Health Policy 123 (2019) 590–594

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Towards safe nurse staffing in England's National Health Service: Progress and pitfalls of policy evolution

Jane Lawless [a], Rob Couch [b], Peter Griffiths [a,c], Chris Burton [b], Jane Ball [a,d,*]

[a] University of Southampton, University Road, Southampton, SO17 1BJ, UK
[b] Bangor University, Gwynedd, LL57 2EF, UK
[c] National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care Wessex, Southampton, UK
[d] Karolinska Insitutet, Stockholm, Sweden

ARTICLE INFO

Article history:
Received 7 December 2018
Received in revised form 8 March 2019
Accepted 12 March 2019

Keywords:
Policy
Nursing workforce
Patient safety
Hospitals

ABSTRACT

In 2013, a national inquiry into care failings at a large public hospital in England resulted in major healthcare reforms that included targeting policy aimed at ensuring the adequacy of nurse staffing levels on hospital wards within NHS England. This paper uses a review of publicly available documents to provide a contextual account of the evolution of nurse staffing policy development prior to and following the inquiry. We found that securing safe staffing policy has been impacted by caveats and competing policy, evidence gaps, lack of coordination, and the absence of readily implementable solutions. Consequently, five years on, safe staffing policy for NHS England is described in aspirational terms that ascribes accountability to providers, but fails to adequately address barriers to delivery. Kingdon's 'policy windows' model is used to explain why policy, even when driven by strong public concern and with high inter-sector support, may struggle to gain traction when the conditions necessary for success are not present, and in the face of practical or political constraints. The progress and pitfalls encountered are not unique and the experience of safe staffing policy in England may have lessons for other countries grappling with policy development or implementation in this area.

© 2019 The Author(s). Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

1. Introduction

In early 2013 a public inquiry into care provided at the publicly-funded Mid Staffordshire Hospital in England, chaired by barrister Sir Robert Francis, concluded that the structure and culture of decision-making was deeply flawed, and had allowed serious care failures to occur [1]. The government accepted the inquiry's finding that the failings indicated systemic issues that required fundamental review of aspects of England's National Health Service (NHS) [2]. The inquiry highlighted that nurse staffing decisions had been made without recourse to evidence of associations with patient safety. Efforts to control finances were prioritised over quality and safety. National policies and guidelines produced following the inquiry, were targeted at ensuring nurse staffing levels were safe, given the health services' *"...most essential duty – to protect patients from unacceptable risks of harm"* [1] p5. A commitment was made that *"patients come first in everything we do..."* [2] p9.

2. Materials and methods

This review uses publicly available documents to chart the development of safe nurse staffing policy for acute NHS hospitals in England. The evolution of safe staffing policy was mapped by examining documents, reports and discourse in the public domain to understand the context of the Francis Inquiry and subsequent development of safe staffing policy. The materials uncovered included reports from government departments; affiliated national bodies responsible for service commissioning, quality and regulation; national newspapers and health services press; professional bodies and nursing unions; think tanks and workforce experts; and public inquiries. Three chronological periods are presented: the pre-inquiry period (before February 2010), the intra-inquiry period (2010–2013), and the post-inquiry period (to 2018). Kingdon's 'policy windows' model is used to frame presentation and discussion around the progress and pitfalls encountered in the evolution of safe nurse staffing policy [3]. Kingdon suggests that potential policies float in a 'primeval soup' of possibilities and policy 'windows' of opportunity open or close due to the coupling/decoupling of three process streams; problem, policy, and politics. When the three streams are coupled, frequently with the help of natural cycles

* Corresponding author at: University of Southampton, University Road, Southampton, SO17 1BJ, UK.
E-mail address: Jane.Ball@soton.ac.uk (J. Ball).

https://doi.org/10.1016/j.healthpol.2019.03.011
0168-8510/© 2019 The Author(s). Published by Elsevier B.V. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

(e.g. elections) or policy entrepreneurs, opportunities for change are more likely. Problem recognition is key, since individual policies compete in a crowded space. The policy stream relates to how policy is shaped by participants both inside and outside government. The political stream comprises the negotiations, conflicts and compromises between the many policy making participants, including the influence of powerful interests.

