SAFE STAFFING IN ACUTE NHS TRUSTS

A study of the Implementation of policy introduced in England after the Francis Inquiry

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Background

The Francis Inquiries drew attention to the vulnerability of nurse staffing decisions to internal and external pressures. Patient safety risks associated with low Registered Nurse (RN) staffing were not considered in the decision to reduce the number of nursing posts at Mid-Staffordshire NHS Trust.

The government response to the Francis Inquiry aimed to put patients, and their safety, 'first and foremost' and included policy on nurse staffing. The National Quality Board (NQB) set out expectations of Trusts for planning nurse staffing. The National Institute for Health and Care Excellence (NICE) were commissioned to produce guidelines for 'safe staffing', which were introduced in 2014. NICE recommended the use of 'red flags' to highlight nurse staffing insufficiency and advised that 8 patients or more per RN should trigger a review of staffing.

Research

The NIHR Policy Research Programme funded a series of research studies to investigate the impact of policies developed after the Francis Inquiry. This included the current two year study, undertaken by University of Southampton in collaboration with Bangor University, to examine the implementation of safe staffing policy.

Aim

This study examined how national safe staffing policies have been implemented by acute NHS Trusts in England and aimed to address the question: *"What difference have safe staffing policies introduced after Francis made to the achievement of safe staffing in the NHS?"*

Design

The methods used comprised four main elements:

→ **Policy mapping:** a review of policies and the health service context in which they have been developed and implemented.

→ **National survey:** online and postal survey of all Directors of Nursing in acute NHS Trusts in March-April 2017, with response rate of 61% (91 of 148).

→ **National workforce data:** analysis of national datasets to explore trends and identify differences between sectors. NHS safety thermometer data and the NHS staff survey also examined.

→ **Case studies:** description of policy implementation and assessment of costs in four acute NHS trusts and a qualitative study using a realist evaluation approach to identify mechanisms that explain how different outcomes of policy implementation may have come about, depending on the context.

Results

Policy evolution

Policy continued to evolve in the post-Francis period. In an unprecedented development, NICE was asked to stop producing guidelines on safe staffing in June 2015. Responsibility for safe staffing was adopted by NHS England, before being transferred to NHS Improvement. Subsequent resources included a focus on sustainability'. Following an efficiency and productivity review led by Lord Carter in 2016, the 'Care Hours per Patient Day' (CHPPD) metric was introduced. Despite the urgency and commitment that characterised the initial policy responses to the Francis Inquiry in 2013, policy messages on safe staffing have become more muted.

Nursing shortages

Directors of Nursing report that the biggest challenge to achieving safe nurse staffing levels is unfilled vacancies. Trust RN vacancy rates ranged from 2-20%, with an average of 10%. Growth in RN staffing has been constrained by Trusts' inability to fill posts due to the ongoing national shortage of RNs. At a shift level, Trusts have difficulty filling planned RN hours (as gauged through 'fill-rate' data). The staff survey reveals that nurses are working a larger number of additional hours. One in four Trusts surveyed reported that the number of patients per RN on day shifts had routinely exceeded 1:8.

Workforce changes

Following a period of zero growth between 2009 and 2013, the number of nursing staff employed in the NHS acute sector increased from 2013; by 10% for RNs and 30% for HCAs/support staff. The expansion seen in the acute sector is not mirrored in other sectors where there has not been the same level of policy attention. Numbers of RNs in community, learning disability, and maternity have decreased.

Relative change in RNs and support staff (Sept 2009 - Dec 2017)
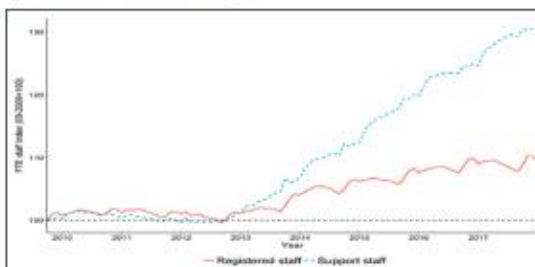
The disproportionate increase in support staff has created a shift in the skill mix; RNs make up 66% of nursing staff in 2017 compared with 69% in 2013.

Admissions, RN FTE, & estimated RN hours per admission (Sept 2009 - Feb 2017)
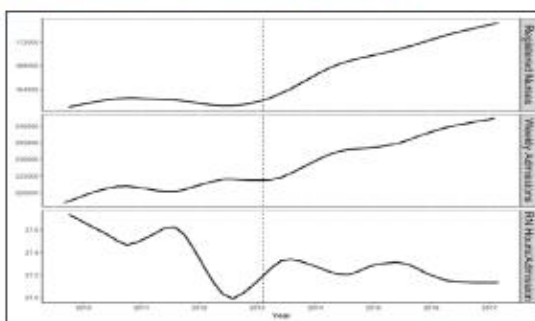
However, as nursing numbers have increased, so has hospital activity; RN hours per admission fell between Sept 2009 and mid-2012 (from 27.7 to 27). Between mid-2012 and mid-2013 levels increased before plateauing (around 27.3)

Trust systems and processes

The majority of Trusts reported that nursing establishments were reviewed at least every six months, meeting the NQB expectation. Almost all were using the NICE-endorsed Safer Nursing Care Tool (SNCT) or a related tool, alongside professional judgment. Trusts review nurse staffing and assess its adequacy, or any shortfall, at the start of each shift, using a combination of professional judgement (75%) and patient acuity and dependency systems (69%). The 'red flags' proposed by NICE are reported at 82% of Trusts.

