The research-policy interface: ‘safe-staffing’ as an example

RCN International Research Conference
Oxford

Jane Ball
6th April 2017
Research-policy interface...?

Research Excellence Framework – ‘Impact’

“an effect on, change or benefit to the economy, society, culture, public policy or services, health, the environment or quality of life, beyond academia” (HEFCE 2012)

http://www.hefce.ac.uk/rsrch/REFimpact/
“Incorporating relevant research findings into policy & practice decisions should be central”

WHITTY, C. J. 2015. What makes an academic paper useful for health policy? *BMC Medicine, 13, 1.*
What gets in the way of impact?

1. Wrong research
   - Not addressing key questions for policy makers
   - Right question, wrong design/poor execution

2. Right research – wrong output: potentially useful research but findings not presented in a way that is useful to policy

3. Policy makers ‘unwilling or unable to take account of good existing evidence’

WHITTY, C. J. 2015. What makes an academic paper useful for health policy? *BMC Medicine, 13, 1.*
“Real-world impact”
Policy maker’s perspective

Policy master class with John Denham ‘Real-world Impact’ – a simple toolkit.
Public Policy, University of Southampton. 2016.
“Real-world impact”
Policy maker’s perspective

Stakeholders
- NGOs
- Politicians
- Media
- Public
- Academics

How will I know if I’ve won?
Who will need to decide?
Who influences them?
Research-policy interface?
Research-policy interface?
Who makes & shapes nursing workforce policy in England?

- Secretary of State for Health
- Department of Health (Nursing advisory unit?)
- NHS England
- Chief Nursing officer
- NHS improvement
- Health Education England
Who reviews/scrutinises nursing workforce policy?

- National Audit Office (NAO)
- Migration Advisory Committee (MAC)
- Health Select committees
- Regulators: Care Quality Commission / (Monitor)
- Efficiency reviews: eg. Carter review
“We use the best available evidence to develop recommendations that guide decisions in health, public health and social care. As well as considering the scientific value of evidence, we also follow a set of principles for making social value judgements.”
Research evidence base

• In the 1980’s... eg.
  - Hinshaw et al (1981) ‘Staff, patient and cost outcomes of all RN staffing’
  - Fagin (1982) ‘Nursing as an alternative to high cost care’ (review of 51 studies)

• Links to ’magnet’ hospital research

• International Hospital Outcomes Study (5 countries)

• Thirty years later: RN4Cast (15 countries)
Kane et al’s systematic review

- 96 studies
- Meta-review of 28
- Increased RN staffing was associated with lower hospital related mortality
  - intensive care units (OR 0.91 CI 0.86–0.96)
  - surgical units (OR, 0.84; 95% CI, 0.80–0.89),
  - medical patients (OR, 0.94; 95% CI, 0.94–0.95)

Kane et al (2007) Medical Care 45: 12, 1195-1204
Lack of staff is often an excuse for poor care… there is no direct correlation between number of staff and good or bad care

Harry Cayton, CHRE regulator, HSJ March 2012
Nursing student places commissioned
England - 2009/10 to 2013/14

Crisis in nursing care

400 -1200 excess deaths?
Francis Inquiry found:

“There does not appear to have been an evidence base for the changes that were made.

The attraction of the advantages – the financial savings – discouraged proper attention being paid to the disadvantages”
Robert Francis:

“So much of what goes wrong in our hospitals is likely, and indeed it was, in many regards, the case in Stafford, due to there being inadequate numbers of staff, either in terms of numbers or skills”
Strengths & weaknesses of the evidence

- Omitted variables
- Simultaneity
- Common-method variance

More research needed?

- Predominance of research from USA
- What about other staff? Possible confounding:
  - Medical staffing
  - Support worker staffing
- What ‘dose’ of RN staffing is associated with effects on safety, quality, outcomes?
- What difference does the context make?
- Correlation does not equal causation – what is the theoretical causal pathway?
3 year EU-funded study: 2009-2011

Nurse Survey
- 31 Trusts (46 Hospitals)
- 401 med/surg wards
- 2,990 RNs

Patient Satisfaction
- National data (secondary)

Patient discharge data
- HES data – mortality rates

Hospital characteristics
- Hospital/Trust survey

15 countries
Nurse staffing levels, care left undone & patient risk of death in hospital

Contect

RNs

other nursing staff

Care (un)done

Patients

Mortality

Doctors
Being proactive at the interface: presenting the evidence differently

“"A ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety”

May 2013
Reaction to research findings

Almost nine in ten nurses ‘forced to ration care’

July 2013

The guardian

Time-poor NHS nurses forced to ration care, study finds

Study from 76 hospitals and 3,000 nurses shows nine in 10 staff are too busy to fulfill all care duties.

Prets Association

Mail Online

Two-thirds of nurses are 'too busy to talk to patients' and 80% admit to rationing care

U.S. Sport | TVShowbiz | Females | Health | Science | Money | Video | Culture

80% 'forced to ration their care because they are too pressed for time'

Aspect of role most likely to disappear is comforting patients

Study questions 3,000 nurses working in more than 400 wards

By JENNY HAY

Published: 09:45 30 July 2013 | Updated: 09:46, 30 July 2013

Mail Online

In this story: the wreckage of flight

Discovery of 'Nebula' means missing jet

Families of 239 missing Malaysia Airlines

Is this proof dry drowning is a waste

University of Southampton

July 2013

Almost nine in ten nurses ‘forced to ration care’

Monday 29 Jul 2013 11.36 pm

198 shares Share on Facebook Share on Twitter

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• NICE to undertake a review of the evidence and provide guidelines for safe staffing in each specialty (July 2014 – ”red flag’ triggers for review)

• Staffing levels in each Trust to be published

• Nurse staffing on each ward to be made visible
Review of Evidence for NICE

Factors influencing staffing
5 reviews
• 21 primary studies

Staffing / outcomes
35 primary studies

Economics
• 5 studies
Safe staffing policy post Francis

- Policies refer to ‘Safe staffing’
- National Quality Board guidelines
- Trust ‘fill-rates’ published
- NICE Guidelines published (2014)
- DH-PRP Study to examine the implementation of safe staffing policies post Francis
NICE evidence based guidelines on Safe Nurse staffing levels

“We use the best available evidence to develop recommendations that guide decisions in health, public health and social care. As well as considering the scientific value of evidence, we also follow a set of principles for making social value judgements.”
Safe staffing in England – policy shifts?

- NICE guidance discontinued by NHS England (June 2015)
- Only fill ‘essential’ vacancies (Aug 2015)
- Trusts told to ‘cap’ the amount spent on temporary staffing (Aug 2015)
- Health Education England commission 300 of the 3,000 extra RN training places needed (Dec 2015)
- Nursing Associates to “bridge the gap” (Dec 2015)
- Migration Advisory Committee: shortage of nurses is NHS own making
- Care Hours per Patient Day - CHPPD (April 2016)
- NHS Improvement guidance: “Safe SUSTAINABLE staffing” (Dec 2016)
- Ban on nurses working agency (March 2017)
Decision making on nurse staffing levels – in the ‘real’ world

“Safety at all costs” ?

vs.

“Finance trumps quality” ?
Bigger messier picture

• Its not linear: Research -> “Evidence” -> Policy
• Other factors shape policy
• Context – the politics of policy development
• Direct and indirect lever for policy change (public, media)
• Active policy formation vs policy evolution
• Multiple interfaces
Conclusion:

Has research on nurse staffing impacted on Policy?

What’s the role of research and researchers?
Thank you!

Any questions?

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