

## Royal College of Nursing response to the Department of Health's consultation on the Regulation of Nursing Associates in England

*A consultation on amendments to the Nursing and Midwifery Order 2001 and subordinate legislation to regulate nursing associates in England by the Nursing and Midwifery Council*

### **1 Do you agree that nursing associates should be identified on a separate part of the NMC's Register? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

1.1 If this role is to be regulated within the current constraints of the healthcare regulatory framework, then we agree with the identification on a separate part of the register in principle. However, we have concerns that there are a number of new assistant or associate roles being developed across the health care professions<sup>i</sup> and these roles are part of the wider debate around ways to ensure public protection and the role of regulation within this. Indeed, at a time of recognition by the Department of Health (DH) that the current regulatory framework for healthcare requires reform (evidenced in the current consultation *Promoting professionalism, reforming regulation*<sup>ii</sup>), we believe there is an opportunity to explore how the Professional Standards Authority's work on 'Right touch reform' can inform new approaches to regulation. The approach consulted on here seems to embed silos between different roles and professions, rather than spearheading the flexibility proposed in the separate DH consultation.

1.2 We believe there must be absolute clarity that the nursing associate (NA) is not a separate profession, but a new role within the nursing family that works under the delegation of the Registered Nurse (RN). Accordingly, urgent guidance on the precise relationship between NA and RN in terms of delegation and accountability must be issued. We also believe that it is unhelpful to describe this as a "new profession" when it is a supporting role within the registered nurse workforce. This has the potential to cause confusion for both the public and for health and social care personnel about the jurisdiction of this role. The correct term is 'new professional role.'

1.3 Considering international evidence of two types of registrants of the same nursing family on the same register with a clear delineation of scope and responsibility, the examples of Australia and New Zealand are instructive. However, there is the clear limitation of their roles being second-level nurses, whereas the NA clearly is not and evidence is not supportive of the reintroduction of a second-level nurse in the UK.<sup>iii</sup> So whilst the NA does by no means equate directly to a second-level nurse, it is insightful to look at this evidence of regulation that enshrines clear delegation and scope of practice.

1.4 In 2010, second-level nurses in Australia came under the regulatory remit of the Nursing & Midwifery Board of Australia (NMBA) – Australia's equivalent to the UK's Nursing & Midwifery Council (NMC). In terms of delegation and scope of practice, second-level

nurses are required to work alongside RNs at all times either under their direct or indirect supervision.<sup>iv</sup> One of the RN standards of practice stipulates that they should, 'use delegation, supervision, coordination, consultation and referrals in professional relationships to achieve improved health outcomes.'<sup>v</sup> Second-level nurses are required to proactively collaborate with RNs in order to ensure that they clearly understand instructions being given to them and that these tasks fall within their remit of practice.<sup>vi</sup>

1.5 The division of the RN and second-level nurses' scope of practice is enforced more clearly in New Zealand. The New Zealand Nursing Council (NCNZ) regulates both roles. Compared with Australia, the NCNZ puts a stronger emphasis on RNs being able to effectively manage, delegate and supervise second-level nurses. Competency 1.3 of the RN Scope of Practice requires all RNs to: 'Demonstrate accountability for directing, monitoring and evaluating nursing care that is provided by support staff.' Even in instances where second-level nurses coordinate a team of health care assistants, this must also be done under the direction and delegation of an RN. Second-level nurses are accountable for their nursing actions and practise competently in accordance with legislation, to their level of knowledge and experience.<sup>vii</sup>

1.6 We believe that there are some best-practice models in Australia and New Zealand in ensuring clarity on delegation and accountability in the regulatory frameworks that should be considered by the Department and the NMC in implementing the regulation of NAs.

## **2 Do you agree that nursing associates (in England) should be subject to the same registration requirements as nurses and midwives? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

2.1 For public protection purposes, the NMC should ensure that all NAs hold approved qualifications, have appropriate indemnity arrangements, are able to evidence that their practice is safe and effective, that they have necessary knowledge of English and pay the relevant fee

2.2 However, we do not believe that this requires the same model of regulation as that of a registered nurse. The regulatory framework for this role should be proportionate, reflecting that this is a role that supports the registered nurse. For example, the current approach to fitness for practice tends towards being reactive, punitive and resource intensive - we would question if perpetuating this model is an appropriate means of ensuring continuing competence for this role. Whilst we recognise that the NMC is limited by its current legislative framework in how it can innovate to regulate differently, and is addressing some of these concerns in its proposed new fitness to practise strategy, perpetuating current approaches will not allow professions to respond flexibly to future population and system health needs.

