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# RCN Policy Unit

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## Policy Briefing 12/2006

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### **‘Patient choice, patient outcomes and nurse staffing’**

**ABSTRACT**

A number of patient organisations were invited to a seminar to update them on the impact of financial deficits, particularly on the nursing workforce, and share high quality research evidence that demonstrates the Registered Nurse impact on patient outcomes. The delegates were given a series of presentations, including one from Prof Anne Marie Rafferty from King’s College London who presented original research on the [impact of nurse staffing levels on patient mortality](#)

July 2006



## Introduction

What is the RCN? With a membership of over 390,000 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 and play an important role in developing new services. The RCN promotes patient and nursing interests on a wide range of issues by working closely with Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Involving patient organisations is important to the work that the RCN has been doing over recent years when considering the impact of policy on nurses and nursing practice. Central to this is the impact on service delivery and for patient care.

It is hoped this discussion paper will prompt further debate from our initial discussions and help us move the patient choice agenda forward, particularly in respect of working together to provide the right information to the right patients at the right time.

The following discussion followed three presentations from members of the RCN policy team and from Professor Anne-Marie Rafferty of Kings College London on what is known about ward staffing levels and patient outcomes. Prof Rafferty's work builds on the significant research pioneered by Linda Aiken and her team published in the Journal of the American Medical Association (JAMA). This found a very positive link between levels of nurse staffing and patient outcomes in terms of mortality rates [better staffing = lower mortality rates]<sup>1</sup>. The second article in 2003 suggested that better educated nurses had a positive impact on mortality rates<sup>2</sup>.

## Summary of the presentations

People generally think of nursing, the impact of nursing, and the essence of nursing care to be kindness, dignity, general care. Nurses have general impact on clinical outcomes and that is generally not known in public circles.

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<sup>1</sup> Linda H. Aiken; et al (2002). 'Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction'. *JAMA*, Oct 2002; 288: 1987 - 1993.

<sup>2</sup> Linda H. Aiken et al (2003). 'Educational Levels of Hospital Nurses and Surgical Patient Mortality'. *JAMA*, Sep 2003; 290: 1617 - 1623.



The evidence presented by Professor Rafferty and others sets out why nurse staffing levels may be important in terms of patient outcomes. Namely that in hospitals with the most favourable staffing levels (the lowest ratio of number of patients: nurses) had consistently better outcomes than those in hospitals with less favourable staffing.

Patients in the hospitals with the highest patient: nurse ratios (i.e. lower registered nurse staffing levels) had 26% higher mortality; the nurses in those hospitals were approximately twice as likely to be dissatisfied with their jobs; to show high burnout levels; and to report low or deteriorating quality of care on their wards and hospitals.

Other evidence also points to reductions in unscheduled care and unplanned hospital admissions; that nurses achieve equivalent patient outcomes and score higher on patient satisfaction; and that there is a positive correlation between higher num



have chosen alternative providers/treatments but why – what are the things that influence those decisions and how should the provider respond?

RCN believes that potential patients (i.e. those about to make a choice of health care provider) may be interested in the kind of information presented above. The purpose of the seminar was to check this assumption out and begin to discuss how this might be achieved.



## Discussion

The discussion centred on three main questions – what follows is a summary of the discussion as agreed with the participants.

### **1. *Would patients be interested in workforce and outcomes evidence?***

There was a general view that patients *would* want to know this kind of information, however patients will have different needs for different kinds of information at different times in their journey through a service.

“...there are some patients who are called ‘frequent flyers’ by some... their views are going to be very different.”

Whilst it is difficult to classify patients into clearly defined groups for analysis, there are patterns of access which may be a helpful starting point for deciding whether or not workforce data would be helpful.

#### Patients with long term chronic conditions

Around 17.5 million people in Great Britain report a long-term condition such as diabetes, asthma or arthritis - some, especially older people have more than one condition<sup>5</sup>. It has been suggested that doctors have only limited time with each patient, and communication may often have a lower priority than medical treatment<sup>6</sup>. Not being told what is wrong with them has been reported as the most common complaint that patients make about the medical profession<sup>7</sup>.

“...patient’s experiences with specialist nurses have changed their worlds...”

There was a view shared in the discussions that Specialist Nurses have made a significant impact on the lives of others. To ensure that self-care is possible for patients, the nurse could act as a facilitator and provider of information but the nurse must acknowledge patients' central role in their care and help them and their family to make informed choices.

