days using rules to capture the data, and then, using nursing multipliers, calculates the total number of nursing staff needed. The tool also considers other activity on the ward which
contributes to the workload of nursing staff, for instance the number of admissions and transfers into and out of the ward. The resulting establishments are then quantified as follows:

- **Average WTE Staff:** The WTE staff establishment required for the ward based on the average patient acuity scores over the month.
- **Recommended WTE Staff:** The WTE staff establishment required for the ward based on the acuity scores over the month, taking into account the daily variance in score.
- **Estimated WTE Staff:** The effective WTE staff establishment based on the staff recorded as present on each shift during the month.

For the purpose of the review current ward establishments have been compared with the average WTE staff derived from the tool.

**Establishment uplifts**

Each ward budget has an assumption of a 21% uplift in establishments. This uplift is to ensure that the establishment is sufficient to provide for planned and unplanned leave and to support continuous professional development. The uplift does not include maternity leave however there is a central budget held for wards to call on to cover for nurses on maternity either by the use of a fixed term contract or temporary staff.

**Supervisory ward sister/charge nurse roles**

Many reports including the Francis inquiry have highlighted the need for the supervisory status of ward sisters/charge nurses to enable closer monitoring and scrutiny of quality and safety in the ward area.

The establishments of wards at the Royal Free London NHS Foundation trust support the ward sister/charge nurse being a supervisory role.

**Planned versus actual staffing**

On 16 May 2014 NHS England issued guidance for publication of planned versus actual staffing levels on NHS Choices. Publication will commence in June and will be at Trust wide level in hours. The data will be RAG rated however at the time of writing the level for determining the RAG rating has not been released. For April for inpatient beds (excluding ITU) the total number of planned hours was 102,426 with an actual level of 99,846. Therefore the actual versus planned was 97.48%.
Divisional Recommendations and supporting data

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
<th>Funded Establishment WTE</th>
<th>SNCT Average WTE</th>
<th>Variance WTE</th>
<th>Registered nurse to patient ratio Day Shift</th>
<th>Registered Nurse Vacancies WTE</th>
<th>Nursing Assistant Vacancies WTE</th>
<th>Sickness absence %</th>
<th>Planned nursing hours (April)</th>
<th>Actual nursing hours (April)</th>
<th>Percent of actual vs total planned shifts (April)</th>
<th>Number of bank hours (April)</th>
<th>Number of agency hours (April)</th>
<th>Falls (Oct 13-March 14)</th>
<th>Pressure ulcers (Oct 13-April 14)</th>
<th>Attributable MRSA Bacteramia (Oct 13-March 14)</th>
<th>Attributable Cdiff (Oct 13-March 14)</th>
<th>FFT Score</th>
<th>No of Complaints related to nursing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 North</td>
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<td>45.48</td>
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<td>6450</td>
<td>6364</td>
<td>99.00%</td>
<td>1103.5</td>
<td>161.2</td>
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<td>4</td>
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<td>1</td>
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<td>0</td>
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<td>4.42</td>
<td>5.06</td>
<td>4.00%</td>
<td>8084</td>
<td>7965.75</td>
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<td>1837</td>
<td>440.75</td>
<td>27</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>34</td>
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<td>0</td>
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<td>6299.5</td>
<td>6267.25</td>
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<td>1064</td>
<td>612.7</td>
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<td>0</td>
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<td>1.79</td>
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<td>5353.5</td>
<td>5235.25</td>
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<td>560.5</td>
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<td>6364</td>
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</table>

Based on the above data the matrons and divisional nurse director will make the following recommendations’ to the Urgent Care divisional board on 28 May 2014:

**9 North**
The Trust Board approved a business case in 2013 to increase the nursing establishment on 9 north based on a review of patient dependency and acuity and changing patient need. The SNCT data for March shows a higher establishment than required for that month.

*Recommendation – No changes to current establishment, to be kept under review*

**8 West**
The Trust Board approved a business case in 2013 to increase the nursing establishment on 8 west based on a review of patient dependency and acuity and changing patient need. The SNCT data for March shows the establishment met the needs of the patients.

