Is it time to set minimum nurse staffing levels in English hospitals?

Increasing economic pressures on healthcare systems are raising concerns about how workforce cuts and reconfigurations may affect quality (Department of Health, 2010). Currently, there are no centrally set minimum staffing levels for NHS organisations; providers are responsible for determining staffing requirements locally. In this Policy+, we look at the impact mandated minimum nurse staffing levels have had in other countries and consider current guidelines and recommendations.

Why are mandated staffing levels an issue in 2012?
In the UK, the Royal College of Nursing has played a key role in lobbying for safe nurse staffing levels (RCN, 2010) and, at congress in 2011, members voted in favour of legally enforceable nurse staffing levels. It is argued that assessment of adequate staffing levels requires robust data on current staffing, as well as data on patient outcomes and quality (Ball and Catton, 2011). The issue was recently debated in the House of Lords (as an amendment to the health and social care bill), where it was proposed that a maximum number of patients per nurse should be mandated (Hansard, 2011). In 2004, the RCN commissioned Professor James Buchan to critically review the use of nurse-to-patient ratios (Buchan, 2004). Key concerns are that a “minimum” ratio of nurses to patients could become a “maximum” and that nationally set levels may fail to take account of local variation. But, arguably, ratios are simple and easy to use and, where they lead to improved staffing levels, they can create a more stable workforce that is less dependent on temporary staffing cover.

Experience outside the UK: the impact of standardised and mandatory nurse-to-patient ratios
In California in the US, ratios were set in 1999 – for example, a ratio of 1:5 was set for medical and surgical wards. To date, 15 states in the US have legislation aimed at ensuring safe nurse staffing but California is the only state to have specific ratios applying to each specialty in all hospitals. Evidence of reported impact in California includes:

» No evidence that ratios have increased costs (McGillis Hall and Buch, 2009).
» Hospital nurses typically care for one patient fewer than nurses in other states; the lower caseload is significantly related to lower patient mortality (Aiken et al, 2010).

In Victoria in Australia, minimum nurse-to-patient ratios were legally mandated in the public sector in 2001 (1:4, plus one in charge on medical/surgical wards). In 2004, the way in which the nurse-to-patient ratio was expressed was changed to 5:20, to give more flexibility on nurse deployment across the ward (Gerdts and Nelson, 2007). The Australian Nursing Federation (ANF) reports that ratios have led to:

» Better recruitment and retention of nurses and greater workforce stability.

KEY POINTS FOR POLICY

* Defining minimum nurse staffing levels could help to stabilise the nursing workforce, ensure safe levels of staffing and deliver care to an agreed standard. However, careful consideration needs to be paid to variations in patient needs and local clinical contexts, as well as the potential impact on patients.
* Setting a mandated minimum has major consequences not just in terms of investment required to set up and establish (and periodically recalibrate) levels, but also in terms of mechanisms needed to monitor compliance and deal with non-compliance.
* Ratios currently in use focus on numbers of nurses to patients. There is a need to look at overall staffing levels, and the skill mix of the nursing team.
* Ratios do not obviate the need for robust mechanisms for workforce planning locally, to ensure that the right staff with the right skills are in place to meet patient needs.
Adequate numbers of nurses rostered six weeks in advance.
Directors of nursing having fully funded budgets to provide safe staffing levels and have reduced their reliance on agency staff.
Better patient care; beds are not kept open unless there are sufficient staffing levels.
More manageable nursing workloads.
Increased job satisfaction for nurses, more workplace stability, and reduced stress (ANF Victoria Work/Time/Life Survey, 2003).

**Recommendations and guidance on staffing levels in the UK**

Professional bodies and associations in the UK have put forward recommendations for nurse staffing levels in different specialities. For example, it is recommended that every patient in a critical care unit has access to a nurse with a post-registration qualification in the specialty, and that there is a ratio of 1:1 for ventilated patients (British Association of Critical Care Nurses, 2009). On children’s wards, a daytime nurse-to-patient ratio of 1:3 is recommended for children under 2 years of age, and 1:4 for other ages (RCN, 2003). On mental health wards, the Royal College of Psychiatry (Burns et al, 1998) suggests that a daytime ratio of 1:5 nurses per patient is likely to be needed for acute wards. However, they go on to caution about the use of minimums, and recommend that “the determination of appropriate staffing will involve dialogue between managers, nurses and other clinicians” (Burns et al, 1998).

This is a common thread; staffing recommendations provided in the UK are accompanied by a proviso that staffing needs to take local issues into account and be based on an assessment of clinical need and other factors that influence staffing requirements, such as the range of services, unit/ward layout and team mix.

**Conclusions and implications**

- International evidence suggests that mandated nurse-to-patient ratios can improve nurse staffing, lead to better recruitment, generate a more stable workforce and make workloads more manageable. The impact on patient outcomes is less clear but there is evidence that the resultant lower caseloads are correlated with lower levels of patient mortality.
- Ratios and recommendations are specific to specialties. Existing recommendations are focused on clearly defined and delineated settings, where patient need is relatively predictable and consistent. Data about staffing related to safe and effective care delivery is needed to determine the appropriate “minimum” or recommendation for a wider range of settings, such as acute care for older people.
- There is a need to clarify how existing ratios are expressed and to explore other measures of staffing, such as nursing hours per patient or per bed.

**References and information**


Hansard (2011) Amendment 138 moved by Baroness Audrey Emerton. 3:40pm 30 November 2011. tinyurl.com/HSBamend138


