

## What difference have safe staffing policies made to hospitals in the NHS?

The Francis inquiries in 2010 and 2013 highlighted nurse staffing as a patient safety factor contributing to the care failings identified at Mid Staffordshire NHS Trust. The reports and government response led to the development of national 'safe staffing' policy.

Research had previously shown that a relationship exists between levels of nurse staffing, and the quality and safety of patient care provided. Low registered nurse staffing levels are associated with worse patient outcomes, creating 'unsafe' conditions. Prior to 2013, decisions to assess and review staffing levels were taken locally with little national guidance on staffing levels. The second Francis Inquiry prompted the development of National Institute for Health and Care Excellence (NICE) guidelines for 'safe staffing' in all NHS acute hospitals.

A two-year study undertaken by the University of Southampton and Bangor University set out to look at the costs and consequences of implementing safe staffing policy, and to identify the factors influencing local responses. This Evidence Brief describes the findings of this research, looking at how NHS safe staffing policy has been implemented locally and nationally, and what impact safe staffing policies have had in practice.

### Impact of Francis Inquiries

The Francis Inquiries<sup>1</sup> highlighted that decisions about nurse staffing had been made without fully considering the risks to patient safety. As Sir Robert himself said:

*"So much of what goes wrong in our hospitals is likely, and indeed it was, in many regards, the case in Stafford, due to there being inadequate numbers of staff, either in terms of numbers or skills"*

Sir Robert Francis, submission to CQC Board, 2013

Responding to the Inquiries, the Government published the "Patients First and Foremost" report<sup>2</sup>. Four strands of policy were developed that aimed to create safe nurse staffing levels in the NHS:

1. **Guidance:** National Institute for Health and Care Excellence (NICE) guidelines for safe staffing were developed and published in 2014<sup>3</sup>.
2. **Tools:** The Safer Nursing Care Tool (SNCT) was endorsed by NICE to help hospitals plan nurse staffing.
3. **Principles:** The National Quality Board 2013 (NQB) expectations report<sup>4</sup> outlined the principles Trusts were expected to apply in relation to planning staffing (refreshed in 2016)<sup>5</sup>.
4. **Transparency:** NHS Trusts were required to monitor and report (through NHS Choices) differences between planned and achieved nurse staffing levels ('fill-rates').

Our research examined the implementation of these safe staffing policies in NHS general acute Trusts in England by looking at costs and consequences, and identifying factors that influenced implementation<sup>6</sup>.

### Study design

A mix of qualitative and quantitative methods were used to examine the impact of policies nationally, and explore commonality and variation in local responses to safe staffing policies.

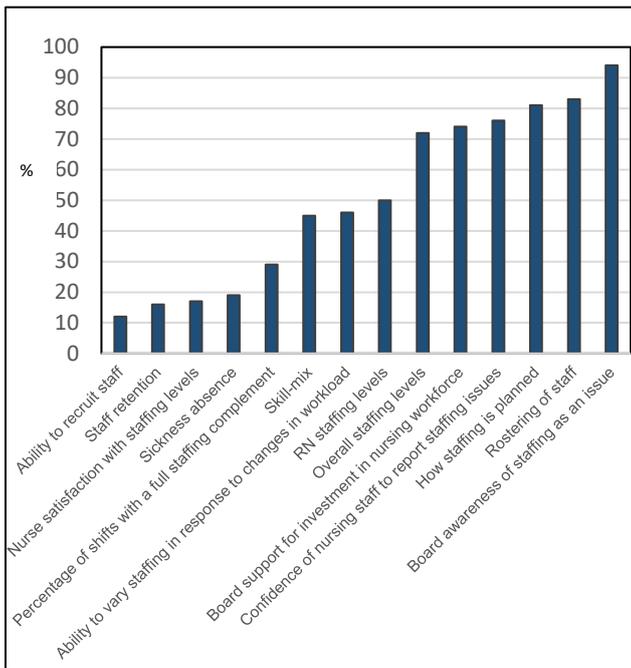
- An analysis of NHS national workforce data was undertaken to explore changes since 2010.
- A national survey of Directors of Nursing in acute NHS hospital Trusts (n=148) was carried out, to which 91 (61%) responded.
- Four NHS Trusts providing acute hospital care were selected as case study sites for a realist informed evaluation plus a descriptive and economic assessment of the impact of policy implementation.

### Effects of safe staffing policies on Trusts

The implementation of safe staffing policies affected case study Trusts in terms of: changes in the language used to refer to staffing, increased visibility of safe staffing within the organisation, use of data to support investment in nurse staffing, data providing a rationale for difficult decisions, policy as a driver for accelerated action around safe staffing, tools changing the nature of management practice, and policies enabling workforce redesign. Case study Trusts reported that they conducted daily site-wide, multidisciplinary staffing reviews and 24-hour escalation at matron level or higher.

In the survey, 86% of Trusts reported that nursing establishments were reviewed at least 6-monthly (in line with NQB guidance). The Safer Nursing Care Tool (SNCT) or related tool was used to set establishments by almost all Trusts surveyed. New approaches to staff planning, rostering and board awareness were viewed as the most helpful changes.

## Have things improved post-Francis?



Directors of Nursing were asked whether various aspects of nurse staffing had got better, got worse or stayed the same in their Trust, since the Francis Inquiry. The percentage reporting things had got better is shown in the graph. 94% said that Board awareness of staffing as an issue had improved; 74% said that Board support for investment in nursing workforce had got better.

## Workforce changes

Following a period of zero growth between 2009-2013, the whole-time-equivalent number of nursing staff employed in the NHS acute sector increased since 2013 by 10% for registered nurses (RNs) and 30% for support staff (HCAs). However, patient numbers also increased; there was no net increase in RN staffing per patient. Growth in nursing workforce was not uniformly distributed: increases in acute hospital services (where policy attention focussed) were seen in neither community, learning disability nor maternity. 25% of Trusts reported that there were more than eight patients per RN in more than 65% of shifts over a year.

Growth in RN staffing had been constrained by Trusts' inability to fill posts. The survey found that the average RN vacancy rate in 2017 was 10%. At a shift level, Trusts had increasing difficulty filling planned registered nurse hours (as gauged through 'fill-rate' data). Nursing staff are reported as working a larger number of additional hours, compared with previous years.

## What influenced implementation locally?

The clarity of the safe staffing policy message, degree of learning and innovation, use of tools and technologies, and credibility/reliability of data all influenced implementation of the policies.

Trusts adopted strategies to cope with and mitigate against staffing shortfalls, but in all four case studies, senior nurses reported imbalances, which led to times

when wards were not operating with safe nurse staffing levels.

Implementation worked best when there was a 'whole-systems' approach with good alignment across organisational strategies and data systems related to safe staffing including those for workforce, finance, quality, safety, and professional practice. Clearly defined leadership, a shared sense of accountability, consideration of wider workforce issues such as recruitment and retention, engagement with external stakeholders and a high degree of goodwill, were all factors associated with success.

A lack of transparency and equity around staffing within organisations risked the goodwill needed for success.

## Conclusions

Policies provided leverage and raised the profile of nursing workforce issues at board level, contributing to a willingness to invest in increasing nursing numbers. However, a lack of assessment of the likely scale of investment (and human resources) required nationally to achieve 'safe staffing' led to financial considerations becoming a barrier to achieving the policy vision.

External pressures, such as lack of workforce supply and reduced access to temporary staffing, have constrained Trusts' abilities to fully implement policies aimed at ensuring safe staffing on acute wards.

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