

Resource impact commentary

**NICE safe staffing guideline:
Safe staffing for nursing in adult
inpatient wards in acute hospitals
Report on the potential resource implications**

Published: July 2014

<http://guidance.nice.org.uk/SG1>

Summary

1. The Department of Health and NHS England asked NICE to evaluate the possible resource impact of implementing the guideline on [safe staffing for nursing in adult inpatient wards in acute hospitals](#) (SG1). The guideline covers nursing in adult inpatient wards in acute hospitals. This excludes other types of ward or unit such as intensive care, high dependency, maternity, mental health, acute admission or assessment. While NICE acknowledges the importance of a multidisciplinary approach in providing safe nursing care, the guideline covers only nursing staff (registered nurses and healthcare assistants).
2. The guideline builds on other existing guidance and requirements that are already in place. Since the [Francis report on Mid-Staffordshire](#), the NHS has made good progress in introducing safer staffing practices and in planning for their resource impact. There are a number of examples of good progress, including increasing the number of nursing staff on wards. There is also local variation in this progress and, therefore, the resource implications of the guideline at a local level depend on the steps towards safer staffing that hospitals have already been put in place.
3. This report outlines the resource implications of the recommendations in the guideline, using the best available evidence and data. It concentrates on potential total staff cost impact of implementation. It is not straightforward to calculate the overall net resource impact (potential costs and savings) of the guideline because it is difficult to estimate the costs and the outcome benefits that will be achieved by implementing its recommendations. Given this and the progress that has already been made by the NHS in matching staffing levels to the required levels of activity on acute wards, it is not possible to be precise about the overall resource impact of the guideline. It is possible that savings could eventually exceed the upfront costs of implementing the guidance.
4. Organisations should evaluate their own progress against the recommendations in the NICE guideline and assess costs locally.

Introduction

5. Safe staffing levels and practices are the focus of several recent national reviews, including the [Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry](#), published in February 2013. In April 2014, NHS England and the Care Quality Commission (CQC) issued joint guidance to trusts on the delivery of the '[Hard Truths](#)' commitments associated with publishing data on NHS Choices about nursing, midwifery and care staff levels. The joint guidance also covers the frequency with which boards and trusts need to display and evaluate staffing data and publish their reports online, and the dates when stocktakes of their progress will be undertaken. Therefore, there is clear evidence that the

NHS has already started implementing safer staffing practices and is planning for the financial and resource impact of safe staffing.

Estimating staffing impacts

6. The Royal College of Nursing (RCN) guidance on safe nurse staffing in the UK (2010) reported that a large-scale RCN survey of 9,000 nurses in 2009 found that on average, for all NHS hospital wards, there was a ratio of 8 patients per registered nurse during the daytime shifts, and 11 per registered nurse at night. Patient numbers per healthcare assistant (HCA) showed a ratio of 12 patients per HCA during the daytime shifts and 17 per HCA at night. The average number of beds per ward was 26. The nursing numbers per ward provide an indication of the average ward levels, accepting that numbers will have altered marginally since 2009, to help to estimate how safe staffing guidance and this guideline may alter the numbers per ward.
7. To assess the potential staff cost impact of the guideline, we applied a series of assumptions and filters to the monthly workforce statistics held by the Health and Social Care Information Centre (HSCIC). This produced an estimate of the nursing staff employed in adult inpatient acute wards. Applying these assumptions, at February 2014, the numbers for adult acute inpatient wards were estimated as 105,000 full time equivalents (FTEs) registered nurses and 47,000 FTEs HCAs. Between the period March 2013 and February 2014, registered nurse numbers increased by approximately 3,000 (3%) FTEs; HCA numbers also rose by approximately 3,000 (7%) FTEs. The growth in the last 12 months is in contrast to the previous 3-year period, in which approximate numbers for the overall staff group remained relatively stable.
8. Average annual employment costs for registered nurses and healthcare assistants were then applied to this estimate to produce a view of the current resource position (the estimated 'national baseline').