3. Results

3.1. The pre-inquiry period

Prior to 2010, determining nurse staffing levels for hospital wards in the NHS was almost entirely undertaken at a local level, with little national guidance [4]. From the early 1980s, these local nurse-staffing decisions were increasingly influenced by ongoing reforms and issues of funding and supply. De-centralisation of funding and decision-making, and the absence of centrally provided standards, guidance or regulation resulted in largely uncontrolled and unmonitored experimentation with nurse staffing. Compounding this, following the 2008 global financial crisis, national 'austerity' measures were introduced, and the NHS was expected to make efficiency savings of £15-20 billion [5]. Throughout this period, concerns were raised about potential negative effects on service provision and staffing [6], but this did not result in any substantive policy movement regarding nurse staffing. It took the stimulus of a major scandal at a public healthcare institution to leverage change.

At the time the scandal came to light, the Mid Staffordshire NHS Foundation Trust (Mid Staffs) was an organisation managing two hospitals in Staffordshire England, serving a population of around 320,000. Following concerns about care and mortality levels at Mid Staffs raised by the Care Quality Commission (CQC), an independent inquiry was commissioned under the NHS Act and chaired by Robert Francis [7]. The subsequent report cited instances of profound neglect, with inadequate nurse staffing implicated. Serious failures of leadership were exposed as occurring within a context of constant sector reform and a focus on targets and financial restraint. Pressure to achieve 'Foundation Trust' status (accreditation as a not for profit public corporation with reduced central government control) was implicated [7]. Initially, the Secretary of State for Health asserted that *"all the evidence confirms this was a local failure, from which we can learn national lessons"* [8]. Subsequent public disquiet, and the efforts of family members of patients who had suffered, led to the government establishing a public inquiry with wider statutory powers than the independent inquiry, to examine how the operating, regulatory, and monitoring systems failed to detect the failures of care.

3.2. The intra-inquiry period

During the three-year period of the public inquiry (again led by Francis) there were few significant developments in national policy relating to the planning of nurse staffing. However, for much of this period nursing workforce numbers showed an overall decline [9] and issues with nurse staffing continued to be raised by the two national nursing unions [10,11]. A group of senior nurses and workforce experts convened the 'Safe Staffing Alliance' [12] to give voice to concerns relating to nurse staffing and to promote the use of evidence (an example of Kingdon's policy entrepreneurs).

Shortly before the public inquiry findings were published, the incoming Chief Nursing Officer (CNO) for England launched 'Compassion in Practice', a national strategy document which included references to staffing, including a commitment to using evidence-based tools to plan staffing, and advocating increased governance oversight and accountability. While lacking detail, the goal was to rapidly develop *"full implementation plans for this vision and strategy. . ..by 31 March 2013"* (p 12) [13].

3.3. The post-inquiry period

In February 2013 the report of the public inquiry [1] was released, describing sector-wide issues. The government responded immediately:

> "This was a systemic failure of the most shocking kind, and a betrayal of the core values of the health service as set out in the NHS Constitution. We must never allow this to happen again. . .We will foster a climate of openness, where staff are supported to do the right thing and where we put people first at all times" [2] p5-6.

There was acknowledgment that the NHS had *". . .veered, or was pushed, too far from its core humanitarian values and in too many places had its priorities wrong [and that] targets and performance management in places overwhelmed quality and compassion"* (p 21). A commitment was made by the government to address the majority of 290 recommendations covering increased compliance and enforcement requirements, greater transparency and candour, actions to support compassionate care, information standards, and leadership [2]. Because of nursing's intimate relationship with patient care and outcomes [14] the report sharply heightened awareness of the consequences of staffing failures. Specific recommendations relating to nursing and the need to restore public confidence created a political climate that rapidly propelled safe staffing from a background expectation to the central policy platform. Kingdon's 'problem stream' was established coupled with a clear political will to address safe staffing through policy.

A series of reviews were commissioned by the government to inform the policy response to the inquiry recommendations, of which two [15,16] reinforced Francis's call for greater specification around nurse staffing. Both emphasised the need for evidence-based tools, a shift-by-shift focus, improved monitoring, and 'board to ward' accountability. Neither these reports, nor the Francis inquiry were asked to consider how any changes to nurse staffing might fit with other sector priorities. Instead, it fell to central Government agencies to identify the qualifiers. Two caveats made in the 2013–2016 business plan for NHS England [17] would influence the scope of policy development. Firstly, the commitment to develop evidence-based approaches to staffing had to be achieved *"within allocated resources"* (p28). Secondly, an inquiry recommendation that mandated minimum nurse: patient ratios be considered, was rejected. No discussion about future funding implications was evident.