**3 Do you agree with the approach taken to allow the NMC to recognise comparable training undertaken outside England, including applicants gaining qualifications in the EEA, overseas and Scotland, Wales and Northern Ireland, for the purposes of registration as a nursing associate in England?**

3.1 Yes, we agree under the assumption that the NMC does so under the general system of the Mutual Recognition of Professional Qualifications Directive 2013/55/EC, which means it is able to assess the training of applicants to this part of the register, rather than the automatic recognition one. We believe both the alert mechanism and language controls enabled by Directive 55 should apply.

**4 Do you agree that these transitional arrangements are fair and would allow the NMC to ensure that applicants with a nursing associate qualification from an HEE course or from an Institute for Apprenticeships approved English apprenticeship meet the required standard for entry on the nursing associate part of the register? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

4.1 Yes, we agree as this is essential to ensure that those trainee nursing associates qualifying ahead of the regulatory framework being in place can transfer onto the register.

**5 Do you agree that the NMC's Registrar should not have the power to annotate a nursing associate's entry in the Register to enable them to prescribe in an emergency? If you do not agree, please set out your reasons why, any alternative suggestions and any evidence to support your views.**

5.1 Yes, we strongly agree. It would not be appropriate for a nursing support role to prescribe.

**6 Do you agree with the proposed approach for education and training for nursing associates including the approval of courses and setting post-registration training requirements? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

6.1 Yes, we agree. However, we wish to highlight the significant risk of variation in training, despite the NMC's regulatory role. As the training for NAs is generic, employers will have a significant role post-registration to ensure NAs can transfer and apply their learning in a range of different contexts to enable them to deliver safe and effective care. The significant cuts to Continuing Professional Development (CPD) are also a particular challenge in this context. The Health Education England (HEE) budget for 'workforce development', which is largely used for CPD for nurses, has been cut by 60% over the past two years, from £205m in 2015/16 to £83.49m in 2017-18.<sup>viii</sup> There is also a

challenge in how NAs undertaking CPD will be adequately supervised and supported in their learning in practice, given the current shortages in the registered nursing workforce.

**7 Do you agree that the NMC should be permitted to select either a nurse or nursing associate as a visitor to inspect nursing associate education and training programmes? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

7.1 Yes, we agree. It will be very long-term until NAs have qualified and gained sufficient experience to take up such a role and a strong quality assurance framework is needed to ensure the right training, monitoring and evaluation for this.

**8 Do you agree with the approach to fitness to practise with regards to nursing associates in England? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

8.1 As set out in our response to the initial HEE consultation<sup>ix</sup>, we believe that statutory, mandatory regulation of all health care support workers is in the interest of public protection. As such, all healthcare support workers should work within established guidelines and protocols, and should be supervised (to varying degrees) by a registered practitioner. This view is supported by other stakeholders, such as the Patient's Association.<sup>x</sup>

8.2 We believe there is a very high risk that the NA may result in the substitution of RNs if that workforce is not grown at the same time, which is not currently the case. For the first time in years there are now more nurses and midwives leaving the profession before retirement, with 27% more nurses and midwives leaving the register than joining.<sup>xi xii</sup> One in three nurses are due to retire within the next ten years<sup>xiii</sup> and the impact of the EU referendum appears to be a significant factor in driving EEA nationals to leave the profession.<sup>xiv</sup> Reports are already coming in of established registered nurse posts being deliberately replaced by nursing associate roles.<sup>xv</sup> Royal Wolverhampton Hospital Trust, for example, has agreed to reduce the numbers of FTE registered nurses on its wards by 23.58 to replace them with 24 new nursing associate roles.<sup>xvi</sup> There is clear evidence regarding the skill mix of registered nurses to other roles required to meet patient safety<sup>xvii</sup> and this must be considered in the context of the NA regulation and this consultation.

8.3 There is also evidence that a mandatory, national model of regulation must clarify the scope of practice of the regulated healthcare support worker, or nursing associates in this instance, and also endorse a clear competency framework or national standards for their education and training. Mandating their scope of practice in this way will help reduce the risk of them carrying out roles which are outside their professional remit. Any competency framework for the regulated healthcare support workforce should ensure it does not contain any of the competencies that lie within the sole remit of the registered nurse.<sup>xviii</sup>

