**Introduction**

This academic writing reviews resources on the policy of Safe Staffing in the NHS particularly within inpatient services. This writing looks at why the policy came into being and its impact on staff and patients. I used the Staffordshire University’s library service to search online using the parameters of “safe staffing in the NHS” I then reviewed the results dismissing newspaper articles and opinion that was not from nursing journals and publications. I filtered results to show those that included the UK. I looked at policies issued by NHS England and its predecessors, the Care Quality Commission (CQC), and by respected commentators such as the King’s fund. I restricted my results to be post-2010 because much of this policy has been put in place in the last few years. Some results which would have been appropriate had to be discarded because their documents were behind pay walls which the university did not subscribe to (for example Royal College of nursing – Nursing Standard journal online).

The issue of safe staffing falls within kingdoms policy windows theory, this is described by Lawless, couch, Griffiths, Burton, ball (2019) as when policy even driven by strong public concern and support within the sector it struggles to gain traction because the conditions necessary for success are not present and in the face of political or practical constraints (24).

**Part 1. An overview of the “Safe Staffing” Policy, its rationale and why it exists.**

Roughly 13% of the total UK workforce works in the health care sector. The effectiveness of workforce planning has been criticised despite substantial efforts. Training, education, and workforce plans were considered by each profession in isolation and have not responded adequately to changing health and care needs. The result is persistent vacancies, low staff retention, poor morale. Particular areas of concern are primary care, nursing, mental health, clinical and non-clinical support as well as social care. The responses to shortfalls in the workforce have included a reliance on foreign and temporary staff with small-scale changes in skill mix and some enhanced recruitment drives. These attempts at stemming the flow have been hampered by an increasing shortfall in unpaid carers, the relative decline in the attractiveness of the NHS as an employer internationally, the decline of the attractiveness of working in the UK since Brexit, and growing multi-morbidity amongst patients and staff (5).

“Safe staffing” was one of the initiatives to come from the recommendations of the Francis report into poor care at the mid Staffordshire hospital. The care of patients in an institution requires a collective approach and responsibility, the Francis enquiry found that the quality of care given to a patient was not solely within the capability and skills of individual carers especially when systems and processes put in place by the institution’s board undermined their ability to provide effective care (6,11).

The Royal College of Nurses (RCN) with assistance from the Kings Fund responded to the Francis report of 2013 with its own report laying bare the state of staffing and projections for the future against the background of government cuts. The RCN agreed that there needed to be a more systemic and responsive approach to determining nurse staffing levels, the Care Quality Commission (CQC) found that 16% of hospitals inspected failed to meet that regulators safe staffing levels with the RCN’s own feedback suggesting that 90% of nursing staff felt that staffing levels were not always adequate to provide safe patient care (10,12).

In addition to the Francis report, the Cavendish review which followed it called for more formalised training for Healthcare assistants. This was then followed by the Keogh review that examined 14 NHS foundation trusts with high mortality rates looking at staffing levels and it found a positive correlation between inpatient to staff ratio and high hospital standardised mortality in those trusts, another key finding was that the actual levels of nurse staffing in those trusts were below those that have been reported in national indicators. In addition, a high use of temporary staff, healthcare assistants, and low levels of nurse staffing at nights and weekends combined with relatively high levels of nurse vacancies were other key staffing issues (10,12,13). All these reports and reviews made recommendations for evidence led staffing levels linked to patient acuity.

The RCN’s report also tied together information from the centre of workforce intelligence (CfWI) which projected in June 2013 a likely further decline in NHS staffing in England, and the review from the King’s fund noting and “an impending shortfall in nursing” in the years from 2013 to 2016 of between 0.6 and 11% (an estimation of 63,800 nurses short by 2016). These estimates of shortfalls were put side-by-side with various estimates of patient demand which ranged from a decline of 7% to an increase of 23% by 2016 (10,16,17).