Eight months after the inquiry's release, nurse staffing policy guidance was published for NHS England [18] by the National Quality Board (NQB), an umbrella group of the key NHS oversight organisations established to focus on quality. The guidance presented an aid to organisational decision-making, identifying resources and examples of good practice. It indicated an intended direction, provided a platform for future work and set policy boundaries. There were no specific staffing standards, and defined staffing ratios were again rejected in favour of the use of *"evidence, evidence-based tools, professional judgement and a truly multi-professional approach"* (p3).

Following an inquiry recommendation, the National Institute for Health and Care Excellence (NICE) was tasked with developing evidence-based nurse staffing policy guidelines [19]. NICE is a non-governmental organisation that has responsibility to produce evidence-based guidance and advice for health, public health and social care practitioners. They are committed to following a set procedure to generate guidance based on an independent and rigorous review of the evidence. NICE commenced work on a guideline

for safe staffing for nursing in adult inpatient wards in the latter part of 2013. Published nine months later [20], the guideline was detailed in its advice, but limited by the evidence underpinning its recommendations. NICE concluded that evidence of the effect of variation in nurse staffing levels and skill mix on patient outcomes, including safety, while plentiful, could not be readily translated into generalisable 'rules-based' guidance at the level of individual wards [21]. Nor was there sufficient evidence about the effects of methods used to determine staffing requirements. Despite evidence suggesting *increased risk of harm associated with a registered nurse caring for more than 8 patients during day shifts"* [21] p 23, minimum nurse staffing levels had been excluded in the scope of the guideline development [22]. NICE was restricted to recommending that staffing should not fall below this level, and the guideline advised that individual wards would need to determine their own staffing requirement, based on local assessment. NICE advised that the guideline be reviewed and updated as more evidence became available. Thus, a key component of Kindgon's policy stream was not able to be realised, namely a readily implementable solution.

Nurse staffing policy development was not taking place in isolation, and by early 2015 tensions with other sector priorities emerged. An ambitious productivity review suggested NHS savings of £5bn annually could be achieved by targeting unwarranted variations, with a strong emphasis on nursing [23]. Concurrently, restrictions on the use of nursing agency staff were announced [24]. In an unanticipated and unprecedented development, NICE's involvement in staffing guideline development was abruptly terminated in June 2015 [25] ostensibly to integrate the issue of 'safe staffing' into wider service reviews by NHS England, and to include a more multi-professional approach. Future work was transferred to a planned new entity, NHS Improvement, which would provide *"a different approach to answering those questions [of] how staffing levels are determined"* [25]. The move followed NICE's inclusion of nurse to patient ratios in the draft A&E guideline. A comment from the CNO that the focus should be on "staffing needs and patient outcomes rather than through input numbers or ratios" [26] raised questions around the motivation for terminating the NICE led guidance, a move that attracted widespread criticism, including from Robert Francis [26].

The resulting "Improvement Resources" would be published under the auspices of the "National Quality Board", an umbrella group which included NHS England, Health Education England, the Care Quality Commission (CQC – a national health regulator) and NHS Improvement. Unlike the rigorous approach taken by NICE, there was no predetermined process and no explicit framework for incorporating research-based evidence into the resulting resources, although the original reviews undertaken for NICE were utilised in the new 'resources' and new summary reviews were commissioned [27]. Communications from central bodies to providers highlighted tensions between the goals of safe staffing and resourcing constraints. NHS planning guidance [28] prioritised workforce productivity and service efficiency alongside challenging expectations towards achieving a balanced NHS budget. The health services regulator, Monitor, warned of an *"almost unprecedented financial challenge"*, recommending hospitals follow guidelines on safe nurse staffing in a *"proportionate and appropriate"* way (implying that this was not currently the case), and only filling *"essential" staff vacancies"* [29]. The Department of Health affiliated agencies wrote to NHS Trusts seeking to clarify the apparent contradiction between the requirements to achieve safe staffing on the one hand, and on the other, *"the need to intensify efforts to meet the financial challenge"* [30] p1.

> "the responsibility for both safe staffing and efficiency rests, as it has always done, with provider Boards" (p 1)..."Trusts are responsible for ensuring that they get the balance right by neither understaffing nor over-spending..." (p 2).