- 8.4 The main concern we have about mirroring the same processes as nurses in fitness to practice (FtP) proceedings is that the approach could be disproportionate. We would support the proposed strategy of the FtP directorate that the NMC supports employers to deal with complaints locally so that the NMC only has to deal with such incidents when they reach a level of seriousness and local processes have been exhausted. The current system means that the NMC will take up all complaints sent to it, so that a discontented patient who might be a dissatisfied with the treatment given by an HCA and a NA would be able to put the latter through a punishing process, whilst the former would suffer no further consequence.
- 8.5 Additionally, it will be important that NAs are held to an appropriate Code and are not expected to perform above the level of a support role. The Code forms a crucial part of setting expectations of the level of professionalism to be exhibited by practitioners. We have real concerns that the current NMC Code is not fit for purpose for both Registered Nurses and Midwives **and** the supporting role of a Nursing Associate. Whilst we do accept that there is merit in having one Code which embodies the principles against which values and behaviours can be measured, the current NMC Code does not offer this. It was developed to support revalidation of registered nurses and midwives and so there are sections of the current code that seem to require a level of responsibility that is beyond the expectations of the NA role. These are as follows:

#### *The Code*

#### **2.3 encourage and empower people to share decisions about their treatment and care**

It is appropriate for a NA to encourage, but “empower” is a higher level of intervention, indicating that the NA has taken on a degree of responsibility for the outcome that a Patient is able to share in their decision-making.

The HCPC Standards use: “encourage and help”

#### **3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care.**

Whilst raising concerns about discriminatory attitudes would be appropriate, taking on the role of advocate is a high expectation.

The HCPC Standards use: “You must challenge colleagues if you think that they have discriminated against... service users, carers and colleagues”

#### **4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person’s right to accept or refuse treatment**

This requires a high degree of interpretation and these are the sorts of considerations that should be in the contemplation of those who have accountability for high level decision-making about treatment.

The HCPC does not have an equivalent section.

**Practise effectively: You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice.**

Making assessments of need or advising on treatment should not be an expectation of the role. Such decisions should be made elsewhere, by those who are more likely to have considered best evidence etc.

A better phrase to replace “assess need and deliver or advise on treatment” would be “support and deliver treatment”

The HCP Standards do not have an equivalent, but have useful sections about keeping within the scope of practice and maintaining knowledge and skills.

**6.1 make sure that any information or advice given is evidence based, including information relating to using any healthcare products or services.**

This level of accountability for the NA practitioner is very high, as it involves taking on accountability for treatment choices.

The HCPC Standards do not have an equivalent.

**13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care**

Preferable wording would be ‘identify’ and then wording that makes clear that the practitioner must escalate their observation as appropriate.

**13.2 make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment**

This suggests a responsibility for treatment decisions, and the expectation of the role is adequately dealt with by 13.3, which says:

13.3 ask for help from a suitably qualified and experienced healthcare professional to carry out any action or procedure that is beyond the limits of your competence

The HCPC Standards do not have an equivalent for 13.1 and 13.2.

*Candour*

**14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place**

**To achieve this, you must:**

**14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm**

**14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers, and**

**14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.**

The requirement to take responsibility for the communication and to put the problem right is a high expectation. However, these are mirrored in the HCPC standards.

**16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so**

Although this requirement is qualified, the expectation of 'investigating' is a high expectation. However, there is the same wording in the HCPC standards.

**18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations**

**To achieve this, you must:**

**18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs**

**18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs**

**18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines**

**18.4 take all steps to keep medicines stored securely, and**

**18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship.**

All the references to prescribing are unsuitable, as is the instruction about advising on treatment in 18.3. Tasks like dispensing or administering are more suitable for the role.

## **20 Promote professionalism and trust**

### **You should be a model of integrity and leadership for others to aspire to.**

This can place an unfair burden on registrants if interpreted in the way that has been seen in relation to registered nurses. At times the NMC panels have imposed a standard on private and personal behaviour that does not appear to have relevance to the registrant's ability to nurse effectively, when others (eg members of the House of Lord, say) are not held to such absolute moral standards. Also, leadership is not necessarily a part of the role.

The HCPC uses plainer language for a more attainable standard:

*9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession.*

### **21.5 never use your professional status to promote causes that are not related to health.**

Here and elsewhere in the Code, there are references to professional status, whereas 'registered status' would be appropriate.

## **9 Do you agree with the proposed approach for appeals against registration and Fitness to Practise Committee decisions for nursing associates in England? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

9.1 Currently, registered nurses and midwives are assessed for registration according to whether they are capable of safe and effective practice. They have to demonstrate good health and good character. Working whilst lapsed, due to having made an administrative error, can lead to a decision by the Registrar that they are not of good character. Often, when things go wrong, they cannot work and are financially disadvantaged whilst very lengthy processes (which can take many months) are undertaken. Health issues can often contribute to these scenarios. The effect of losing pay can be particularly damaging for those already on low pay. We would ask that the NMC ensure that there are safeguards against protracted processes and over-zealous Registrar decisions.