*Recommendation – No changes to current establishment, to be kept under review*
8 North
The SNCT data suggests that for March the establishment was higher than that required. The SNCT is a tool that is designed for a general ward and not a Medical Assessment unit. There is a specific version for such wards currently in design. The MAU has 8 monitored beds and the acuity of patients can peak alongside multiple admissions and changing profile of patients during a day. There is higher level of vacancies on the ward than in general. These are being actively recruited to as part of the rolling recruitment programme and specific targeted activity such as international recruitment.

Recommendation – No changes to current establishment, to be kept under review

10 West
The data derived from the SNCT shows a difference from the actual establishment of +3 WTE. In response there is a 3 month review of staffing and clinical activity. This will include a review of the Heart Attack Service which is supported by the 10 west establishment but which is not captured in the data collection.

Recommendation – No changes to current establishment and 3 month review as described

8 East
The ward cares for general medical and respiratory patients and patients with high nursing needs and those receiving non-invasive ventilation. There are also 10 side rooms on the ward. The establishment of 29.15 was originally for 30 beds however due to the recognition that this was not sufficient the number of beds was reduced from 30 to 26. The SNCT data would suggest that the required establishment is not sufficient for the acuity and dependency of the patients. This is also supported by the professional judgement of the senior nursing leadership team. The needs of the patients are assessed each shift and temporary staff are booked where required over and above the established numbers. There is a prepared business case to increase the establishment to reflect the needs of the patients and to open the ward to 30 beds.

Recommendation – submission of the prepared business case
**Paper 3.1**

Based on the above data the matrons and divisional nurse director made the following recommendations to the Surgery and Associated Services divisional board on 19 May 2014:

### 6 South
The funded establishment on 6 south was increased in September 2013 by 4 WTE. During March there were a number of patients who required the presence of a nurse special due to their dependency/acuity. It is recognised that there can be seasonal variation associated with stroke patients and consequently there is a risk assessment tool in use for requests for one to one nursing which is reviewed on a daily basis.

**Recommendation** - the current funded establishment is correct but will continue to need daily review and assessment of the use of specials.

### 7 East A
The SNCT data suggested a larger proportion of acutely unwell patients than appeared to the case using professional judgement

**Recommendation** – the matron and divisional director of nursing will be repeating the acuity tool in June and this will be subject to further review.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Beds</th>
<th>Funded Establishment WTE</th>
<th>SNCT Average WTE</th>
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<th>FFT Score</th>
<th>No of Complaints related to nursing care</th>
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</thead>
<tbody>
<tr>
<td>6 South</td>
<td>28</td>
<td>40.3</td>
<td>45.1</td>
<td>-4.8</td>
<td>1:4</td>
<td>1.4</td>
<td>4.5</td>
<td>4.80%</td>
<td>5783.5</td>
<td>5654.5</td>
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<td>1279.25</td>
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<tr>
<td>7 East A</td>
<td>20</td>
<td>24</td>
<td>31.8</td>
<td>-7.1</td>
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<td>2.60%</td>
<td>3913</td>
<td>3741</td>
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<td>7 East B</td>
<td>13</td>
<td>17</td>
<td>11.5</td>
<td>+5.5</td>
<td>1:4.3</td>
<td>0</td>
<td>0</td>
<td>2.20%</td>
<td>2160.75</td>
<td>1935</td>
<td>89.50%</td>
<td>64.5</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>53</td>
<td>2</td>
</tr>
<tr>
<td>7 West</td>
<td>32</td>
<td>37.3</td>
<td>46.3</td>
<td>-9</td>
<td>1:4.7</td>
<td>1.93</td>
<td>0</td>
<td>5.40%</td>
<td>4977.25</td>
<td>4708.5</td>
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<td>604.25</td>
<td>322.5</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>38</td>
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<tr>
<td>7 North</td>
<td>32</td>
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<td>4773</td>
<td>4515</td>
<td>95%</td>
<td>523.5</td>
<td>64.5</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>49</td>
<td>1</td>
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</tbody>
</table>
7 East B
The SNCT data suggest that the ward has more staff in the establishment than required. This is an anomaly of the ward having just 13 beds. It is not possible to have any less than 2 qualified nurses on a shift. The ward can only take clean orthopaedic patients which also means there are occasions when the occupancy rate is less than other wards. The staff provide nursing support to 7 East A when required.