As early as 2011 the RCN were highlighting that an ageing workforce would lead to a reduction in supply (18), so by 2013 with the RCN, King’s fund, CfWI, and the Francis report all calling for effective safe staffing levels to be introduced, and projecting the shortfall in staffing numbers it is astonishing that in 2016 the UK government removed the nursing training bursary making it significantly more expensive for students to choose nursing as a career in addition to removing training schools and apprenticeships, replacing this with degree led education and the imposition of student loan debt on student nurses with this being repayable for up to 30 years after completion of training.

Buchan (2005) reviewed safe staffing as implemented in California and Victoria state of Australia in 2005, here the bottom-up approach of managers setting staffing levels based on local workload and resources was replaced by a top-down standardised and mandatory nurse-to-patient or nurse-to-bed ratios. His paper identified the use of nurse patient ratios as being inflexible and potentially inefficient if they were wrongly calibrated, its strength was that it was simple and transparent, the impact would be most pronounced when the ratios were mandatory and where they offered a mechanism to improve and maintain staffing levels at a predetermined level (41). In 2014 West et al. reported that the availability and number of medical and nursing staff is associated with the survival chances of critically ill patients (49).

In May 2013 Health Education England (HEE) set out a blueprint for NHS staff training with a long list of objectives to be reached by 2015 to improve NHS staff training at a local level, however whilst this targeted itself on recruiting new local training providers, and a requirement to increase trained community health visitors by 4200 posts there was no other targets that it gave itself (19).

Even as early as 2013 the RCN and the King’s Fund were together predicting that NHS funding levels in England were that the very best be a standstill for 2014-2015 in real terms and for the other areas of the UK there would be reductions of between 2.2 and 10%, with initial responses from the NHS being national level pay freezes and local level staffing cuts or even keeping vacant posts deliberately unfilled (20). Despite the requirement above by HEE to improve training, the cost containment measures meant that the RCN could see a reduction in the number of nurse education places, reduced investment in upscaling of the current staff, and other measures which were combining to reduce the number of new nurses entering the labour market and the job opportunities and career mobility for current nurses (10). The Nuffield Trust is also cited by the RCN as having noted a reduction of £1.5 billion between 2010 and 2012 on staffing (10,21,22). News reports from 2009 cited by Lawless, Couch, Griffiths, Burton, Hall (2019) stated that the NHS chiefs had told hospital trusts to make £20 billion worth of savings in 2009 (24).

An early attempt at government led quality improvement intervention was “Productive Ward releasing time to care” which was designed by the NHS Institute for innovation and improvement in conjunction with manufacturing and industry. Its basis was on the lean principles of manufacturing and design to improve productivity and reduce the waste of time, movement, effort, and stock. This was an early attempt to increase the time nurses spent on direct patient care, and improve the safety and reliability of care, and improve the experiences of staff and patients, and making changes to the physical environment to improve efficiency. Its implementation came with a funding package that was adopted by most UK acute NHS wards but within 3 years funding had run out and most trusts by 2012 had stopped using this method because they did not have the resources (31).

In the period between 2010 and 2013 hospital foundation trusts were established to take over direct control of budgets from central government. Their watchdog’s report (Monitor) stated that these foundation trusts intended to recruit 4133 nurses in 2013 to 2014 but then have a decline in staffing as a result of the need to meet funding constraints. These reports lay bare the impact of cost controls on NHS staffing numbers, the RCN and Monitor reports describe this as “Go-Stop” effect which presents real difficulties in planning nurse numbers for training and recruitment, and for upscaling and career mobility (10,14,23).

The RCN stated that contrary to government announcements in 2013 actual nurse staffing numbers have decreased and were projected to decrease further (10,15), they stated that between 2010 and 2013 8842 nursing posts including healthcare support workers, midwives, health visitors and school nurses had been lost and that there was a projection of 68,000 posts being lost by 2015 as part of the drive to save £20 billion, they described this as a “red flag”(39).