Capturing existing planning within the NHS

9. The NHS has already started implementing safer staffing practices and is planning for the financial and resource impact of safe staffing.
10. Health Education England (HEE) reported in the HEE workforce plan 2014/15 that there was a requirement from NHS providers to see a 9% growth in training numbers in the nurse 'acute, elderly and general' group. This increase will impact in 2017. HEE analysis of NHS staffing numbers for 2014/15 showed that the number of nurses required for care for adults in all acute settings would be a minimum of 173,000 FTEs (registered nurses) and a maximum of 182,000 FTEs. At February 2014, there were 175,000 FTE nurses, and therefore the minimum level (173,000 FTEs) was passed before the start of the 2014/15 financial year.

11. The total amount that NHS foundation trusts and trusts have invested or will invest in care improvements, post Francis, for the 2-year period 2013/14 and 2014/15 is £1.2 billion, according to a Foundation Trust Network (FTN) members' survey. The survey showed a split of approximately £450 million in 2013/14 and then £712 million in 2014/15. At least 90% of this investment was stated as being to provide for extra staff and recruitment costs, particularly nursing staff. The FTN survey estimated that the investment equates to increasing nursing staff by around 39,000 FTEs.

NICE field test work

12. NICE carried out exploratory field testing to gain insight into how the guideline recommendations worked in practice, compared with professional judgement. The data collected also provided a current 'in hospital' baseline position for the nursing staff requirements, including registered nurse and HCA staffing. These data were based on an average of 26 beds per ward, in almost 100 different wards in 14 hospitals.

Net staffing cost impact

13. Based on the external sources of data, and incorporating the NICE field testing, 3 scenarios were developed: 'no need for change', 'some change needed', 'significant change needed'.
14. The total staff cost impact ranges from zero to £414 million with a mid-point at £207 million. The range represents the uncertainty in knowledge about exactly how much NHS organisations have already invested in care improvement and increased staff levels.
15. The mid-point cost impact represents approximately a 5% increase in staff costs over current planning projections. To align with the 9% growth of nurses in training already highlighted in the HEE workforce plan 2014/15 which is to have full impact in 2017, it would be prudent to plan for costs to be spread across financial years, taking account of the potential benefits and savings identified below.

Benefits of implementing the guideline

16. The staff costs and impacts outlined above exclude cost offsets achieved by improved outcomes and other benefits of safe staffing. Financial benefits realised as a result of the implementation of the guideline will serve to reduce net cost impact. Safer care has the potential to significantly reduce costs to the NHS in the long term. The main benefits are listed below:
 - Reduction in the number of pressure ulcers: total costs in the UK were estimated as being £1.4–£2.1 billion or around 4% of the total NHS expenditure in 2004. Levels will have reduced since 2004, because of the

increased focus on preventing pressure ulcers. However further reductions in numbers of pressure ulcers are still needed, which will both improve patient care and decrease the costs associated with their management.

- Reduced risk of healthcare acquired infections: the cost to the NHS of surgical site infections is estimated to be around £700 million a year.
- Potential reduction in mortality rates.
- Improved patient experience: the potential reduction in costs to the trust include those associated with adverse events.
- Reduced risk of litigation claims due to poor care: the average cost of a claim classed by the NHSLA under the 'nursing' category was £75,000 plus the claim excess and legal advice costs.
- Potential reduced incidence of IV fluid-associated complications by better management of fluids: patients with complications appeared to spend an additional 2.5 days in hospital compared with patients without complications (Walsh 2008).
- Reduced levels of falls, with a saving of approximately £1,400 per fall avoided.
- Potential reduction in bed days due to providing more effective care: potential resources released as a result of a reduced hospital length of stay have been estimated at £236 per bed day (national tariff, 2014-15).
- Reduction in readmissions within 30 days.
- Achieving CQUINS more easily and avoiding potential contract penalties as result of providing more effective care.

References

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About this commentary

This commentary accompanies the clinical guideline: Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE guideline SG1).

Issue date: July 2014.

This commentary is written in the following context

The cost and activity assessments in the commentary are estimates based on a number of assumptions. They provide an indication of the potential impact of the principal recommendations and are not absolute figures.

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