SUMMARY

Good staffing is one of the ten priorities for action identified by Nursing Standard’s Care campaign. Diluting skill mix is tempting for NHS executives when finances are tight, but evidence is mounting that this puts patient care at risk.

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Getting ratios right, for the patients’ sake

When nursing is undervalued, care is inevitably undermined, say Alison Moore and Adele Waters

How would you describe your job in terms of its value to patients? You might choose to list your typical tasks or count the patients you look after.

If a patient were to ask you the difference between a nurse and a healthcare assistant (HCA), you might explain that one is registered and educated to a recognised UK standard, and the other is not.

But how would you express your ‘net worth’ to your employer? How would you articulate the difference you make to patient care, over that of a support worker?

These questions are becoming more important. All the research shows that quality of patient care is relative to registered nurse staffing levels, but in lean financial times it is tempting for managers to spread their registered nurses ever more thinly. Nurses can be seen as ‘nice but expensive’.

Unions are becoming more concerned. Last month Unison ran a survey on registered nurse staffing levels across the UK. It will publish its findings this month as part of its campaign for safe staffing levels.

At its annual conference in October, Unison has invited a number of speakers to make the case for the introduction of minimum staffing levels. The union’s head of health Gail Adams says: ‘Nurses are under huge staffing pressures. We need to stand up for them and the best way of doing that is by setting minimum staffing levels.’

The RCN is also making staffing a priority and is worried about the decline in the ratio of registered nurses per patient employed on wards.

Last month, it published two reports. The first outlined the case for introducing mandatory safe staffing levels – something the RCN has traditionally been against – and the second set out what these levels should be on older people’s wards.

Nurse-to-patient ratios should move from the current one registered nurse to nine patients to one registered nurse per five to seven patients, the report advised.

Downward trends have been established for some time, says the college. In 2007, the average number of patients per registered nurse was 6.9 during the day and 9.1 at night. Two years later, those figures had increased to 7.9 and 10.6 respectively.

But the picture is even more variable across specialties, with older people’s wards faring the worst. Latest figures show there is one registered nurse to an average of between 9.1 and 10.3 patients. The average on an adult medical ward is 6.7 patients, and on a typical children’s ward it is 4.2.
Another major concern is that skill mix – the ratio of nurses-to-support staff – is diluting. In 2005, registered nurses accounted for an average of 65 per cent of the staff on day duty, compared to 60 per cent in 2009. In some organisations this dropped to 50 per cent, and latest figures from the UK arm of the global RN4CAST study found rates as low as 43 per cent.

The picture varies widely. NHS Information Centre figures show that the ratio of HCAs to nurses in some organisations is nearly double that in others.

Greater investment in nursing needs to be encouraged, and perhaps the first step is wider acceptance that registered nurses make a difference. Research in the United States and the UK has quantified the effect of extra nurses on patients. Pioneering research a decade ago by Linda Aiken, professor of nursing at the University of Pennsylvania, showed that with each additional patient assigned to a nurse:

- 30-day patient mortality increased by 7 per cent.
- Failure-to-rescue rates went up by 7 per cent.
- The odds of nursing job dissatisfaction rose by 15 per cent.
- The odds of nurse burnout increased by 23 per cent.

Research in the UK a few years later led by Anne Marie Rafferty of King’s College London showed similar effects. However, NHS managers have been receiving conflicting messages. In December 2010 the Audit Commission advised the NHS it could save money in four ways – reducing nursing per bed costs could save £500 million, for example, it said.

Weighing up cost
Similarly, an NHS cost-saving report drawn up by management consultancy McKinsey in 2009 left a legacy. It recommended that 28 per cent of nurse activity could be done more cheaply by support workers.

Recently NHS London published a survival plan for acute hospitals in London. It singled out nursing as ‘the most significant productivity gain’, advising spend on nursing could be slashed by almost one third.

Justifying this decision, the report noted: ‘There is not clear evidence that investment in increasing the number of nurses as the mechanism to increase the quality of nursing care is a guarantee of good patient care.’ Battle lines on this issue are being drawn, with commentators refusing to acknowledge research linking the value of nursing to patient outcomes.

Harry Cayton, the former patient tsar and now chief executive of the Council for Healthcare Regulatory Excellence, said recently: ‘There is no direct correlation between the number of staff and good or bad care.’

Yet more research is under way to contest this. Jane Ball, deputy director at King’s College London’s National Nursing Research Unit, is overseeing a UK data collection for the RN4CAST survey, carried out on 3,000 nurses. She says early findings point to a correlation between low nurse-to-patient...
ratios and care left undone. She said: ‘We gave nurses a list of 13 types of activity and asked them to tick which they did not get done on their last shift. Nine out of ten said at least one necessary activity had not been done, including comforting patients, educating them and updating care plans. We see a correlation between care being left and nurse-to-patient ratios.’

Skill perception
Nurses’ contribution to care and recovery is often underestimated, believes independent healthcare researcher Alison Leary. She says nurses often carry out complex tasks while they are in contact with patients that may appear easy, such as assessing the patient and collecting information.

Dr Leary’s work on the value of specialist nurses has found much of their worth is in ‘rescue’ work – preventing readmissions, for example, is a cost-effective activity.

‘Nursing is one of those things that, until it is gone, you do not realise how good it was,’ she says.

This is not just a UK issue. Nursing organisations throughout the world are concerned about the effect of low staffing levels on care. The Canadian Nurses Association has issued an explicit statement of its belief that nurses make a difference, and it details the evidence of this.