There were 2 caveats in the 2013 – 2016 business plan for NHS England that would influence the scope of any development of safe staffing. Firstly, developing evidence-based approaches to staffing had to be achieved “within allocated resources “and secondly an enquiry recommendation that mandated minimum nurse-patient ratios was rejected.

The government tasked the National Institute for health and care excellence (NICE) to develop guidelines for safe staffing and an evidence-based nurse staffing policy, this guidance was launched for acute adult inpatient wards in 2014 with other areas to follow but because it was guidance it wasn’t mandatory (53), and guidance for community settings was being worked on for publication in 2015 when that work was suspended (54).

The National quality Board (NQB) report in 2016 stated that one way of improving nursing staff ratios could be to actually reduce the number of healthcare support workers whilst at the same time introducing a triangulated approach of “right staff, right skills, right place and time” and care hours per patient day (CHPPD) stating that this would now be the way of managing staffing on hospital wards (33). A safer staffing “tool” was developed in conjunction with Imperial College London and the Shelford group and offered to NHS organisations for them to subscribe to and is regularly updated (38).

With the safer staffing tool now available research found that those involved in workforce planning including ward managers and nurses were not being supported to prepare for its implementation, without support, safe staffing couldn’t be implemented properly (42).

Healthcare providers had been guided by The National Quality Board (NQB) requirements stating that providers must deploy sufficient numbers of suitably qualified, competent, skilled, and experienced staff to make sure they can meet people’s care and treatment. In addition, it said that there should be a systematic approach to determining the number of staff and the range of skills required to meet the needs of the people or service users. They must also use an approach that reflects current legislation and guidance including an evidence based tool. Staffing decisions based solely on professional judgement (the expert opinion of clinical staff) were considered subjective and not transparent (1).

However despite the Wanless report stressing that the United Kingdom does not have enough health professionals (as cited in 4), NHS funding is now being constrained as part of overall measures to reduce UK public expenditure, with the Conservative government approving NHS budget cuts over 2 years of £20 billion. This is leading to a deskilling process where previously specialist roles are now being undertaken by less experienced staff on lower salaries or by staff sharing roles. The staff-mix has been found to have a direct correlation on inpatient mortality rates (4).

Unfortunately, at the same time as these changes were being made the government bought in a new pay and grading structure for all frontline staff called “agenda for change”. Frontline staff received a pay freeze for 2 years but basic pay for health chiefs including ward managers, human resources directors, and finance officers has soared, whilst senior hospital managers have enjoyed 2% pay rise. It’s worth noting that due to current rates of inflation that is in effect a 10% wage cut for frontline staff. There’s also been changes to the NHS pension scheme, and contract terms the new starters are being changed in some areas and others are currently engaging in a fire and rehire approach to engage workforces on worse terms and conditions (4).

**Part 2. How is Patient Care impacted, what does the patient think of their care? Does safe staffing lead to good or better outcomes for patients?**

Guidelines for safe staffing rules were published in 2014 for adult inpatient acute wards, these were detailed but lacking in evidence. NICE concluded that although there was plenty of evidence of the variations in nurse staffing levels and skill mixes and the impact on patients, they couldn’t actually translate this into generalised rules-based guidance, in addition there was insufficient evidence about the methodology used to determine staffing requirements. Evidence already existed which suggested an increased risk of harm when a nurse cared for more than 8 patients during day shifts but the government had restricted the scope of the report to say that this had to be a guideline not fall below and that individual wards will determine their own staffing requirement based on local assessments (24,53).

The introduction of CHPPD included a requirement for NHS providers have a coordinated approach in routinely seeking the views of patient’s carers and staff and requiring the board to consider any feedback relevant to staffing capacity capability and morale such as national and local surveys, stories, complaints, and compliments.

