

*In short supply: pay policy
and nurse numbers –*
Nurse staffing

Nurse staffing: can the new guidelines make a difference?

About this supplement

This supplement is produced to accompany the report *In short supply: pay policy and nurse numbers*

Nurse staffing: can the new guidelines make a difference?

Introduction

Nursing shortages and challenging NHS funding conditions are conspiring to make it difficult to assure safe staffing levels in the NHS in England. *Staffing matters; funding counts*, a 2016 Health Foundation review of the workforce of the NHS in England, highlighted the growing problems of recruiting and retaining nursing staff, and also stressed that NHS funding constraints were an anchor on NHS staffing improvements.¹

The situation has not improved in recent months. A survey by NHS Providers, published in November 2016, reported that over half (55%) of NHS and foundation trust chairs and chief executives said they were worried or very worried that their trust may not have the right number, quality and mix of staff to deliver high quality care. Most expected the situation to deteriorate over the next six months. NHS Providers reported that this workforce challenge ‘is now as large as the challenge of balancing NHS finances’.²

In December 2016, an assessment of the introduction of local sustainability and transformation plans (STPs) in England identified potential large-scale staffing reductions or skill mix changes in some plans, raising concerns about the likely impact on safe staffing levels. This led NHS Improvement to clarify that it would ‘check the safety implications of significant workforce changes being made by individual providers’.³ (Such workforce impact assessments had been recommended by the Health Foundation in *Staffing matters; funding counts*.¹)

Recent analysis by the *Health Service Journal* reported that 96% of NHS hospital trusts in England had fewer nurses covering day shifts in October 2016 than they had planned and 85% did not have the desired number working at night.⁴

The recently published 2016 NHS staff survey also highlights that nearly half (49%) of registered nursing staff do not agree that staffing levels are adequate for them to do their job properly. Among district/community nurses (55%), health visitors (52%) and midwives (64%), this proportion was even higher.

Table 1: Nursing and midwifery staff responses to statement ‘There are enough staff at this organisation for me to do my job properly’ (NHS Staff survey, 2016)

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Base (number of respondents)
	%	%	%	%	%	n
Registered nurses and midwives	16	33	21	25	5	109,510
- adult / general nurses	14	32	23	25	6	61,971
- mental health nurses	14	30	22	27	7	14,968
- learning disabilities nurses	13	32	23	28	4	2,225
- children’s nurses	16	35	21	26	3	7,886
- midwives	26	38	15	18	2	7,608
- health visitors	17	35	20	24	4	4,349
- district / community nurses	23	32	17	24	5	5,681
- other registered nurses	15	29	23	27	5	4,822
Nursing or health care assistants	15	27	25	26	6	27,546

Against this backdrop of a difficult nurse labour market, staffing and funding constraints, the NHS in England is consulting on a new guideline-based approach to determining local nurse staffing levels. Can the new staffing guidelines make a difference?

This document examines the policy context that has led to the new guidelines, and also looks at their likely impact. It first describes recent national policy developments on nurse staffing in the NHS in England, then describes local approaches to determining nurse staffing levels. It then summarises the related evidence base, before considering how other countries determine nurse staffing levels. It concludes by assessing what difference the new guidelines may make to the NHS in England.

The national policy context for nurse staffing levels in the NHS in England

Determining safe nurse staffing levels in the NHS has been a particular concern since the 2013 report of the Mid Staffordshire Inquiry, led by Robert Francis (the ‘Francis Report’⁵). This inquiry shone a light on what can go wrong when local nurse staffing concerns are not dealt with adequately, and its report continues to be cited as a baseline to check on subsequent improvements.⁶

Background assessment indicated that between 400 and 1,200 patients died at Mid Staffordshire Hospital as a result of poor care over the 50 months between January 2005 and March 2009. The inquiry report identified ‘a chronic shortage of staff, particularly nursing staff’ as being largely responsible for substandard care.⁷ Other contributory factors identified included poor governance, with NHS trust boards often having poor ‘line of sight’ of actual day-to-day staffing levels, a lack of focus on standards of service and inadequate risk assessment of reducing staff numbers.

Among the 290 recommendations in the inquiry report was that the National Institute for Health and Care Excellence (NICE) should develop ‘evidence-based tools for establishing the staffing needs of each service’.⁸

The Department of Health accepted all of the inquiry’s recommendations, and NICE was charged with developing evidence-based approaches to establishing nurse staffing levels for NHS employers in England. Initially, NICE commissioned research on what was known about nurse staffing and outcomes. Following this, it made clear that it was not going to promote standardised ‘top-down’ nurse:patient ratios.⁹ ‘There is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients’ nursing needs. Each ward has to determine its nursing staff requirements to ensure safe patient care.’¹⁰

NICE published its first guidelines, on adult inpatient wards in acute hospitals, in 2014¹¹ and its second, on midwifery, in early 2015.¹² Its initial schedule for the development of guidelines covered a total of nine care environments.¹³

However, before NICE had completed its scheduled work on these different care environments, in 2015 the Department of Health shifted lead responsibility for safe staffing to the National Quality Board (NQB). ‘The National Quality Board and its members will help oversee the [safe staffing] programme, working closely with its members; NHS England, NHS Trust Development Authority, Monitor, Health Education England, the Care Quality Commission, NICE and the Department of Health... Our safe staffing programme will not in any way replace or change the NICE guidance that has already been issued.’¹⁴ The NQB had published a report on nurse staffing in response to the Mid Staffordshire Inquiry.¹⁵

The shift of responsibility away from NICE led to criticism in the nursing press both about the shift from an organisation perceived to have greater independence, and about the slow pace of response to the Mid Staffs Inquiry, in terms of the development of policies and safe staffing tools.¹⁶