Views of the policies: which have been most helpful?

Directors of Nursing reported that how staffing is planned and rostered had got better, and 94% said board awareness of staffing had improved since Francis. Almost all said that accountability for providing safe staffing was now part of the culture at every level of the organisation (76% to a great extent, 24% to some extent). But they report that ability to recruit and retain staff had got worse since Francis.

Aspects of nurse staffing that have got better since the Francis Inquiry - percent
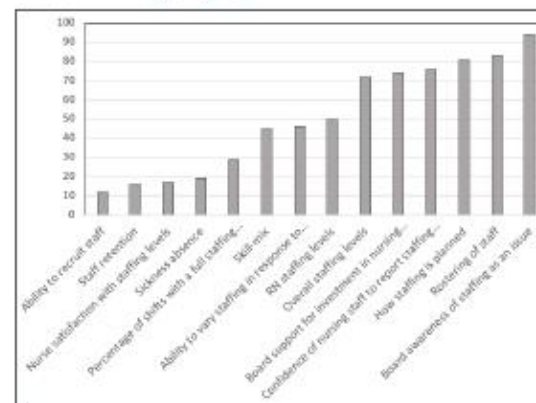
The Francis recommendations and NQB guidelines from 2013 were both seen as having been helpful in supporting safe staffing. The elements of guidance related to monitoring – use of 'red flags' and CHPPD – were less frequently seen as positive by Directors of Nursing.

Assessment of costs

Estimated nurse staff costs for NHS acute care increased by 15% between July-September 2012 and the end of 2017 (from £1.9bn to £2.2bn): RN costs increased by 12%, support staff costs increased by 30%. Staff spending at case study sites followed a similar trend to that identified nationally from mid-2012 onwards. In the case study Trusts, the roles of existing staff had changed to enable safe staffing policy to be implemented and a small number of new posts had been created specifically related to safe staffing.

Changes in information technology (IT) and management processes over time make it difficult to determine whether changes in cost are directly attributable to policy post-Francis. Substantial IT investment has been made, for example through use of electronic rostering systems to collect and collate patient acuity data, which are supported by analytical staff to collate and feedback staffing requirements.

Factors influencing implementation

Ward level safe staffing is seen as a balancing act, balancing patient need against real time resources, in a context of internal and external influences. The realist evaluation described strategies Trusts used to cope with, and mitigate against, staffing shortfalls. Nevertheless, across the four hospitals, senior nurses reported times when an imbalance occurred, when wards were not operating with safe nurse staffing levels.

Policy had impacted on Trusts in terms of: the language used to refer to staffing, visibility of safe staffing within the organisation, use of data to support investment in nurse staffing, use of data to provide 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.

Four main influences on policy implementation were identified:

i. Clarity of the safe staffing policy message

ii. How organisations innovated and learnt to deliver safe staffing

iii. Tools and technologies to support decision making

iv. Credibility and reliability of staffing and outcome data used.

Implementation worked best when there is a 'whole-systems' approach with alignment across organisational strategies and data systems including: 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 staff goodwill, were all factors associated with success. A lack of transparency and equity around staffing within organisations risked this goodwill.

The requirement that Trusts both deliver safe staffing in every situation and remain within budget was a source of tension identified in both the case studies and the survey of Directors of Nursing.

Conclusion

The Francis Inquiry and subsequent policy have been instrumental in reinforcing the link between nurse staffing and patient safety; a principle embodied in the term 'safe staffing', now used across the NHS.

Safe staffing policy has acted as a catalyst, accelerating a change in thinking which has led to changes in the processes, technologies and systems that support safe staffing as an outcome. Heightened board awareness of safe staffing has been accompanied by increased Trust willingness to invest in the nursing workforce.

The Francis report was published after a period in which staffing had stagnated. The national shortage of RNs has constrained Trusts' ability to fill the number of nursing posts that they identified – using the NICE endorsed systems – as necessary for safe care.

Financial consideration has been introduced into safe staffing policy retrospectively, as a limit that Trusts must work within, rather than at the outset, as an anticipated investment needed to achieve safe nurse staffing levels, in line with policy.

Checks and balances recommended by Francis to safeguard safe staffing from being compromised have not been instigated, allowing the changes made to only partially meet the objective of improving nurse staffing levels in NHS acute hospitals.

Safe staffing policies following Francis set out a vision for safe staffing which appears to have been embedded in Trust actions and attitudes, despite the competing priorities and a context of labour market difficulty. Achieving safe staffing however, requires the wider workforce and resource restrictions to be overcome.