A key aspect of CHPPD is that there has to be account of patient numbers at a consistent time, the NQB decided that this time would be midnight because it was the least burdensome on NHS trusts however it was accepted that counting patient numbers and acuity at this time did not reflect all the work going on around the ward (33). Whilst the report accepts that midnight is not the optimum time in terms of staffing numbers it does not suggest what to be what can be done for times when the staffing becomes inadequate. What is stated is that patient outcomes, people productivity and financial sustainability must be measured and improved. For patients a requirement to report and investigate and act on incidents including red flags (such as a patient falling whilst mobilising), and the requirement to take patient care and staff feedback, the aim of this being that hopefully patient outcomes should improve.

Managers, clinicians, policymakers, and service users have all expressed concerns regarding the quality of patient care with violence and difficulties on inpatient psychiatric wards, high staff vacancy rates, high sickness rates which costs the NHS around £1.7 billion a year, and issues over leadership (3).

A new Nursing Associate (NA) role has been developed to bridge the skills gap between healthcare support workers and registered Nurses (RN), this is a regulated (by the NMC) role. Its deployment was intended to free up more senior nurses to work at their appropriate skill level (1), – in practice the NA does routine items which take time such as bloods, cannulation, wound care dressings where a healthcare support worker can assist them. However, the RN that is allocated to the patient remains the person responsible for their care and the NA will in practice often have to refer to the RN for advice or instruction. There is little evidence of the impact of deploying nursing associates (24).

Limited resources feature highly in patient expectation surveys with more patients reporting doctors and nurses do not have sufficient time to communicate, therefore affecting their ability to involve patients in their care and listen to their concerns. Involving patients fully in their care is a key requirement of the nursing and midwifery Council’s standards for nurses (brought in after the Francis report) (56) and features continuously through nursing training and NHS literature. Studies suggest that if patient expectations and emotional needs are met then outcomes are enhanced (2).

In one study 87% of patients interviewed identified that staff attentiveness was a safety issue (28).

Patients can rate their care using the “friends and family test” (FFT) which was introduced in 2012. This scoring tool aimed to identify the issues that would prevent the patient recommending an area but this was considered inappropriate for a healthcare setting because it was based on the retail environment (2). Research found that 20% of patients completing the FFT felt that there were not enough nurses on duty. Other areas of note were that there was a perceived overreliance on “bank staff” with staff and patients having uncertainty over the staff member skills and knowledge. Patients were reluctant to approach a member of staff they did not know (3).

There is a general level of discontent among staff across the NHS and this can impact on patient care. Before the agenda for change pay-scale changes, research showed that staff felt settled but new policies brought job cuts, limited resources, extensive work hours, cuts in pay, the banding of staff, high staff turnover, unrealistic targets, and quick turnaround times (4,43).

In surveys, patients are often supportive of nursing staff saying that “not everything got done because the nurses were so busy but I didn’t mind that”. Patients are unsupportive when nursing staff are rude or have an uncaring attitude so it’s clearly important despite the pressures of nursing under these staffing constraints that nurses keep a caring attitude and keep speaking to patients and dealing with them in a person-centred manner (26).

86% of Nurses who responded to a survey by the health union Unison stated that in their last shifts elements of care were not carried out (27), and 63% of Nurses felt that there was inadequate staff to provide safe, dignified, and compassionate care (48).

The NHS staff survey details job satisfaction amongst healthcare staff in specific settings, research in 2013 found a weak correlation between job satisfaction and staff and patient outcomes which it reported might be useful information for patients when choosing a care location (52).

Patients have commented that medication is given late, or not at all or sometimes even given twice, other patients have commented that they would have preferred additional help and support perhaps, when walking to the toilet, and on admission to the unit or ward, and that information in notes can be missed because people just don’t have time to read them (28). Research from the King’s fund found that staff and patients perceptions about quality of care were consistent, stresses from the staff about care were being transmitted to the patients and conversely concerns from the patients were negatively impacting the staff. Despite the NHS set up, the UK lies below average according to the Organisation for Economic Cooperation and Development (OECD) in terms of the number of acute beds, doctors, and nurses relative to its population (29). Patients in particular rate that a lack of a doctor on a ward as a negative factor in their care.