NQB membership was then altered in April 2016 when the NHS Trusts Development Authority, Monitor and other agencies were merged to create NHS Improvement (NHS I).¹⁷ NHS I highlighted that ‘Together with our national partners we are leading the national programme to develop and deliver NHS safe staffing improvement resources which will support and enable NHS providers with making safe and sustainable staffing decisions in specific care settings’¹⁸ and noted that that ‘national workstreams’ to develop safe staffing had been established for mental health, learning disability, community, maternity, acute inpatients, children’s services, urgent and emergency care.¹⁹

NHS I and the NQB then published initial guidance in 2016, focused on adult inpatient acute care, based on a ‘triangulated’ approach (‘right staff, right skills, right place and time’) to support local decisions on nurse staffing.²⁰ Early in 2017 it then published an updated version of the guidance for adult inpatient care, with a consultation period until the end of February 2017.²¹

The revised guidance for adult inpatient care follows a similar approach to that in the previous, 2016, version, that ‘A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.’²² In practice this meant ‘using a systematic, evidence-based approach to determine the number and skill mix of staff required... exercising professional judgement to meet specific local needs... benchmarking with peers... taking account of national guidelines, bearing in mind they may be based on professional consensus.’²³ This guidance also provides links to commissioned evidence and to ‘decision support tools’. At the time of writing, the latter is only a link to the NICE website,²⁴ where three ‘endorsed’ staffing tools for acute/hospital based nursing are listed. These three tools had already been endorsed at the time of the partially completed work by NICE in 2014. In April 2017 NICE endorsed a safe staffing toolkit designed to support senior nurses to review, plan and budget for safe, affordable ward staffing in adult inpatient wards.²⁵

Most recently, draft guidance for three more areas of care – learning disabilities,²⁶ mental health²⁷ and adult community nursing services²⁸ – have been put out for consultation. Each follows a similar structure, and each is accompanied by a commissioned review of evidence. The evidence review conclusion for learning disabilities (LD) was that ‘there was no empirical, synthesised or opinion literature that could be located that specifically related to sustainable safe staffing in LD services’.²⁹ The review conclusion for mental health was that ‘No robust empirical studies have yet been carried out that can underpin national or local policies in this area.’³⁰ The review conclusion for community nursing was that ‘There remains a lack of published evidence about how to manage safe caseloads for community adult nursing services at a national and local level.’³¹ It also noted that ‘Providers of IT support systems for caseload management were reluctant to share their approaches and outcomes of their systems due to the commercial sensitivity of the data.’³²

Local approaches to determining nurse staffing levels in the NHS in England

A range of approaches to determining nurse staffing are available to NHS trusts and other employers (see Box 1). Some have been locally developed, some use ‘open source’ variants, others are mainly based on proprietary systems. Some of the approaches require little data and rely on professional judgement, others are driven by information on patient profile, patient acuity or workflow, and require both significant data, and the capacity to analyse and interpret data projections.

All these approaches have been used to some extent in the NHS in England, other than mandatory ratios. However, there is no publicly available overview of which NHS employers use which approach(es), or what their experiences and views of different approaches have been.

Box 1: Approaches to determining nurse staffing used in the NHS in England^{33,34,35}

- Fixed/mandatory nurse:patient (or nurse:bed) ratios.
- Calculating the number of staff per occupied bed or by patient day.
- Calculating the number of nursing hours per patient day (HPPD),* based on patient acuity.
- Determining a skill/staff mix (usually expressed as a % requirement for registered nurses), using timed-task/activity approaches.
- Regression-based systems (statistical approach that predicts the required number of nurses for a given level of activity).
- ‘Professional judgement’ or expert opinion.

* now replaced in the English NHS context by care hours per patient day (CHPPD)

The Department of Health last published a report describing the strengths and weaknesses of the main different approaches 15 years ago.³⁶ While it has recently commissioned new research to examine safe staffing,³⁷ this will take several years to fully complete and focuses only on acute trusts.

In 2012 the Royal College of Nursing (RCN) published its own guidance on safe staffing. It noted ‘There has not been a recent review of the systems/tools available for planning staffing and these have not been tested for their reliability or validity.’ The RCN advocated a ‘triangulation’ approach across activity, professional judgement, and quality indicators.³⁸ This triangulation approach has been endorsed in the NHS Improvement/NQB guidance.

The approaches listed in Box 1 are not all mutually exclusive, and all have strengths and weaknesses. The simpler approaches may be inadequate in care environments where patient acuity and workflow can vary significantly and unpredictably over time, while the more

complicated data-based approaches may be too costly or complex to sustain. They may also require data sets that are not routinely generated in some health systems, as well as staff expertise in fully understanding both how to apply the tools and interpret the results.

Coverage of data-based tools and approaches is also patchy. Most of the staffing tools in use in the NHS in England have been developed for use in acute care settings.³⁹ However, more recently there has been some limited progress in developing methods or prototypes for use in other care environments, for example mental health workforce⁴⁰ and community nursing.⁴¹

It is important to note that these methods and tools for identifying day-to-day staffing levels can only be fully effective if aligned with staff rostering, to match staffing needs with individual staff availability, particularly where there is a requirement for 24/7 nursing care.⁴² In addition, they need to take account of the possible deployment of temporary staff, either because of staffing gaps or projected peaks in workload/workflow. They must also have the scope to look beyond registered nurses, in terms of the mix of staff, if they are to fully capture safe staffing needs and options. With increasing recognition of the need to enable team working across occupations and disciplines, any staffing tool that cannot take account of staff teams and mix will deliver, at best, a partial picture.