## **10 Do you agree with the proposed approach for the selection of registration appeal panel members to hear nursing associates' registration appeals? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views.**

10.1 We agree the proposed approach.

**11 Do you agree with the approach to offences regarding regulation of nursing associate's in England? Do you agree with the proposal that, where the matter concerns the use of the nursing associate title, nursing associate qualifications or an entry in the nursing associate part of the Register, the offences in article 44(1) to (3) of the Nursing and Midwifery Order (described above) will be offences only if committed in England? If not, please set out why you disagree, any alternative suggestions and any evidence to support your views**

11.1 We agree the proposed approach.

**12 Do you have any comments on these proposed consequential amendments? The closure of sub-part 2 of the register is discussed further at para 3.4.**

12.1 We have no comments.

**13 Do you agree with the removal of the screener provisions at articles 23 and 24 of the Nursing and Midwifery Order? If you do not, please set out why you disagree, any alternative suggestions and any evidence to support your view.**

13.1 We have no objection to the removal of the unused screener provisions.

**14 Do you agree with the closure of sub-part 2 of the nurse part of the register to all new applicants? If not, please set out why you disagree, any alternative suggestions and evidence to support your view**

14.1 Yes, we agree that this part of the register should be closed to all new applicants, given that this training no longer exists in the UK and there are no up to date NMC standards to assess applicants with second-level nurse qualifications from other countries who might apply to join this part of the register.

14.2 There are no current education standards for second level nurses – the last ones available are from 2004. We therefore have concerns about how second level nurses who wish to return to the register (through a return to practise programme) will be assessed. The NMC need to address this to ensure that this group of potential registrants are not disadvantaged if they wish to return to practise.

**15 Do you have any further comments on the draft Order?**

15.1 None

**16 Do you agree with the costs and benefits identified in the table above? If not, please set out why you disagree, any alternative impacts you consider to be relevant and any evidence to support your views. We are keen to identify evidence on the likely benefits of statutory regulation and whether regulation will enable nursing associates to carry out any additional activities (benefit B1 above).**

16.1 We are supportive of regulation of all HSCWs, including NAs, but it is unclear to what “additional activities” refers. As we stated previously, we believe that there is currently an opportunity to review regulation across assistant and associate roles to ensure that these roles deliver the workforce flexibility and productivity required whilst ensuring patient safety and protection of the public.

**17 Our initial assessment assumes that nursing associate training numbers will increase to 5,000 per year in 2018 and 7,500 per year in 2020 and beyond, in line with the Secretary of State for Health’s commitment to expand training numbers. We have assumed a 10% annual attrition rate during training and 4% per year attrition rate from fully qualified nursing associates leaving the NMC register. Do you agree with these growth assumptions? If not, please set out why you disagree, any alternative forecasts and any evidence to support your views.**

17.1 In the first year of the NA pilots, attrition has been less than 5%. However, it is too early to be able to predict the trends in attrition and retention for this role. There are many complex factors which may impact on the growth assumptions, including the impact of the proposed NMC fee on NAs from 2019, the introduction of the apprenticeship model and how this impacts the learner experience, potential numbers who will choose to progress into registered nurse training and career satisfaction in the new role.

**18 Do you think that any of the proposals for how we are intending nursing associates are regulated will help achieve any of the following aims:**

- **eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010**
- **advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it**
- **fostering good relations between persons who share a relevant protected characteristic and persons who do not share it**

**If yes, do you believe that the proposals could be changed so that they are more effective in doing so? If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?**

18.1 We do think that the Nursing Associate route will be an attractive route into nursing for those, especially women, who have the academic potential to enter nursing though the

graduate route, and would have relied upon bursaries previously, but who are not in a position to finance student fees. These may typically be women who are more mature and who may have caring responsibilities.

- 18.2 There is a danger that the NA role will be used by employers as a way of substituting Nursing Associates for Registered Nurses, and employers are likely to have very able candidates in the NA role for the reasons outlined above. We consider that the NA role must have very clear boundaries to avoid substitution from occurring. If substitution does take place, it will be primarily women affected, and there will be a danger that without clear boundaries, discriminatory practices creating lower pay for women may be an unintended consequence of the new role. We would want to see assurances that such candidates will have a realistic prospect of developing their career and avoiding a glass ceiling.
- 18.3 To mitigate any risk of disadvantage on the basis of different qualifications, clear guidance and advice should be in place to enable overseas applicants to understand the implications of their choice of registration, particularly in terms of scope of practice.

### **The Royal College of Nursing**

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

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