A lack of activity for people affected by dementia who are living within institutional care can manifest itself with patients showing boredom, agitation, and other signs of distress. There have been attempts to combat this on some wards by the introduction of protective engagement time (pet), whilst patients felt at the heart of care, because care is increasingly being given by unregistered staff their deficiencies in training, and confidence, were affecting how pet was being delivered, meaning that patient engagement attempts were not effective (30). In addition when activities were chosen, staff reported that some of the activities actually distressed the patients rather than stimulate them. When a patient with dementia gets distressed it is extremely difficult and stressful for all concerned trying to settle them back down again and it can lead an entire ward becoming unsettled, so the impacts on patients can be quite serious if these engagements are got wrong.

A key aspect of patient outcomes that is surveyed is patient mortality, studies have found a statistically significant association between the numbers of regularly employed Registered Nurses (as opposed to agency Nurses) and patient mortality, they found that for each additional regular registered nurse 12 hour shift a patient could expect between a 7% (Ball, 2020) and 9.6% (Zaranko et al. 2022) reduction in the risk of mortality, and additional Senior Registered Nurse (NHS band 7 or 8) had 2.2 times the impact of an additional band 5 Registered Nurse. The reasons for this improvement are put down to familiarity, and experience in both the job, the ward environment, and patients. They concluded that Healthcare Support Workers and agency Nurses were not effective substitutes for regularly employed Registered Nurses (34, 40). Bridges, Griffiths & Oliver et al. (2019) agreed with this concluding that low registered nurse staffing levels were associated with changes in the quality and quantity of staff patient interactions, and that increasing Healthcare Assistants without correspondingly increasing registered nurses to supervise them was ineffective thus limiting the scope for Registered Nurses to be substituted with Healthcare Assistants (36). It would appear to be vital that a standardised process is adopted within hospital trusts because studies have found variations in nurse-to-patient ratios within different wards in the same hospital varying from one Nurse to every 5.5 patients to one Nurse to every 11.5 patients (37).

Following a period of no-growth between 2009 and 2013, the full-time equivalent number of nursing staff employed in the NHS acute sector increased from 2013- 2017 by 10% for nurses and nearly 30% for support staff however the rate of increases in staff has not kept pace with the rate of increase in patients. Furthermore, the rate of increase in staff was not uniform across the NHS (40). Sadly 10 years on from Francis there are still patient safety concerns occurring, including with vulnerable groups and infants, there appears to be failure to listen to the voices of patients and carers. This is a recurrent theme and the governance system seems to be incapable of heeding warnings. Together with a persistent lack of valid and reliable measures for surveillance, early warning and risk-based regulation and the ongoing problems of culture and behaviour including toxic working environments this is creating failures for the patients (47).

**Part 3. How does “Safe Staffing” work for staff? Is a staff members mental or physical health and well-being affected by the policy?**

Many ward staff identify the composition of the frontline team and relationships within it as crucial for morale and safe staffing levels being central to this. Many frontline staff described feeling overworked, with the physical and emotional toll of a shift, finding difficulty in taking a break, or being able to organise training or supervision especially in areas where the risk of incidents was intensified (3,44).

Replies to NHS staff surveys shows little or no mention of support given by professional bodies or trade unions which suggests that these are no longer prominent sources of support or outlets for staff in the current NHS (3). Whilst many staff use these surveys to report that they are satisfied with their work and gain a sense of achievement from it, a substantial proportion (up to 49% on acute wards) rated themselves as ‘burnt out’ on the emotional exhaustion subscale of the Maslach burnout inventory (3). Some staff members raised concerns that bank staff would not adhere to ward routines and protocols and raised uncertainty over their skill levels and knowledge, which put further pressure on the existing staff base (3).