It is also important to acknowledge that there can be variation between the ‘established’ nurse staffing in NHS and foundation trusts, and the ‘actual’ staffing at any specific time. This was noted by the Keogh review, undertaken to explore higher than expected mortality rates in 14 trusts in the aftermath of the Mid Staffordshire Inquiry. The review noted marked variations between the picture of nurse staffing levels gained when analysing administrative data (full-time equivalent (FTE) staff per bed, etc) compared to actual observations of nurse staffing levels on wards, shift by shift.⁴³

This suggests that the reality of nurse staffing is not always captured by the staffing systems in place. A recent National Audit Office report on clinical services highlighted that many NHS providers do not have the capacity to plan long-term staffing. It concluded that ‘Trusts’ workforce plans appear to be influenced as much by meeting efficiency targets as by staffing need’.⁴⁴

In summary, there is no comprehensive picture of which nurse staffing approaches are being used where in England. There is also little evidence available on the utility of different approaches to inform local decisions on which approach might be most appropriate, other than the link to the tools that were first endorsed by NICE in 2014. The new draft guidelines do not provide a full range of existing tools or detail their strengths and weaknesses. It is notable, as highlighted in the evidence reviews commissioned for the new draft guidance, that there is practically no evidence available on adult inpatient nursing, and no robust evidence or recommended safe staffing tools for learning disabilities, mental health, or for community nursing – the focus of much current national policy attention in England. The review of community nursing also noted that commercial concerns may prevent the sharing of local staffing related data.⁴⁵

The evidence of ‘what works’ in determining local nurse staffing

The starting point for any examination of the evidence on ‘what works’ in determining local NHS staffing numbers has to be the acknowledgement of a very weak evidence base.

NICE commissioned three linked international reviews of the evidence to support its recommendations on approaches to determining staffing but concluded that the relevant evidence base was ‘extremely limited’. Among the main limitations it identified were:

- a lack of high quality studies exploring and quantifying the relationship between registered nurse and health care assistant staffing levels and skill mix and any outcomes related to patient safety, nursing care, quality and satisfaction
- a lack of evidence from UK data that allowed the effects of actual nursing staff that are present (as opposed to variations in nursing staff) to be readily determined
- a lack of research that assessed the effectiveness of using defined approaches or toolkits to determine nursing staff requirements and skill mix (only one study, which assessed one particular approach, was identified)
- no economic evidence that explored the relationship between ward-based management approaches (including the use of toolkits) and organisational factors and nursing staff requirements.⁴⁶

An updated evidence review⁴⁷ was commissioned as part of the background for the NHSI/NQB work. In respect of nurse staffing and outcomes in acute care, it noted that ‘There is ample evidence demonstrating associations between nurse staffing levels in hospital wards and important patient and staff outcomes. Reviews have concluded that the evidence is consistent with low registered nurse staffing causing worse outcomes. But much of the evidence is from health systems that are very different to the NHS and gives little indication of the actual staffing levels that should be deployed.’

The evidence review commissioned to support guidance in learning disabilities (LD) summarised that ‘No empirical evidence was located that directly relates to sustainable safe staffing... The lack of robust empirical evidence regarding sustainable safe staffing in LD services means the need for robustly designed research in this area cannot be overemphasised.’⁴⁸ As noted above, the more recently published evidence reviews for mental health and for adult community nursing are equally negative in their conclusions about the availability of relevant evidence.

In short, the current draft NHSI/NQB guidelines advocate ‘using a systematic, evidence-based approach to determine the number and skill mix of staff required’.⁴⁹ However, the available evidence from NHS in England is too fragmented to provide a solid platform on which to base any universal approach to determining nurse staffing, or even to underpin detailed guidelines on best practice in the use of available tools in most care environments.

The next section provides a brief overview of approaches to determining nurse staffing levels used in other countries. It highlights similar evidence constraints, but different approaches being used to those in England.

How is nurse staffing determined in other countries?

Northern Ireland

The current approach to determining nurse staffing was established in 2014 and uses what has been termed 'Normative Staffing Ranges'. This is based on a standard framework, developed nationally and used locally to help determine nurse staffing ranges. The framework initially covers general and specialist medical and surgical adult care hospital settings. The framework is clear that it describes a range ('not ratio') of nurse staffing which would normally be expected in specific specialities. For example, the reported nurse:patient range for 'the majority of general medical wards' is defined as between 1:3 and 1:4, 'recognising that a small number may fall below 1.3 to 1.2 and similarly, a small number existing at the higher end of the range at 1.4'. The framework makes it clear that it does not prescribe the staff numbers that should be on every ward and at every point in time, 'as this must be developed in discussion with staff, managers and commissioners and is dependent on a range of factors which influence planning processes'.⁵⁰ The framework sets out factors that influence the point within the staffing range that is appropriate for an individual service or care setting. 'How to Use' guidance is also provided for ward sisters, charge nurses, general and professional managers.

Scotland

Scotland established a Nursing and Midwifery Workload and Workforce Planning Group last decade which led to recommendations in 2004 for a 'whole systems' approach to developing, testing and piloting nurse staffing tools before then standardising their use across the NHS in Scotland.⁵¹ This mandatory use of approved nursing and midwifery workforce planning tools is reported to cover '98%+' of all clinical areas.⁵² The tools 'use rigorous statistical analysis to calculate the whole time equivalent for current workload; they have been tested extensively across NHS Scotland before being confirmed as fit for purpose'.⁵³ The tools are accessible online, and are supported by YouTube videos, users' manuals, etc (see Box 2).

Box 2: Suite of Tools, Nursing and Midwifery Workload and Workforce Planning Programme (NMWWP), NHS Scotland

The suite includes 11 tools which were developed in Scotland (including the Emergency Department & Emergency Medicine workload tool which is a multi-professional workload tool). One (Adult Inpatient) is a UK-wide tool which has been validated within Scotland.