Hospitals were invited to treat NICE's recommended minimum 1:8 nurse to patient ratio for day shifts as a *"guide, not a requirement"* (p 2) implying a tolerance for staffing below the level identified as the risk threshold in the acute-ward guideline. A commitment to the development of 'new' guidance on staffing was announced. The intention to go ahead with controls on using nursing agency staff, and the introduction of price caps was confirmed.

During 2016, wider government policies with immediate or potential future impact on workforce supply were emerging, that included the UK's intention to withdraw from the European Union (Brexit) resulting in a reduction in EU nurses registering, an ongoing sector salary-freeze, and a decrease in the number of student nurses [31]. In December 2016 the government announced changes to the funding for nurse education and the introduction of a 'nursing associate' role to be piloted in 31 Trusts. Pressure on NHS hospitals to perform on both quality and financial fronts continued, with struggling health care providers advised that headcount reductions would be required in order to address financial deficits [32]. The National Audit Office reported that in 2014–2015, 61% of temporary staffing requests were for covering vacancies [33] and stated that "Trusts' workforce plans appear to be influenced as much by meeting efficiency targets as by staffing need" and were being driven by financial planning imperatives including "significant recurrent pay savings" [33] p8. The report warned that the likely impact on spending of the [NICE staffing recommendations] was not well understood" (p 5), noting that no extra funding had been allocated centrally to cover any additional costs associated with safe staffing.

Within this context, the third general policy document relating to nurse staffing was published by the NQB [34], replacing its 2013 guidance. Although providing more direction on staffing expectations and actions, little guidance was provided on how to deliver services within financial boundaries, beyond acknowledging that *"difficult decisions about resourcing"* (p 9) would be required in strategic planning. This implied trade-offs between cost containment, provision of services and quality of services. Hospitals were encouraged to consider changes to skill mix and models of care. An 'improvement resource' focussed specifically on adult inpatient wards [35] followed, providing an updated 'how to' method for approaching ward level nurse staffing. A supporting resource for the 2016 general guideline was published in January 2018 [36]. In January 2019, the NQB published an improvement resource for the employment of nursing associates in acute care [37]. The resource noted however that "there is little evidence of the impact of deploying the nursing associate" (p23) and cited research evidence that identified risks associated with a more dilute nursing skill-mix [38].

Neither the 2016 nor 2018 policies substantively changed the guidance provided by the 2014 NICE guideline; the 2019 resource however downgraded its status to that of a "useful benchmark" (p4). All three tempered NICE's recommendations by reinforcing local hospital responsibility to balance staffing investment with other obligations, specifically quality, productivity and fiscal responsibility goals.

4. Discussion

Despite the urgency and commitment that followed the Francis Inquiry, and recommendations framed around quantification and certainty about nurses staffing levels, five years of policy development has fallen short of these goals, leading to questions around the policy trajectory that was followed.

Many models have been developed to explain the public policy process [39–41] ranging from prescriptive or rational, versus pragmatic or incremental approaches to decision-making [42,43].

Kingdon's policy framework is useful to explain why policy, even when driven by strong public concern and with high inter-sector support, may struggle to realise its aims when the conditions necessary for success are not present. Kingdon's 'policy windows' model largely builds on incrementalism but recognises that far from being rational, the policy process can be messy and unpredictable [3,40] and requires the coupling of three process streams, problem, policy and politics. The model suggests that for a policy to gain traction and to be successfully implemented, there must be recognition that there is a significant problem to be addressed; a technically and fiscally deliverable solution congruent with public and policymaker values needs to be available [3]; and a conducive political climate must exist.

For nurse staffing policy, the coupling was most evident in the initial post-inquiry period. The problem of safe staffing gained sharp definition in the wake of the Mid Staffs scandal creating pressure within the political stream, which in turn sparked movement in the policy stream. A powerful 'master narrative' [45] initially leveraged from the revelations of the inquiries, focused national attention on the problems of unsafe staffing levels. Unlike some of the less direct recommendations in the inquiry, such as those relating to culture and power, safe staffing was more tangibly described, and thus easier for the parties, including the public, to engage with. Political momentum around the need for safe staffing was readily established and was aided by a community of safe staffing policy advocates, including Francis himself. Safe staffing was acknowledged as a policy problem, and work on policy development was rapidly devolved and initiated. The window appeared to be wide open, an assessment that in retrospect appears questionable.