Looking to the future, a radical long-term strategic vision is needed to ensure that the future NHS workforce is fit for purpose in the face of growing multi-morbidity for both patients and staff as well as changes in the skill mix, enhancing career opportunities, promoting staff well-being and enhancing multidisciplinary working (5).

The Covid 19 pandemic exposed staff to high-risk situations on a regular basis as well as continuous trauma and stress. it exposed weaknesses in the supply chain and in management which caused additional stress for frontline staff.

The King’s fund (2018) found that staff morale and experience was inextricably linked with sickness absence rates, spend on agency staff and staffing levels. Also the patient experience impacted on staff morale because they found that patients comments and criticisms about their environment, especially comments about cleanliness, staffing, and operational issues were having negative effects on the staff. Although essential to maintain staffing ratios the use of agency and bank staff has been found to have negative impacts on the staff group (29).

You can’t write about staff morale work pressures without bringing into the equation car parking for although this is not related to safe staffing it has a huge impact on the morale and well-being and goodwill of workers. Many hospitals charge their staff for parking with some charging up to £80 for a 40 hour working week, there’s no guarantee that you’ll likely find a parking space when you need it, This means that a member of staff turning up for a 12.5 hour shift actually needs to allow an extra hour finding a parking space and then have to pay. English health services made a profit of £69.5 million in 2017 from parking charges levied on their own employees and there is no consideration, or concessions for staff whose shifts are altered, or extended which can lead to a parking fine being levied. English hospitals current approaches for car parking undermines the morale and financial security of NHS workers (8). This is a key area of criticism in NHS staff surveys, a heathcare worker who is already feeling under-pressure from the issues around parking may not be in the best frame of mind to care for patients.

A study of maternity units and outcomes narrowed down to one particular maternity unit which had sustained excellent safety outcomes. This study identified mechanisms that were important for patient safety, collective competence, insistence on technical proficiency, monitoring, coordination, and distributed cognition, clearly articulated and constantly reinforced standards of practice, behaviour and ethics, monitoring multiple sources of intelligence about the units state of safety, and a highly intentional approach to safety and improvement. This was also tied in with staffing levels and the physical environment of the unit (25).

Another study found that 97% of staff members found variation in patient safety between different wards with particular processes identified as being most likely to be error-prone; ward rounds (57%), medication prescribing and administration (49%), the presence of outliers (43%), and deficiencies in communication between clinical staff (43%). In addition, there were structural factors found which included organisational factors in shortages of staff and the use of temporary staffing and environmental factors including the layout of the ward and visibility of patients, and concerning the cleanliness and leadership (28).

Ulrich (2013) wrote that fatigue in Nurses affects Nurses as well as patients, inadequate sleep or quality of sleep can lead to lapses in attention, diminished reaction time and memory lapses which were all elements that could lead to unsafe conditions in which to practice. They cite Trinkoff, Geiger-Brown, and Lipscomb (2007) who said that nurses who work long hours and do work shifts other than day shifts have higher rates of occupational injury (32).

Many staff no longer recognise what “sufficient” means in terms of staffing, when staffing is sufficient then staff feel that they can get jobs done without rushing patients, they can give the right level of information and education. When staffing is insufficient they miss breaks and will often give unpaid extra hours (26).

The health union Unison has been critical of the government axing the nursing bursary and replacing it with loans, it said “nursing students will end up with debts between 47 and £59,000 at the end of their training. The government wants to take £1.2 billion out of public spending for health education England and put it onto the back of students” (27).