*Recommendation – the current funded establishment is correct.*

7 West
The SNCT data consistently suggests that the dependency and acuity of the patients is higher than the current funded establishment provides for. The last data collection carried out in September 2013 showed a similar disparity. The reconfiguration of vascular services with the Royal Free now acting as the surgical hub for complex cases has contributed significantly to the change in acuity and dependency of the patients on 7 west

*Recommendation – the staff establishment be reviewed with a proposal to increase the day shift from 7 registered nurses to 8 and associated business case.*

7 North
The data collected in March shows that the current funded establishment is correct for the needs of the patients.

*Recommendation – the current funded establishment is correct and no additional staffing is required to meet the acuity and dependency needs of the patients on 7 North currently.*

The recommendations outlined above were supported by the SAS divisional board at its meeting on 19 May 2014.
Based on the above data the matrons and divisional nurse director made the following recommendations’ to the Transplantation and Specialist Services divisional board on 14 May 2014:

9 West
The professional judgement of the ward sister and matron is that the establishment is correct for the 26 beds on 9 west. The SNCT suggests a variance of –2.76 WTE. On occasions the ward is required to open escalation beds which the establishment does not cover and temporary staff are required.

Recommendation: the current funded establishment is correct and no additional staffing is required to meet the acuity and dependency needs of the patients on 9 west currently. The flexing of surge beds and the use of temporary staff to support the beds will be kept under review.

10 North
There has been an increase in the number of liver transplants undertaken at the Royal Free which has in turn increased the dependency and acuity of the patients on 10 north which is reflected in the SNCT data and is supported by the professional judgment of the senior nursing team. The liver transplant business case has recognised this increase and includes funding to increase the establishment by 2.83 WTE qualified nurses and 2.43 WTE nursing assistants.
**Recommendation:** To proceed the agreed business case for the increase in establishment as outlined

**11 West**
The SNCT data demonstrates that the establishment currently meets the acuity and dependency needs of the patients cared for on 11 west. This is supported by the professional judgement of the ward sister and matron.

**Recommendation:** the current funded establishment is correct and no additional staffing is required to meet the acuity and dependency needs of the patients on 11 west currently.

**11 South**
The SNCT data for March shows that there is a deficit in the current establishment of 1.95 WTE. In September 2013 the data showed a deficit of 7.35 WTE. The professional judgement of the ward sister and matron is that the current establishment is not meeting patients’ needs which are primarily due to the increase in numbers of patients undergoing bone marrow transplants who are on high dose chemotherapy regimens.

**Recommendation:** The establishment should be increased by 1.95 WTE (1 band 5 and 1 band 2). This can be achieved within the allocated budget by converting band 6 posts.

**11 East**
The SNCT data for March shows a deficit of 4 WTE in the current establishment. In September 2013 the data showed the same deficit. The professional judgement of the ward sister and matron is that the current establishment requires review to meet the dependency and acuity needs of the patients. 11 east is the acute oncology ward and a significant number of patients are palliative and require end of life care. Patients and their families require a high level psychological intervention in order to support them at this stage in their disease pathway. This gap in establishment is currently being reviewed daily by the ward sister and matron and filled by temporary staff.

**Recommendation:** A business case be developed to support the increase in establishment by 2wte band 5 qualified nurses and 2wte band 2 nursing assistants.

**10 East**
10 East was recently opened as an inpatient ward for patients with acute kidney injury and included provision of level 2 beds in a high dependency bed base. The business case for the ward included the appropriate establishment to staff the level 2 beds. The SNCT tool data for March suggests that the current establishment is too high for the current acuity and dependency of the patients. However, the implementation of the alignment of the level 2 beds and the introduction of the renal admissions unit will be supported by the current establishment. The tool does not allow for patients undergoing dialysis which in the professional judgement of the ward sister and matron impacts on the numbers required.
**Recommendation:** To keep the current establishment under review in line with the further implementation of level 2 beds and the introduction of the renal admission unit.

**10 South**
The SNCT data for March demonstrates that the establishment is broadly correct to meet the needs of the patients. This was also supported by the data in September 2013. The professional judgement of the ward sister and matron is that the funded establishment is correct.