While Kingdon suggests that recognition of a significant problem aids uptake of policy attention, it is significant that safe staffing policy had its genesis in a sector scandal. When scandals such as Mid Staffs occur, Butler and Drakeford [44] suggest that pressure to address the failures often trigger unplanned rapid-response policy development. This type of policy evolution can be disruptive because it is not part of the natural cycle, it demands and drives change, has complex underlying causative factors, and often falls outside the policy direction of the day [44]. Indeed, the policy direction that preceded the scandal may be found to have contributed to the conditions that allowed it to occur. The remedies may thus be in conflict with and threaten to override the established sector direction. Thus while the Mid Staff's failures opened the window, strong counter forces provided by the status quo worked to narrow the scope and influence of any resultant policy. For example, NICE's evidence-based conclusion that the implementable solution pointed in the direction of higher staffing levels contributing to safer staffing, ran directly counter to policies driven by pressure and constraints on health services. Thus, despite the early post-inquiry government narrative that *"patients come first in everything we do...*" [2], support for safe staffing came with caveats; mandated solutions underpinned by legislation such as ratios adopted in California, parts of Australia and Wales were excluded, and any staffing policy solution was required to be reconciled with other policy priorities, specifically funding.

Compounding the policy conflict, the policy stream was obstructed by the absence of a readily implementable technical solution. Despite early advances made by NICE in establishing what good safe staffing practice should look like (e.g. evidence-based and accountable), and evidence that nurse staffing levels impact on care quality and patient outcomes, this was not easily translatable into clear guidance. This led to a loss of momentum that allowed other sector priorities, perhaps inevitably, to be reasserted at a critical time and to the window of opportunity narrowing.

Some visible gains have been made, with references to nurse staffing now embedded in key policy documents and an ongoing programme of sector activity and monitoring. However, policy advice on nurse staffing is currently described in aspirational 'how to' terms that ascribe accountability to providers, but do not adequately address barriers to delivery. In terms of future progress, there is a risk that in the absence of ongoing evidence of problems of the magnitude uncovered in the Mid Staffs scandal, the acuteness of the safe staffing problem is somewhat muted. In a sector facing many challenges on multiple fronts, the 'lurching attention' of the sector [45] could result in safe staffing sinking back into Kingdon's 'primeval soup' of potential policies competing for attention. Sir Robert Francis, the person with the most intimate knowledge of the Mid Staffs scandal and its root causes, continues to advocate for keeping attention focused commenting publicly in late 2017:

> I think [conditions in the NHS] are pretty bad. We've got a virtual storm of financial pressures, increased demand, difficulties finding staffing, and pressure on the service to continue delivering. And some of that sounds quite familiar – as it was, those were the conditions pertaining at the time of Mid Staffordshire (Francis 2017) [46].

In Francis's comprehensive statement to the 2017 House of Commons Health Committee Inquiry into the Nursing Workforce he summarised the lack of progress made in relation to the recommendations of the 2013 inquiry suggesting that "the NHS leadership has shied away from accepting that numbers of staff of particular types can be associated with acceptably safe care" [47] (para 10).

Keeping the policy window open will require not only sustaining sector interest and political commitment, but also addressing identified gaps and challenges in implementation [48]. Further progress requires that the evidence gaps identified by NICE in 2014 [20] are addressed and translated into technically feasible solutions that providers are able and empowered to consistently implement, and that are acceptable to a broad range of stakeholders. Giving ongoing attention to nursing workforce supply will also be important, if this is not to obstruct the achievement of safe staffing policy goals.

5. Conclusions

After many decades in the health sector policy hinterland, safe nurse staffing was recognised as a policy problem for the NHS following the Mid Staffs scandal. The gradual coupling of the process streams that culminated in the opening of the safe staffing policy window since 2013 has resulted in progress, but this work is incomplete. Tensions remain between the desire to resolve safe staffing and the practical implications of doing so. Evidence gaps and failure to identify and secure a technical and economically justifiable solution, coupled with a context where demand for health services outstrips resource have had a major impact. The effect of policy at the service level, although the subject of evaluation [48], is as yet unclear. Time will tell whether momentum can be maintained long enough for sustainable policy solutions to be identified and implemented without requiring the tragic stimulus of a future health care scandal.