- Adult Inpatient
- Small Wards
- Neonatal
- SCAMPS (Scottish Children's Acuity Measurement in Paediatric Settings)
- Maternity
- Emergency Department & Emergency Medicine
- Mental Health
- Community Nursing
- Clinical Nurse Specialist (CNS)
- Community Children & Specialist Nurses (CCSN)
- Professional Judgement
- Quality

Source: <http://www.isdscotland.scot.nhs.uk/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/Tools/> accessed 14 March 2017

Each of the tools is applied within a 'triangulation process' which includes the use of professional judgement and local indicators of quality. The NHS in Scotland has also developed guidance and training material for those involved in applying the approaches in practice: the Nursing and Midwifery Workload and Workforce Planning Learning Toolkit.⁵⁴

In 2016, the Scottish government announced that it would become a legal requirement for these approved planning tools to be used by NHS organisations.⁵⁵ It is planned that legislation will be delivered within this current parliamentary session. Consultation on the legislative approach began in April 2017, with initial proposals focusing on extending coverage to all 'organisations providing health and social care services, and be applicable only in settings and for staff groups where a nationally agreed framework, methodology and tools exist', with an emphasis on using 'existing performance and monitoring processes to ensure compliance'.⁵⁶

It should be noted that legislation in itself is not a guarantee that staffing will always be determined safely at local level, but does provide additional impetus to local management to implement and pay heed to the results of staffing tools.

Wales

The Nurse Staffing Levels (Wales) Act 2016 received royal assent in 2016 and is scheduled to be introduced in phases until April 2018. The Act focuses on two areas:

- a general duty requiring Welsh NHS organisations to consider what nurse staffing levels are needed to care for patients
- specific instructions on determining staffing levels in acute adult inpatient medical and surgical wards.

The latter requirements will come into force from April 2018, and will subsequently (2021) require NHS trusts in Wales to report to government on implementation. The Act does not set out minimum ratios, but will require ‘senior nurses to determine the staffing levels appropriate for patients in specific areas’ by using an approved workforce tool, supported by a triangulation approach similar to that in use in NHS Scotland – using activity/outcomes data and professional judgement.⁵⁷

UK summary

Given the similarities between the four UK countries in terms of system characteristics, nurse staffing profile, patient population and regulatory framework, it is instructive to note that, while there has been recent divergence in terms of how each country addresses the national policy issue of how to determine ‘safe staffing’, the approach in England is notably less ‘top down’ than the other three countries. It also currently lags well behind NHS Scotland in terms of the extent of claimed coverage of different care environments (see Table 2).

The health system in Northern Ireland uses nationally determined staff ranges, backed up by triangulation (but as yet with only limited coverage). NHS Scotland has developed a suite of tools that it is claimed now covers nearly all care environments and will soon legislate for mandatory use of these tools. NHS Wales already has the legislation and is now developing the tools. It appears likely that within a few years the approaches in NHS Scotland and Wales could be virtually identical.

Table 2: An overview of national approaches to determining nurse staffing in the four UK countries

	National or local?	Triangulation	Approved 'tools'	Current coverage	Legislation?
England	Local; national guidance	Yes	Three only, from NICE work in 2014-15	Acute surgical: drafts issued for learning disabilities, mental health and adult community nursing services	No
Northern Ireland	Required local use of nationally determined nurse: patient 'ranges'	Yes	No	Medical and surgical, acute Midwifery is reportedly being planned	No
Scotland	Required local use of nationally approved and mandated tools	Yes	Yes, mandatory use of a suite of tested and approved tools	Claimed coverage of '98%' of nursing and midwifery service areas	Commitment to legislate within current parliament
Wales	National legislated approach being developed	Yes	Currently consulting with NHS Scotland on development of suite of tested tools	When legislation is implemented will be 100%, with progressive coverage of tools	Yes, in 2016
* NICE endorsed a fourth tool for adult in-patient in April 2017.					

Other countries

Other high income countries report similar challenges in terms of identifying relevant approaches to determining staffing, and then implementing them effectively and consistently. The USA merits most attention as it has a long established focus on developing tools and systematic approaches to determining nurse staffing levels at operational level, in part because of the need for accuracy in identifying staffing costs for reimbursement, and to meet hospital accreditation requirements. Activity and outcome data is also routinely captured in US hospital care, which can assist in determining nurse staffing levels.

Even so, a recent review of patient classification systems used to determine nurse staffing in the USA noted that a ‘gold standard’ patient classification system could not be identified, highlighting difficulties in measuring nurse workload, inadequate definitions of nursing work, lack of consistent validity and reliability testing, and incomplete understanding of the relationship to nurse-sensitive outcomes.^{58,59}

Another recent review of approaches to determining nurse staffing and outcomes in the USA noted that ‘The need for effective, reliable, credible, usable systems for projecting appropriate staffing is increasing, driven in part by state requirements that do not mandate minimum staffing but do require hospitals to have staff projection systems that have been vetted by management, staff, and sometimes outside agencies.’⁶⁰

In the USA, safe staffing is primarily an organisation-level responsibility. However, seven US states require hospitals to have staffing committees responsible for plans and staffing policy; five states require some form of disclosure and/or public reporting of nurse staffing levels; one state (Massachusetts) has recently passed a law requiring specific nurse:patient ratios in intensive care units (ICUs); and one state (California) stipulates in law the required minimum nurse to patient ratio across different hospitals and care settings.⁵¹ The ‘core’ nurse:patient ratio in medical–surgical wards in California is 1:5 or fewer,^{62,63} with other ratios determined for other care settings.

In Australia, the state of Victoria put nurse:patient ratios into law in 2015.⁶⁴ The main nurse:patient ratio in acute general medical or surgical wards in Victoria (morning and afternoon shifts) is a minimum 1:4 ratio.

While nationally recognised minimum NHS nurse staffing levels have been rejected by the Department of Health as ‘not the answer’,⁶⁵ there has been continued interest in the UK about the use of legislated or mandatory ratios. ‘Top-down’ mandatory nurse:patient ratios are a relatively blunt instrument, which can reduce local flexibility and local management decision making, but their use does give greater certainty about minimum staffing levels if resources are limited or local management are unresponsive to justifiable staffing concerns.^{66,67,68} One key issue is how to reach agreement on the calibration of ratios in different types of hospital and care environment. In both California and Victoria this took several years of analysis, consultation and negotiation before implementing agreed ratios.