Much of the work on safe staffing has involved staffing numbers during daytime hours however concerns are being raised about staffing rates at levels at night which are much less than in the daytime. Some hospitals will only have one doctor on duty to cover a number of wards and will have a skeleton staff of nurses and carers and yet they all have the same workload as in the daytime including added problems of night-time wandering and confusion amongst patients. It’s not unusual at the shift handover for the day staff to give to the night staff tasks that haven’t been completed during the day, so an even smaller team has to do their own work plus what’s been left by the day staff (28). In the same way that the evidence is found that reducing the number of patients to a nurse improves outcomes the same can also be said for doctors with a decrease in patient numbers to doctors or better availability of doctors leading to better health outcomes for patients (45). Savile, Monks and Griffiths et al. (2021) tested the model of taking average demand to plan baseline nurse staffing levels and found that when baseline staffing was set to meet average demand 32% of patients shifts could be understaffed by more than 15% after redeployment and hiring from a limited pool of temporary staff. They found that employing low numbers of permanent staff and relying on temporary staff and redeployments risked quality of care and patient safety and that the way of having a safe environment was to have a higher number of permanent staff (46).

The introduction of pet on certain wards has meant that ward routines are adjusted so that staff can spend time together with patients without interruption. The aim is to increase staff and patient interaction on the ward, improve patient well-being, relieve patient boredom, and improve staff morale. Dodd et al. (2018) found however that there is no systematic evidence as to how this pet is carried out, nor how it is experienced by staff, patients, and families. The study found that the application of pet was dependent on staff, its implementation could be challenging, and attempts to implement it highlighted existing tensions between individuals needs, and the needs of patients on the ward as a whole (30). The key elements of pet are that it should occur at regular times and for a regular duration, during this time the ward is closed to visitors and professionals from outside the ward, all ward staff are involved in the protected time, during this time ward staff do not make phone calls or carry out administrative duties, all of the time is focused on staff to patient engagement which might include one-to-one meetings, group work, games, activities, or eating meals together (30). In a busy hospital environment trying to segregate the ward and effectively close it off for a period of time is extremely challenging. In this small survey the staff sampled had positive opinions about pet that it improved person-centred care, improved their understanding of the patients, and improved the well-being and morale of both staff and patients (30).

For hospital trust boards the introduction by the NQB of the right staff expectation brought with it a requirement to have an annual review of staffing done by a triangulated approach with the use of evidence-based tools, professional judgement, and comparison with peers taking into account healthcare professional groups but also in line with financial plans alongside the requirement to present a comprehensive staffing plan. Under the right skills expectation the NQT states that clinical leaders and managers should be appropriately developed and supported to use the competencies of their existing workforce to the full, whilst the document has several paragraphs talking about developing existing staff and competencies and matching competency and quality frameworks, there is only one line for recruitment which states it is to recruit to avoid the use of temporary staff (33). The third and final expectation of right place and time states that lean working principle should be adopted to eliminate waste of people, the escalation processes should be in place should staffing numbers and skill mix fall short, or clinical capacity is exceeded. That this should be managed all day and adjusted where needed, it requires the elimination of agency staff use and stipulates the NHS bank staff should be called upon in the first instance because this offers better value for money (33).

The theory of human capital (as described by Becker (1962)) suggests that team composition, in addition to size matters. There is a distinction between general and firm specific human capital, which is derived from higher skills or qualifications, workers familiarity with their physical environment, and their co-workers. It goes on to state that a team composed of individuals with different levels of general and firm specific human capital in addition to team size will influence outcomes for patients (34).

The King’s fund (2017) found that high staff engagement reduced sickness, potentially saving between £600,000 and £2.7 million in agency staff cover costs, the report found that even a minor increase in staff engagement an average sized organisation could save approximately 2000 sick days per year (35).

There is also the problem of staff being unable to take their breaks whilst on shift this was reported in 2015 by the Lancet (51) and has been reported on by the Royal College of nursing on at least 10 occasions in the last 3 years so this would appear to be growing.

**Conclusion**

you can’t begin to a write a conclusion without firstly addressing pay in the NHS budget, in order to sustain growth in the workforce at approximately 2 to 4% requires an increase in NHS expenditure 4% annually in real terms (5). This is likely to require policy change and government intervention.