In California, pressure led to legislative change, requiring hospitals to respect set ratios. Statutory ratios were introduced in the Australian state of Victoria, where 96 per cent of nurses regard ratios as vital. Now pressure is mounting in New South Wales.

It is time for the UK to follow suit, argues former RCN president Dame June Clark. She says there has been ‘pussyfooting’ in the UK.

‘We ought to go for it, especially in the current climate and as managers do not seem to want to believe the evidence.

‘You can put pressure on trusts to re-evaluate their staffing models, but I do not know how you convince finance directors or chief executives who do not want to listen,’ she says.

‘Nurses need to be more upfront about their value. The public has a right to know who is looking after them and needs to know the difference between staff.’

Advocates of mandatory ratios claim they bring lower mortality rates, improved patient satisfaction and fewer clinical errors. But is there a point at which an extra nurse on a ward brings only a marginal benefit?

Tim Currie, assistant head of nursing at the RCN, says there is a law of diminishing marginal rates. ‘But there does seem to be some tipping points – above which care is excellent, where it is good and where it is unsafe.’

In 2006, the RCN suggested a ratio of 65 per cent registered nurses to 35 per cent HCAs for all acute general and surgical wards.

While this benchmark is widely recognised as an aspirational goal, pressure is mounting for something that is legally enforceable. Indeed, RCN council was asked to campaign for this at last year’s congress meeting.

It is impossible to review nurse staffing without considering HCAs. Despite the government’s commitment to ‘light-touch’ regulation, there is growing pressure for support worker registration.

The wide variation in training standards and lack of clarity about what support workers are capable of makes it difficult for nurses – who are responsible for care – to delegate with confidence.

RCN general secretary Peter Carter called the situation ‘scandalous’ during a workforce conference in February.

The drive for reduced spending will continue to challenge the case for registered nursing and the
value executive teams put on it. But nursing experts say there is a strong business case for nursing. Perceived quality of care is likely to influence patient choice and satisfaction, which could have financial benefits for hospitals. In the Midlands and eastern regions in England, hospitals are to be offered additional payments linked to the level of patient satisfaction. If a richer skill mix makes patients feel better about their experience, it may increase income.

Independent researcher and analyst Keith Hurst points to evidence that organisations assessed as performing well have significantly higher nurse-per-bed ratios. He says there is emerging evidence that a higher number of nurses is associated with better patient-reported outcomes scores. Certainly clinical commissioning groups may be interested in patient satisfaction scores when considering where to buy services. But he warns that managers may see cutting beds as the only way to improve staffing ratios.

Risk assessment
Peter Griffiths, chair of health services research at the University of Southampton, insists that a richer skill mix may be more cost-effective. ‘Investing in registered nurses might be a cost-effective strategy as opposed to other less expensive employees.’ The most valuable thing the research does is alert trusts to the risks if they experiment with skill mix, says Professor Griffiths.

Investigations into a number of recent care scandals have revealed low nurse levels. Mid Staffordshire was 120 nurses short of the number needed to provide a high standard of care, for example. Before that, at Maidstone and Tunbridge Wells NHS Trust, 70 per cent of wards had nurse-to-HCA ratios below RCN recommendations. And it is worth remembering that such scandals cost chief executives and board chairs their jobs NS

A tool for commissioners
Elaine Maxwell and Elizabeth Robb want to see a continuous evaluation of nursing input

At times of change and financial challenge, the role of nursing comes under intense scrutiny in relation to how it adds value. For this reason we need to develop a staffing tool for commissioners.

National and international research has consistently linked nurse-to-patient ratios with patient outcomes such as mortality and patient satisfaction.

At the Florence Nightingale Foundation, we believe that registered nurses make a special contribution that is still best encapsulated by nurse theorist Virginia Henderson, who in 1966 wrote: ‘The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he/she would perform unaided if he/she had the necessary strength, will or knowledge.’

That nurses need to be compassionate and caring is self-evident, but it takes intelligent application of specialist knowledge to help individuals to maintain their own health with dignity where they lack the strength, will or knowledge. In other words, compassionate values are not enough.

There is some evidence linking patient outcomes to the level of nurse education as well as the total number of nurses, as described by Jarman et al in 1999 (doi: 10.1136/bmj.318.7197.1515).

But the Audit Commission’s 2001 conclusion on NHS ward staffing still prevails in its assertion that: ‘Unless and until trusts that spend more [on staffing] can demonstrate a clear link with the quality of care that is delivered, movement towards a more even allocation of resources seems reasonable both for patients and staff.’

This illustrates a key problem with current research on staffing ratios. First, researchers use large populations to achieve statistical significance. However, the scale of this research loses the nuanced, local, contextual features.

In addition, by its nature, research is a snapshot in time and the data generated are several years old by the time findings are published.

Tools to determine ideal staffing are therefore based on historical and static formulae that reflect neither the changes in caseload, patient needs and nurses’ skills, nor the local context.

Critically, there is a gap between the large-scale research findings and local evidence needed to persuade NHS executive boards that there is an immediate and significant impact of their internal staffing on clinical outcomes and efficiency.

Dynamic approach
We believe that there is a gap in our knowledge and it demands a dynamic and continuous evaluation of nursing input and nursing outcomes that would lead to an accurate, predictive tool.

Based on a core model, this tool would be built using data from individual NHS organisations and would be sensitive to local changes, allowing real-time evaluation of different skill mix configurations.

Such a model would inform not only providers. It would also solve the conundrum that clinical commissioning groups face: how much should we spend on nursing to achieve the outcomes we seek?

Elaine Maxwell (left) is a trustee of the Florence Nightingale Foundation, and Elizabeth Robb (right) is chief executive

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