This brief summary of policy and practice in other countries has highlighted that, compared to England, very different approaches to determining nurse staffing are being developed in the other three countries of the UK. It has also highlighted the risk of placing too much emphasis on ‘the evidence’ alone to identify how best to determine nurse staffing levels at a local level, because the current evidence base on nurse staffing and outcomes, although improving, is weak, narrow and incomplete.

Can the new nurse staffing guidelines for England make a difference?

It is now more than four years since the Mid Staffs Inquiry report first highlighted the need for effective approaches to safe staffing in the NHS in England. Since the first NICE guidelines were published in 2014/15, there has been relatively slow progress in England in providing stakeholders with practical support on which staffing approaches and tools are available and have utility.

Evidence reviews published in 2016–17 essentially confirm the earlier NICE conclusions about the paucity of research on safe staffing in the NHS. There is a strong case to be made that safe staffing policy and practice cannot wait for perfect evidence – or even substantial evidence, given the time needed to commission and carry out in-depth analysis in this complex field. The effort must be on providing improved understanding of the strengths and weaknesses of available approaches and tools, the optimal use of local data on staffing and workflows, and the provision of training to responsible staff to make the best use of local staffing metrics.

Almost 20 years ago, the Audit Commission examined nurse staffing in the NHS in England and recommended that whatever method was used to determine staffing, it should be ‘simple, transparent, integrated, benchmarked and linked to ward outcome measures’.⁶⁹ More recent reviews of safe staffing approaches have reinforced these criteria, focusing on this need for utility, in terms of relevance and ease of use by local staff, for best use of available data, for consistency in application, and for inclusion of expert judgement.^{70,71}

The new guidelines on nurse staffing in the NHS in England look relatively ‘light touch’ in comparison to what is being developed elsewhere in the UK. This in itself is not a problem if they meet the needs of local managers and practitioners, while supporting safe staffing levels. However there has also been recent criticism from the professional nursing press that the consultation approach used by NHS I for the draft guidelines has been too low key, without the use of press releases, meaning the guidelines were ‘at risk of being lost’ and ‘might easily have slipped through the net, when... steps should have been taken to not only prevent this but also to actively highlight and promote them’.⁷²

At the time of writing, the new draft guidelines on nurse staffing in the NHS in England continue to place the emphasis on local-level decision making, within the loose parameters of the need for ‘triangulation’. The available guidelines do not cover all the main care areas, do not present a full range of tools or methods, and do not list the relative strengths and weaknesses of different approaches. While there is an emphasis on ‘evidence-based’ approaches to safe staffing, the commissioned evidence reviews have all highlighted that the available evidence is practically non-existent and, as such, of little use in supporting either well informed consistent local practice or national policy. The only tools currently endorsed are the three that were initially promoted by NICE in 2015, and a fourth, endorsed by NICE in April 2017. In addition, the evidence review on community nursing highlighted an additional constraint, that some providers may not make staffing data

available because of commercial considerations. This latter point may take on greater prominence if more care is provided by new types of organisation emerging from local sustainability and transformation plans (STPs).

Recommendations

The recommendations, which are aimed at the national level in England – at NHS I, NQB and the Department of Health – take as a starting point that the current approach to safe nurse staffing guideline development in England is relatively slow, risks uneven and incomplete coverage, and is compromised by the lack of a comprehensive evidence base. There are several areas where there is scope for improvement, which can be addressed immediately, if the need for relevance and ease of local use is to be prioritised, and which do not require the long wait for improved research. These are discussed below.

Harness technology and data analytics

Technological progress means that there can be more emphasis on provision of timely, ‘live’ and easy-to-read data ‘dashboards’ and apps to support local decision making on staffing levels, based on a clearer assessment of workflows and workload variations. There are already examples of such tools being used successfully, both in the UK⁷³ and elsewhere.^{74,75} Innovation and successful implementation of these technologies would help local practitioners to understand better the links between safe staffing levels and workflow, identify local staffing needs in a more timely manner, and improve overall productivity. It would also allow a much improved ‘line of sight’ for NHS trust boards so that they can be better informed in discharging their governance responsibilities related to safe staffing.

Train and develop lead staff in the use of staffing tools, analysis and data interpretation

Tools, systems and dashboards can only be effective when local staff fully understand the scope and benefits of their use. They can drive the process of turning analysis and live data into immediate responses. This is in part about empowering these staff to make staffing decisions, but also relates to providing them with appropriate training and development, both in the practical aspects of using tools, and in the ability to optimise their application. Both Northern Ireland and Scotland have invested in this aspect of support for safe staffing.

Safe staffing is about being inclusive: coverage, mix and teams

Some of the tools and approaches, and most of the limited evidence, available to support decisions on safe staffing focus only on registered nurses, and only on hospital-based adult acute care. Several areas of care identified as policy priorities in the NHS in England, including community care and mental health, are virtually tool- and evidence-free. The focus on local sustainability by better integration of health and social care will also raise new staff mix challenges. And while registered nurses are central to the safe delivery of care in virtually all care environments, they usually are not the only staff working to ensure safe care. There is a need to accelerate the pace of coverage to build up evidence on ‘what works’ for safe staffing across these important but underexamined areas, and to reinforce that tools and approaches must give consideration to team-based delivery, and to maintaining effective skill mix as part of the overall process of determining safe staffing.

Systematically link safe staffing methods with staff rostering and planning

NHS organisations in England make use of a range of approaches to determine staffing levels. Not all are, or can be, well aligned with systems required for staff rostering, scheduling and identifying the need to deploy temporary additional staff ('e-rostering'). This link must be made and sustained for a fully effective approach to determining safe staffing levels.