Partha Karr (2018) states that for the NHS to succeed “it has to be about the team achieving the goal” – “the NHS would certainly be a better place if we could learn how to work together and use the skills of the whole team” (7).

The practice of charging staff for car parking should be banned from hospitals in place of fairer and more understanding approach (8). The government has prioritised controlling finances over quality and safety (24). In 2019 5 years on from its introduction safe staffing was still being described in aspirational terms, it requires accountability from providers but does not adequately address barriers to delivery (24).

The failure to find a technical and economically justifiable solution, coupled with a context where demand for health services is outstripping resources is having a major impact on staff and the effect of the policy on patient care is unclear (24).

Every report I have read has had the same conclusion that there must be organisational and standards set by government, there must be financial planning including an uplift in finances for staffing, recruitment, retention, training et cetera, and yet most of these reports were for the period 2015 to 2018. Since 2018 the UK has left the European Union which has had further negative impacts on NHS staffing. The number of beds is declining, the number of staff is declining, the amount of money is declining, but the workload is increasing. Where does this problem end? Patient mortality has been linked by many studies to staffing levels. The King’s fund (2018) sampled 134 NHS acute trusts and found correlations between staff experience variables and organisational outcomes, for example staff engagement (motivation involvement, and advocacy), is linked to patient satisfaction, mortality, and the overall performance indicators in the CQC annual health check as well as strongly being linked to staff absenteeism (29). The NQB guidance (2016) directs trusts to have a daily snapshot of current responsibilities and patient numbers, itself has caveats that it can only be a snapshot of patient acuity and need, service user levels, and staff numbers, and can vary during a day and hour by hour.

It was concerning to read that a way of improving nursing staffing to patient ratios would be to reduce the numbers of healthcare support workers although there is little evidence to suggest the effectiveness of healthcare support workers (45). If a member of staff is unable to take a break even to go to the toilet during their shift, they can become fatigued, and this can lead to the risk of accidents and safety incidents. The most significant barrier to safe staffing is the shortage of nurses to fill vacancies and to meet the required levels (40). 10 years on from the Francis report Martin, Stanford, and Dixon-woods (2023) found that many of the recommendations were not followed by policy changes, with financial, and workforce challenges, along with post-pandemic pressures on services have made safe staffing increasingly contentious politically. Furthermore changes to the CQC’s approach do not appear to have had an effect on organisations, and there continues to be patient safety crisis situations (47). It is interesting to note that the English safer nursing tool has recently received validation for use in Canada although this is only in a single hospital and comes after extensive validation and trials comparing this hospital to a number of UK acute hospital trusts (50). The CQC assessment framework (2017) now firmly puts the issue of financial performance, compliance with agency spend, and staff rostering and management in the same area of importance as patient care (55).

Some people might say that safe staffing has been cobbled and hobbled, that is to say cobbled together with no clear plan and limited government backing, and hobbled by reductions in finances, changes to nurse training, and top-level reorganisation. As Francis recently said on the 10th anniversary of his report into the Stafford Hospital disaster “we are dangerously close to another Mid-Staffs”. With an overreliance on under-trained bank and agency staff with their unfamiliarity with wards, patients, and situations, set against the length of time and cost of nurse training which is borne by the individual and not the state, and increasing age of NHS staff together with the increases in patient and staff multi-morbidity and health conditions the NHS is dangerously close to being unfit to care for people.

NHS England, and the Department of Health and social care have published plans and goals to tackle these shortfalls, but it remains plans on paper hobbled by a lack of government commitment and cash. With a general election looming the writer feels that there is perhaps one parliament to get this resolved before the various pressures building from the lack of recruitment, time taken to train, up-and-coming retirements, and renewal of financial budgets make safe staffing, and effective patient care impossible which would be a disaster for the United Kingdom.

DISSERTATION REFERENCE LIST

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