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EDITORIALS

Mid Staffordshire should lead to a fundamental rethink of government policy

The QIPP initiative threatens safe levels of staffing

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NHS staffing levels emerged as a key concern of the Francis inquiry into substandard care at Mid Staffordshire NHS Foundation Trust. Inappropriate and low levels of staffing have previously come to light in the corporate nursing home and residential care sector through scandals such as the one at Winterbourne View. Francis notes that as part of the trust's financial recovery plan, "Savings in staff costs were being made in an organisation which was already identified as having serious problems in delivering a service of adequate quality, and complying with minimum standards. Yet no thought seems to have been given in any part of the system aware of the proposals to the potential impact on patient safety and quality."[1]

According to Francis, the solution is training and regulation of staffing levels, including "evidence based tools for establishing the staffing needs of each service," proper risk assessment "when changes to the numbers or skills of staff are under consideration," and advice during commissioning when major changes to staffing or facilities are proposed.[1]

The Department of Health in its initial response published last month focuses on inspection and training and says that although it will work with other agencies "on tools to inform [staffing] decisions," such decisions are a local responsibility.[2] Concerns that inquiry findings might be "diametrically opposed to the direction of travel set out by the government" were last year attributed to David Nicholson, then NHS chief executive.[3] Evidence suggests that the government cannot square the inquiry's findings with the Health and Social Care Act and its productivity targets.

The market brought in by the Health and Social Care Act 2012 abolishes the secretary of state's control over health services. At the same time, the controversial "hands off" duty that requires the minister to promote autonomy of service providers underpins the principle that care providers should be free to determine staffing levels, terms, and conditions.[4] Staffing norms (as opposed to minimum standards) are difficult to reconcile with a market model in which providers are free to manage financial risk by controlling workforce costs.

Last year, the NHS Confederation told the health select committee that defined staffing numbers or ratios for key hospital services could be an effective way of ensuring quality and safety are maintained but could also significantly increase costs.[5] However, staffing norms run counter to the £20bn (€23.6bn; $30.5bn) savings that the NHS is expected to make by 2015 under the Quality, Innovation, Productivity, and Prevention Programme (QIPP), first set out in the NHS Annual Report 2008-09.[6] QIPP is driving controversial service reconfigurations, including the closure of accident and emergency services and hospitals throughout England.

NHS trusts have already prioritised short term QIPP savings to meet financial targets, according to the House of Commons Health Committee,[7] but the targets are not evidence based. Claims by the Department of Health that productivity gains will not be detrimental to patient care rest largely on a set of 120 PowerPoint slides prepared by McKinsey and Company.[8] The company's assertions that, for example, community services can be delivered by "11-15% less staff" or that savings of £0.8-1.6bn in unscheduled care costs can be achieved by reducing variations in emergency admission rates are not grounded in research.

The House of Commons Public Accounts Committee has highlighted government's failure to spell out how savings are to be made, and its members have questioned whether the Department of Health can reliably differentiate between a productivity gain and a service cut.[9 10] Francis is clear about the impact of financial targets and foundation trust status: "The result was both to deprive the hospital of a proper level of nursing staff and provide a healthier picture of the situation of the financial health of the trust than the reality, healthy finances being material in the achievement of foundation trust status. Although the system as a whole seemed to pay lip service to the need not to compromise services and their quality, it is remarkable how little attention was paid to the potential impact of proposed savings on quality and safety."[1]

Research shows that staffing norms do matter. Evidence from North America shows that in the mainly for-profit sector, low staffing levels are associated with increased mortality and hospital infection rates, inappropriate prescribing, and other outcomes.[11] California established minimum staffing standards

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for hospitals in 2004 that improved hospital staffing levels, a policy that healthcare corporations have resisted in other states on grounds of cost.[12] In a study of patient safety, satisfaction, and quality of hospital care in the United States and in 12 countries in Europe, improved work environments and reduced ratios of patients to nurses were associated with increased care quality and patient satisfaction.[13] In European and US hospitals, after adjusting for hospital and nurse characteristics, nurses with better work environments were half as likely to report poor or fair care quality and give their hospitals poor or failing grades on patient safety.

The Francis inquiry shows that staffing levels and norms do matter. A major review of staffing is long overdue across the NHS. Deregulation and privatisation of staff and services is not in keeping with the spirit of the Francis report or his recommendations. A responsible government would suspend the QIPP initiative, restore staffing and needs based planning norms, and reinstate the secretary of state's control and power of direction over health services.

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1 The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary. Stationery Office, 2013:42.
2 Department of Health. Patients first and foremost. The initial government response to the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf.
3 Calkin S. Nicholson: "very real" chance Francis recommendations will conflict with policy. *Health Serv J* 2012. www.hsj.co.uk/news/acute-care/nicholson-very-real-chance-francis-recommendations-will-conflict-with-policy/5045460.article.
4 House of Commons. Health and Social Care Act 2012. Stationery Office, 2012.
5 House of Commons. Health Committee written evidence from the NHS Confederation (PE32), 23 January 2012. www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1499/1499we01.htm.
6 Nicholson D. The year: NHS chief executive's annual report 2008/09. NHS, 2009. www.healthcare-today.co.uk/doclibrary/documents/pdf/215_the_year_2008-09.pdf.
7 House of Commons Health Committee. Report on Public Expenditure, volume 1, HC 1499, January 2012.
8 McKinsey. Achieving world class productivity in the NHS 2009/10-2013/14: detailing the size of the opportunity. Department of Health, 2009.
9 House of Commons. Uncorrected transcript of oral evidence taken before the Public Accounts Committee. Progress in delivering NHS efficiency savings Monday 14 January 2013. www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/uc865-i/uc86501.htm.
10 Vize R. Reality of the NHS budget squeeze. *BMJ* 2011;343:d8027.
11 Kane RL, Shamliyan T, Mueller C, Duval S, Wilt TJ. Nurse staffing and quality of patient care. *Evid Rep Technol Assess* 2007;151:1-115.
12 McHugh MD, Brooks Carthon M, Sloane DM, Wu E, Kelly L, et al. Impact of nurse staffing mandates on safety-net hospitals: lessons from California. *Milbank Q* 2012;90:160-86.
13 Aiken LH, Sermeus W, Van den Heede K, Sloane DM, Busse R, McKee M, et al. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. *BMJ* 2012;344:e1717.

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