Engage in cross-UK collaboration on tools and experiences

NHS England is maintaining a relatively 'hands-off' approach at national level, based on recommended application of triangulation methods. This reflects an approach which has emphasised local autonomy and flexibility, but failed, so far at least, to provide consistent national direction. There have been several shifts in the lead responsibility for the issue at national level in recent years, and the current approach has been criticised by some commentators as being too low key. In contrast, the other three UK countries have all shifted towards a more systematic, nationally determined and consistent, if arguably less locally flexible, approach. The staffing approaches adopted in the other three UK countries represent alternative approaches to dealing with a common problem which England shares.

There is clear scope across the UK countries for greater collaboration on some aspects of nurse staffing. For example, there appears to be no reason why the NHS in England could not collaborate with Wales and Scotland on the testing and endorsement of staffing tools, given that Scotland has reportedly now developed an almost full suite, and as yet England only endorses three – only for acute care – that were all approved several years ago. In addition, there is scope to compare and assess the impact of these different safe staffing tools and systems as they are fully implemented, providing an opportunity to share experiences across UK borders, assessing the strengths and weaknesses of the different nationally determined safe staffing approaches. This could be a joint approach which would give economies of scale and avoid unnecessary repetition of evaluation.

Conclusion

The NHS in England's approach to nurse staffing has been relatively slow to evolve since the Mid Staffs Inquiry report in 2013, in comparison to the other three UK countries. This leaves it open to criticism that the current guideline-based approach does not, as yet, cover important areas. It does not favour the mandatory, legal-based, or standardised systems being advocated in the other UK countries. It can 'look' relatively weak and incomplete in comparison.

If it is to turn this apparent weakness into the potential strength of an approach based on local flexibility in nurse staffing decisions, then it will have to accept that the inevitable result will be greater variation in local staffing levels. Local autonomy of decision making will have to be supported, but shored up by the necessary checks and balances to prevent any recurrence of a Mid Staffs-type event. This means meeting a higher level of need for local management capacity and responsiveness in analysing, determining, implementing and monitoring what is 'safe', and making much more rapid progress in identifying, and networking 'what works' in terms of local team-based safe staffing tools and approaches, and effective and consistent use of local data and systems.

References

1. Buchan J, Seccombe I, Charlesworth A. *Staffing matters; funding counts*. London: The Health Foundation, 2016. www.health.org.uk/sites/health/files/StaffingMattersFundingCounts.pdf
2. NHS Providers. *The State of the NHS Provider Sector*. London: NHS Providers, 2016. <https://www.nhsproviders.org/state-of-the-provider-sector-11-16/workforce>
3. Lintern S. Health economies and NHS Providers plans for major workforce changes will be subject to NHS Improvement checks on safety, its chief executive has said. *Health Service Journal*. 2016. <https://twitter.com/Shaulintern/status/806030760557871104>
4. Lintern S. Revealed: The hospitals with the worst nurse staffing. *Health Service Journal*. 19 January 2017.
5. <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com>
6. Merrifield N. Leading nurse staffing expert warns that Francis report lessons are being 'forgotten'. *Nursing Times*. 23 February 2017. <https://www.nursingtimes.net/news/hospital/top-nurse-academic-warns-francis-lessons-being-forgotten/7015933.article>
7. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary*. HC 947. London: The Stationery Office, 2013.
8. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary*. London: The Stationery Office. p69. <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>
9. NICE. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE, 2014. <https://www.nice.org.uk/guidance/sg1/chapter/1-Recommendations>
10. NICE. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE, 2014. <https://www.nice.org.uk/guidance/sg1/chapter/1-Recommendations>
11. NICE. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE, 2014. <https://www.nice.org.uk/guidance/sg1>
12. NICE. *Safe midwifery staffing for maternity settings*. London: NICE, 2015. <https://www.nice.org.uk/guidance/ng4>
13. NICE. *NICE to produce guidance on safe NHS staffing levels*. 2013. <https://www.nice.org.uk/news/article/nice-to-produce-guidance-on-safe-nhs-staffing-levels>
14. NHS England. *Safe staffing*. 2017. <https://www.england.nhs.uk/ourwork/safe-staffing> (accessed 17 March 2017).
15. NQB. *How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability*. 2013. <https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf>
16. Longhurst C. Safe staffing guidance still elusive – three years on from Mid Staffs. *Nursing Standard*. 2016;30(23)12–13. <http://dx.doi.org/10.7748/ns.30.23.12.s14>
17. NHS Improvement. *Who we are*. <https://improvement.nhs.uk/about-us/who-we-are> (accessed 25 April 2017).
18. NHS I. *Update on safe staffing improvement resources for specific care settings*. July 2016. <https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-specific-care-settings>
19. NHS I. *Setting-specific safe staffing improvement resources – update*. July 2016. https://improvement.nhs.uk/uploads/documents/Bulletin_NHSI_setting_specific_safe_staffing_improvement_resources_for_publication.pdf
20. National Quality Board. *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing*. London: NQB, 2016. <https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf>
21. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals*. London: NQB, 2017. https://improvement.nhs.uk/uploads/documents/Adult_in-patient_safe_sustainable_staffing.pdf
22. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals*. London: NQB, 2017. p24. https://improvement.nhs.uk/uploads/documents/Adult_in-patient_safe_sustainable_staffing.pdf
23. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals*. London: NQB, 2017. p5. https://improvement.nhs.uk/uploads/documents/Adult_in-patient_safe_sustainable_staffing.pdf
24. NICE. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE, 2014. <https://www.nice.org.uk/guidance/sg1/resources>
25. National Institute for Health and Care Excellence (2017) Safe staffing for nursing in adult inpatient wards in acute hospitals: Establishment Genie <https://www.nice.org.uk/about/what-we-do/into-practice/endorsement>
26. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for learning disability services*. London: NQB, 2017. https://improvement.nhs.uk/uploads/documents/Learning_Disability_safe_sustainable_staffing.pdf
27. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for mental health*. London: NQB, 2017. https://improvement.nhs.uk/uploads/documents/Mental_Health_Setting_Improvement_Resource_Engagement.pdf

28. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for the district nursing service*. London: NQB, 2017. https://improvement.nhs.uk/uploads/documents/Community_safe__edit_v30_proofed_final.pdf
29. Mafuba K, Gates B, Sivasubramanian M. *Report of a mixed methods systematic review of literature to inform the development of 'sustainable safe staffing' improvement resource in learning disability (LD) services for NHS Improvement*. London: UWL/NHS I, 2016. p36. https://improvement.nhs.uk/uploads/documents/LD_evidence_review.pdf
30. Lawes A, Marcus L, Pilling S. *What staffing structures of mental health services are associated with improved patient outcomes? A rapid review*. Safe, sustainable staffing/National Collaborating Centre for Mental Health, 2017. https://improvement.nhs.uk/uploads/documents/NCCMH_Literature_Review_Mental_Health_Final.pdf
31. Jackson C, Wright T, Martin A. *Safe Caseloads for Adult Community Nursing Services – An Updated Review of the Evidence*. London: ECPD/NHS I, 2016. p37. https://improvement.nhs.uk/uploads/documents/Final_Version_Managing_Safe_Caseloads.pdf
32. Jackson C, Wright T, Martin A. *Safe Caseloads for Adult Community Nursing Services – An Updated Review of the Evidence*. London: ECPD/NHS I, 2016. p19. https://improvement.nhs.uk/uploads/documents/Final_Version_Managing_Safe_Caseloads.pdf
33. Hurst K. *Selecting and Applying Methods for Estimating the Size and Mix of Nursing Teams. A systematic review of the literature commissioned by the Department of Health*. England: Nuffield Institute for Health, 2003. http://www.who.int/hrh/tools/size_mix.pdf
34. Ball J. *Guidance on safe nurse staffing levels in the UK*. London: Royal College of Nursing, 2012.
35. Park S, et al. Comparison of Nurse Staffing Measurements in Staffing-Outcomes Research. *Medical Care*. 2015;53(1):e1-e8.
36. Hurst K. *Selecting and Applying Methods for Estimating the Size and Mix of Nursing Teams. A systematic review of the literature commissioned by the Department of Health*. England: Nuffield Institute for Health, 2003. www.who.int/hrh/tools/size_mix.pdf
37. University of Southampton, Health Sciences. *New study to assess safe staffing levels on hospital wards*. www.southampton.ac.uk/healthsciences/news/2016/05/17-safe-staffing-levels.page (accessed 25 April 2017).
38. Ball J. *Guidance on safe nurse staffing levels in the UK*. London: Royal College of Nursing, 2012.
39. Association of UK University Hospitals. Patient Care Portfolio (Safer Nursing Care Tool). www.aukuh.org.uk/index.php/affiliate-groups/directors-of-nursing/patient-care-portfolio (accessed 25 April 2017).
40. Health Education West Midlands/NHS England. *Mental Health Staffing Framework*. 2016. <https://www.england.nhs.uk/6cs/wp-content/uploads/sites/25/2015/06/mh-staffing-v4.pdf>
41. Kirby E, Hurst K. Using a complex audit tool to measure workload, staffing and quality in district nursing. *British Journal of Community Nursing*. 2014;9(5). <http://dx.doi.org/10.12968/bjcn.2014.19.5.219>
42. NHS Improvement. *Rostering: good practice*. <https://improvement.nhs.uk/resources/rostering-good-practice> (accessed 25 April 2017).
43. Keogh B. *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*. London: NHS England, 2013. www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf
44. National Audit Office. *Managing the supply of NHS clinical staff in England*. London: NAO, 2016. <https://www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england>
45. NQB (2017) *Safe, sustainable and productive staffing An improvement resource for the district nursing service*. https://improvement.nhs.uk/uploads/documents/Community_safe__edit_v30_proofed_final.pdf
46. NICE. *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE, 2014. <https://www.nice.org.uk/guidance/sg11/chapter/3-Gaps-in-the-evidence>
Evidence Review 1: Griffiths P, Ball J, Drennan J, Jones J, Reccio-Saucedo A, Simon M. *The association between patient safety outcomes and nurse/healthcare assistant skill mix and staffing levels and factors that may influence staffing requirements*. University of Southampton, 2014.
Evidence review 2: Simon M, Ball J, Drennan J, Jones J, Reccio-Saucedo A, Griffiths P. *Effectiveness of management approaches and organisational factors on nurse sensitive outcomes*. University of Southampton, 2014.
Economic analysis: Cookson G, McGovern A. *The cost-effectiveness of nurse staffing and skill mix on nurse sensitive outcomes*. University of Surrey, 2014.
47. Griffiths P, Dall'Ora C, Ball J. *Nurse staffing levels, quality and outcomes of care in NHS hospital wards: what does the evidence say?* Health Work Evidence Briefs, University of Southampton, 2017. https://improvement.nhs.uk/uploads/documents/Evidence_review.pdf
48. Mafuba K, Gates B, Sivasubramanian M. *Report of a mixed methods systematic review of literature to inform the development of 'sustainable safe staffing' improvement resource in learning disability (LD) services for NHS Improvement*. London: UWL/NHS I, 2016. https://improvement.nhs.uk/uploads/documents/LD_evidence_review.pdf
49. National Quality Board. *Safe, sustainable and productive staffing: An improvement resource for adult inpatient wards in acute hospitals*. London: NQB, 2017. p24. https://improvement.nhs.uk/uploads/documents/Adult_inpatient_safe__sustainable_staffing.pdf