Funding

The research study was commissioned and funded by the UK National Institute of Health Research (NIHR) Policy Research Programme (grant number: PR-ST-1115-10017). The views expressed are those of the authors and not necessarily those of the NIHR, the Department of Health and Social Care, 'arm's length' bodies or other government departments.

Conflicts and declaration of interests

The authors declare that they have no conflicts of interest.

CRediT authorship contribution statement

J. Lawless: Conceptualization, Investigation, Data curation, Writing - original draft, Writing - review & editing, Project administration. **R. Couch:** Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing. **P. Griffiths:** Conceptualization, Validation, Writing - review & editing, Supervision, Funding acquisition. **C. Burton:** Conceptualization, Validation, Writing - review & editing, Supervision, Funding acquisition. **J. Ball:** Conceptualization, Validation, Writing - review & editing, Supervision, Project administration, Funding acquisition.

Acknowledgments

The authors acknowledge the support of the Safe Staffing study team, in particular: Hannah Barker, Jeremy Jones, Jo Rycroft Malone and Francesca Lambert.

References

[1] Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary. London: The Publishing Office; 2013.
[2] Department of Health, London Patients first and foremost: the initial government response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry; 2013.
[3] Kingdon J. Agendas, alternatives, and public policies, Second edition New York: Longman Classics in Political Science; 2011.
[4] Hurst K. Selecting and applying methods for estimating the size and mix of nursing teams: full version. Nuffield Institute of Health; 2003.
[5] Ball J, Sawer P, 13 June, Available at NHS chief tells trusts to make £20bn savings. The Telegraph; 2009 [Accessed 24 September 2018] https://www.telegraph.co.uk/news/health/news/5524693/NHS-chief-tells-trusts-to-make-20bn-savings.html.
[6] Royal College of Nursing, London RCN policy unit policy guidance 15/2006: setting appropriate ward nurse staffing levels in NHS acute trusts; 2006.
[7] Francis R. Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005–March 2009 London; 2010.
[8] Burnham (Health Secretary) A, 25 February. Available from Department of Health, government response to the Mid Staffordshire Independent Inquiry report, media release; 2010 [Accessed 24 September 2018] http://www.mynewsdesk.com/uk/pressreleases/department-of-health-government-response-to-the-mid-staffordshire-independent-inquiry-report-376843.
[9] Buchan J, Seccombe I. The end of growth? Analysing NHS nurse staffing. Journal of Advanced Nursing 2013;69(9):2123–30.
[10] RCN. Mandatory nurse staffing levels. London: Royal College of Nursing.; 2012.
[11] UNISON. Care in the balance: a UNISON survey into staff/patient ratios on our wards. London: UNISON; 2012.
[12] Waters A. It is time we took a firm stand in the battle for safe staff levels. Nursing Standard 2012;26(50):16–9.
[13] Cummings J, Bennett V. Developing the culture of compassionate care: creating a new vision for nurses, midwives and care-givers. London: Department of Health; 2012.
[14] Kane RL, Shamliyan TA, Mueller C, Duval S, Wilt TJ. The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. Medical Care 2007;45:1195–204.
[15] Berwick D. A promise to learn, a commitment to act: improving the safety of patients in England. London: Department of Health; 2013.
[16] Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. London: NHS England; 2013.
[17] NHS England. Putting patients first: the NHS England business plan for 2013/14–2015/16. London: NHS England; 2013.
[18] National Quality Board. How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability; 2013.
[19] Calkin S, 13 November, Available at: NICE to start work on safe staffing guideline. Nursing Times; 2013 [Accessed June 11 2018] https://www.nursingtimes.net/clinical-archive/patient-safety/nice-to-start-work-on-safe-staffing-guideline/5065325.article.
[20] National Institute for Health and Care Excellence. Safe staffing for nursing in adult inpatient wards in acute hospitals. London: NICE.; 2014.
[21] Griffiths P, Ball J, Drennan J, James L, Jones J, Recio-Saucedo A, et al. The association between patient safety outcomes and nurse/healthcare assistant skill mix and staffing levels & factors that may influence staffing requirements. University of Southampton; 2014.
[22] National Institute of Care and Health Excellence. Safe staffing guideline scope. London: NICE; 2013.