**Recommendation:** The current funded establishment is correct and no additional staffing is required to meet the acuity and dependency needs of the patients on 10 south currently.

The recommendations outlined above were supported by the SAS divisional board at its meeting on 19 May 2014.

**Maternity**
There are a number of factors which impact on midwifery staffing which include:

- The increasing medical and social complexity of pregnancies and births associated with factors such as advanced maternal age, obesity and socio-demographic factors
- Use of analgesia and interventions during labour including operative interventions which require midwifery attendance
- Expectations for individualised care in relation to one to one care, continuity of care and maternal choice

NHS London recommended in 2011 that all maternity units should have a minimum midwife to birth ratio of 1:30. At the Royal Free maternity unit for the financial year 2013-2014, the midwife to birth ratio was 1:29.9 which is in line with NHS London standards. Table 1 provides the month by month breakdown of the midwifery staffing and midwife to birth ratio for the last financial year (2013-2014).

**Table 1: Monthly midwife to birth ratio (2013/4)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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</thead>
<tbody>
<tr>
<td>Midwife to birth ratio 2013-2014</td>
<td>27.0</td>
<td>27.9</td>
<td>32.6</td>
<td>31.9</td>
<td>28.9</td>
<td>34.0</td>
<td>27.8</td>
<td>29.0</td>
<td>30.6</td>
<td>29.6</td>
<td>28.3</td>
<td>25.0</td>
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</tbody>
</table>
The maternity unit has contingency plans to address short term staffing shortfalls for instance as a consequence of increased workload, sickness and other staff absences. This is supported by a systematic process underpinned by standards outlined in the following maternity guideline: *Suspension of unit activity, escalation and divert- guidelines for shortfall in staffing levels, unexpected increase in clinical activity and temporary suspension of the unit* (2013).

Staffing levels in relation to clinical activity are monitored on a continuous basis by the labour ward co-ordinator in conjunction with the maternity bleep holder and maternity on-call manager. There is a well-established pathway for escalation within the maternity service. This is shown in the flow chart below.

The National Service Framework for Children, Young People and Maternity Services sets a standard for women to receive one-to-one care (one woman receiving the dedicated time of a midwife) once labour is established. In collaboration with the North Central London (NCL) trusts, the Royal Free maternity unit is required to provide evidence of 2 monthly monitoring of the ratios of one to one care for women in labour over a one week period and we have consistently met 100% with this standard. This is demonstrated by the results shown in Table 2 of the compliance for the last 8 months.

### Table 2: One to one care in labour compliance 2013-2014

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>No of women in established labour</th>
<th>No of women in established labour receiving 1:1 midwife care</th>
<th>One to one compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2013</td>
<td>82</td>
<td>82</td>
<td>100%</td>
</tr>
<tr>
<td>November 2013</td>
<td>79</td>
<td>79</td>
<td>100%</td>
</tr>
<tr>
<td>January 2014</td>
<td>71</td>
<td>71</td>
<td>100%</td>
</tr>
<tr>
<td>March 2014</td>
<td>66</td>
<td>66</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Paediatrics**

The current staffing levels in paediatrics meet the Royal College of Nursing guidance, *Defining Staffing Level’s for Children and Young People in Hospital (Latest Revision 2013)*. The guidelines state that:

- Children under 2 – a nurse/child ratio of 1:3, day and night
- Children over 2 – a nurse/child ratio of 1:4, day and night

Staffing is also effectively flexed to meet the needs of more dependent children and they also effectively flex the staffing to meet the needs of more dependent children.

The professional judgement of the senior nurse leadership team is that the current establishment is correct for the patients cared for on 6 north. The SCNT applies to adult inpatient setting. The paediatric service are exploring the use of PANDA, an dependency and acuity tool for use in paediatrics.

Conclusion

Ensuring the correct numbers and skill mix of staff available on wards is a complex and dynamic process requiring continuous review on a shift by shift basis. Regular formal reviews such as that which form the basis of this report are also required. The review considered ward acuity and dependency data, planned versus actual staffing and quality and safety data supported by the professional judgement of ward sisters/charge nurses, matrons and divisional nurse directors. The board is asked to consider if the report provides sufficient assurance that the staffing levels are meeting the needs of patients and providing safe care.