50. Department of Health, Social Services and Public Safety, Northern Ireland. *Delivering Care: Nurse Staffing in Northern Ireland. Section 2: Using the Framework for general and specialist medical and surgical adult in-hospital care settings*. Belfast: DHSSPS, 2014. <https://www.health-ni.gov.uk/publications/delivering-care-nurse-staffing-levels-northern-ireland>
51. NHS Scotland. *Nursing and Midwifery Workload and Workforce Planning Programme*. <http://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP> (accessed 25 April 2017).
52. NHS Scotland. *Nursing and Midwifery Workload and Workforce Planning Programme: Tools*. www.isdscotland.scot.nhs.uk/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/Tools (accessed 25 April 2017).
53. NHS Scotland. *Nursing and Midwifery Workload and Workforce Planning Programme*. www.isdscotland.scot.nhs.uk/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP (accessed 25 April 2017).
54. NHS Education for Scotland. *Nursing and Midwifery Workload and Workforce Planning: Learning Toolkit (Second Edition)*. Edinburgh: NES, 2013. www.nes.scot.nhs.uk/media/248268/nursing_midwifery_workforce_toolkit.pdf
55. Scottish Government. *NHS safe staffing to be enshrined in law*. <http://news.gov.scot/news/nhs-safe-staffing-to-be-enshrined-in-law> (accessed 25 April 2017).
56. Scottish Government. *Safe and Effective Staffing in Health and Social Care. Consultation 11 April 2017 – 5 July 2017*. <https://consult.scotland.gov.uk/nursing-and-midwifery/safe-and-effective-staffing-in-health-care-setting> (accessed 25 April 2017).
57. White J. Staffing levels law will bolster the front line. *Nursing Standard*. 2016;31(5):27.
58. Fasoli DR, Haddock KS. Results of an integrative review of patient classification systems. *Annual Review of Nursing Research*. 2010;28:295–316.
59. Malloch K. Measurement of Nursing's Complex Health Care Work: Evolution of the Science for Determining the Required Staffing For Safe and Effective Care. *Nursing Economics*. 2015;33(1)20–26.
60. Needleman J. *Nurse Staffing: The Knowns and Unknowns*. *Nursing Economics*. 2015;33(1)5–8.
61. American Nurses Association. *Nurse Staffing*. www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-StaffingPlansRatios (accessed 25 April 2017).
62. California Department of Public Health. *Nurse-to-Patient Staffing Ratio Regulations*. www.cdph.ca.gov/services/DPOPP/regs/Pages/N2PRegulations.aspx (accessed 25 April 2017).
63. Buchan J. A certain ratio? The policy implications of minimum staffing ratios in nursing. *Journal of Health Services Research and Policy*. 2005;10(4):239–244.
64. Department of Health & Human Services, State Government of Victoria, Australia. *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015*. <https://www2.health.vic.gov.au/health-workforce/nursing-and-midwifery/safe-patient-care-act> (accessed 25 April 2017).
65. Calkin S. Minimum nurse staffing levels 'not the answer', says minister. *Health Service Journal*, 2013. <https://www.hsj.co.uk/home/francis-report/minimum-nurse-staffing-levels-not-the-answer-says-minister/5055585.article> (accessed 25 April 2017).
66. Spetz J, Harless D, Herrera C-N, Mark B. Using Minimum Nurse Staffing Regulations to Measure the Relationship between Nursing and Hospital Quality of Care. *Medical Care Research and Review*. 2013;XX(X) 1–20; Burnes Bolton L, et al. Mandated Nurse Staffing Ratios in California: A Comparison of Staffing and Nursing-Sensitive Outcomes Pre-and Postregulation. *Policy Polit Nurs Pract*. 2007;8(4):238–250; Donaldson N, Shapiro S. Impact of California Mandated Acute Care Hospital Nurse Staffing Ratios: A Literature Synthesis. *Policy Polit Nurs Pract*. 2010;11(3):184–201.
67. Spetz J, Harless D, Herrera C-N, Mark B. Using Minimum Nurse Staffing Regulations to Measure the Relationship between Nursing and Hospital Quality of Care. *Medical Care Research and Review*. 2013;XX(X) 1–20
68. Chapman S, et al. How Have Mandated Nurse Staffing Ratios Affected Hospitals? Perspectives from California Hospital Leaders. *Journal of HealthCare Management*. 2009;54(5):321–334.
69. Audit Commission. *Ward staffing: review of national findings*. London: Audit Commission Publications, 2001.
70. Fasoli DR, Haddock KS. Results of an integrative review of patient classification systems. *Annual Review of Nursing Research*. 2010;28:295–316.
71. Ball J. *Guidance on safe nurse staffing levels in the UK*. London: Royal College of Nursing, 2012.
72. Ford S. Safe staffing guidelines must not fly under the radar. *Nursing Times*, 21 March 2017. https://www.nursingtimes.net/7016688.article?utm_source=newsletter&utm_medium=email&utm_campaign=NT_EditorialNewsletters.Reg:%20Send%20-%20The%20weeks%20highlights&mk_tok=eyJpIjoiWXpsbU1qVTFaR00yT1RNeSIsInQiOiJFakdrOXcxbjJyVlBaSWY2ekloelVhNFFIMUdOd3VuTk9XV0NYK0gweUhYekRHbUxjZVJSazJWb1hxV2VKaVJ1R3FTNHFXcVPTFwvQlweFF3MjM4ZFI0M43MEdjVkhOT2J6Y1IKU3VpTG55MkhReE1rZEIWOXFuQnRGYzNWWTVPln0%3D
73. Academy of Fabulous Stuff. *Safe Staffing App*. <http://fabnhsstuff.net/category/safe-staffing> (accessed 25 April 2017).
74. Lawless J. *Safe Staffing: The New Zealand Public Health Sector Experience. Expert Paper 1: Expert testimony presented to the Safe Staffing Advisory Committee*. London: NICE, 2014. <https://www.nice.org.uk/guidance/sg1/documents/safe-staffing-guideline-consultation11>
75. Tuominen O, Lundgren-Laine H, Kauppila W, Hupli M, Salanterä S. A real-time Excel-based scheduling solution for nursing staff reallocation. *Nursing Management*. 2016;23(6):22–29. doi: 10.7748/nm.2016.e1516.

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