[23] Lord Carter of Coles. Operational productivity and performance in English NHS acute hospitals: unwarranted variations. London: Department of Health; 2016.
[24] Lintern S, 1 June, Available at: NHS chief confirms' collective' action on agency staff spending. Nursing Times; 2015 [Accessed 22 September 2018] https://www.nursingtimes.net/nhs-chief-confirms-collective-action-on-agency-staff-spending/5085440.article.
[25] NICE, 4 June NHS England asks NICE to suspend safe staffing programme; 2015 [Accessed 24 September 2018] https://www.nice.org.uk/news/article/nhs-england-asks-nice-to-suspend-safe-staffing-programme.
[26] Cooper C. The National Institute of Health and Care Excellence (NICE) has suspended work on safe nurse-to-patient ratios with immediate effect. The Independent; 2015, 4 June 2015. [Accessed 7 March 2019].
[27] Griffiths P, Dall'Ora C, Ball J. Nurse staffing levels, quality and outcomes of care in NHS hospital wards: what does the evidence say? Health Work Evidence Briefs, University of Southampton; 2016 [Accessed 7 March 2019] https://improvement.nhs.uk/documents/586/Evidence_review.pdf.
[28] NHS England. Building the NHS of the five year forward view: NHS England business plan 2015/2016. London: NHS; 2015.
[29] Watt N, 4 August. Available at: 'NHS told to fill only essential vacancies due to' almost unprecedented' finances. The Guardian; 2015 [Accessed: December 11 2017] https://www.theguardian.com/society/2015/aug/04/nhs-told-to-fill-vacancies-only-where-essential-due-to-looming-funding-crisis:.
[30] Care Quality Commission, Available from: NHS Improvement: quality and finance must be on equal footing; 2016 [Accessed December 1] http://www.cqc.org.uk/content/financial-performance-and-quality-must-work-together.
[31] Buchan J, Charlesworth A, Gershlick B, Seccombe I. Rising pressure: the NHS workforce challenge. London: Health Foundation Report; 2017.
[32] Campbell D, 29 January. Available at: Hospitals told to cut staff amid spiralling NHS cash crisis. The Guardian; 2016 [Accessed November 11 2017] https://www.theguardian.com/society/2016/jan/29/hospitals-told-cut-staff-nhs-cash-crisis.
[33] National Audit Office. Managing the supply of NHS clinical staff in England. London: National Audit Office; 2016.
[34] National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: safe, sustainable and productive staffing. London: National Quality Board; 2016.
[35] National Quality Board. Safe, sustainable and productive staffing: an improvement resource for adult inpatient wards in acute hospitals. London: National Quality Board; 2016.
[36] National Quality Board. Safe, sustainable and productive staffing: an improvement resource for adult inpatient wards in acute hospitals. London: National Quality Board; 2018.
[37] National Quality Board. Safe, sustainable and productive staffing: an improvement resource for the deployment of nursing associates in secondary care; 2019.
[38] Griffiths P, Ball J, Murrells T, Jones S, Rafferty AM. Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study. BMJ Open 2016;6:e008751.
[39] Cairney P, Heikkila T, editors. A comparison of theories of the policy process, Third edition Chicago: Westview Press; 2014.
[40] Hill M. The public policy process, Fourth edition Harlow, England: Pearson Longman; 2005.
[41] Parsons W. Public policy: an introduction to the theory and practice of policy analysis. Cheltenham: UK: Edward Elgar Publishing; 1995.
[42] Simon H. Administrative behaviour, Second edition New York: The MacMillan Company; 1957.
[43] Lindblom C. The science of muddling through. Public Administration Review 1959;39:78–88.
[44] Butler I, Drakeford M. Scandal, social policy and social welfare. Bristol: The Policy Press; 2005.
[45] Cairney P, Kwiatkowski R. How to communicate effectively with policymakers: combine insights from psychology and policy studies. Palgrave Communications 2017;3(37).
[46] Francis R. In: Marr A, editor. Sir Robert Francis on NHS crisis. BBC; 2017.
[47] House of Commons Health Committee. The nursing workforce. Second Report of Session 2017–19. Published Written Evidence – 96-Sir Robert Francis (NOW 0120). http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Health/Nursing%20workforce/written/73226.html.
[48] Ball J, Barker H, Burton C, Couch R, Griffiths P, Jones J, Lawless J, Rycroft-Malone J. Implementation, impact & costs of policies for safe staffing in acute trusts. Report to NIHR Policy Research Programme; 2018. Submitted to funder July 2018.