Information should be given on the basis of the patient’s individual needs in order to be easily understood and provided with the opportunity for discussion<sup>8</sup>. In the Cochrane review (a ‘gold standard’ structured review of research) it was found that nurse practitioners in primary care had at least

<sup>5</sup> Department of Health (2005) ‘*Supporting People with Long-term Conditions: Liberating the Talents of Nurses who Care for People with Long-term Conditions*’. The Stationery Office, London

<sup>6</sup> Meredith, C., and P, Symonds, *et al* (1996) ‘Information needs of cancer patients in west Scotland: cross sectional survey of patients’ views’. *BMJ*; 313:724-726

<sup>7</sup> Fletcher C. (1990) ‘Listening and talking to patients’. *BMJ*; 281:994-6

<sup>8</sup> Meredith, J. (2005). ‘The management of patients with long-term conditions’. *Nursing Standard* (19), 45: pp53-60.





However if the public were more used to discussing workforce factors in care, this may also make it easier for patient organisations to lobby with other hard hitting figures like the above - people may be more receptive to receiving the information.

“...think about marketing...you need to tell people *why* they need to know not just *what* they need to know”

During the discussion it was felt that the NHS has been bad at creating a case for change in the past and hasn't really explained *why* things need to be different. If patients were given this kind of information to inform their choices, maybe providers would have to respond.

Examples were given by delegates where patients were 'campaigning like mad' for specialist nurses. The question was raised – would it be right to say that these patients are 'campaigning like mad' simply because they had read evidence regarding specialist nurse effectiveness or because they had heard stories from other patients they meet at conferences or support groups? A delegate from a specialist patient interest group felt that patients were clear that they were getting good care because they encountered nurses who know about their disease and were able to assist them in all kinds of ways with all kinds of information. They go to great lengths to say they want *these* kinds of services.

“...for the public more generally...could this be like choosing schools based on class sizes, or choosing first class travel?”

For the wider public, it was felt that there would be little 'buy-in' to the workforce evidence simply because they would not generally seek information about local health services unless their health was at risk or they intended to use them. This does not mean that the information is not important, simply that there is a time and a place for this information to be relevant – for e.g. one participant said that she had gone beyond being interested in class sizes as her children had left school, but with some aspects of health need (i.e. those living with long term conditions), there is an on-going interest in the state of health services, even if not actively using them at that point.

From a patient's point of view with little or no understanding of health services, the information may need to be carefully presented. It was felt that there may be parallel workforce/service quality issues in other public services such as education, or even in private sector services like travel.

There is already a perception about what first class means for a range of services such as air travel but it is not so easy in education or in health. How have the public decided that big class sizes are less desirable than smaller class sizes? Similarly, how would the public general know that hospitals with better staffing ratios are better than those with poor patient: nurse ratios?



“...What level should it [this information] be pitched? ... this depends on the market but it’s an important question.”

Delegates agreed it was important to think more about how to put outcomes and workforce evidence out into the public domain. Patients would be concerned to know that one type of health care service has potentially higher outcomes than another. There was a wide ranging discussion about how to identify measure and disseminate quality of care evidence – it was clear that much work remained to be done in terms of determining what is meant by quality.

One delegate remarked that this isn’t simply about academic research. Patients often share stories with friends and families about how they experienced the NHS and that stories can be very valuable feedback for a range of agencies that commission or provide services<sup>11</sup>.

“...don’t miss out on the soft factors such as how it feels to be looked after and the feeling of having nurses around.”

It was confirmed that those ‘soft indicators’ have been discussed before and there is plenty of literature about them. The Department of Health has previously released a document called “Now I feel tall”<sup>12</sup> about patient experiences. It details how such experiences can be used to improve patient services by looking at the ‘emotional experience and the relevance’ of various factors identified by patients from their recent encounters with hospital or community based care. In the publication, patients were asked what they wanted from the hospital experience and those “soft factors” were encapsulated by the DH and set out as good practice standards.

Professionals may also have their own perceptions of what kind of information related to health, treatment and health care delivery should be introduced to the patient<sup>13</sup>. It was felt important from the discussions to present information that is accessible and user-friendly.

“...they [patients] go great lengths to say they want services in a way that works for them.”

The question was posed – how do we inform patients about developments in evidence around outcomes and workforce? Is it just about marketing and putting out leaflets, advertising campaigns, and focus groups? Or is there something more subtle, as discussed – publishing quality of experiences and getting patient stories? It was agreed that more could be

<sup>11</sup> Wilcock, P M., Brown, G., Bateson, J., Carver, J. Machin, S. (2003). ‘Using patient stories to inspire quality improvement within the NHS Modernization Agency collaborative programmes’. *Journal of Clinical Nursing*. Volume 12(3). May, p422–430

<sup>12</sup> DH, (2005). ‘Now I feel tall: What a patient-led NHS feels like’. The Stationary Office; London

<sup>13</sup> Jacobs, V. (2000). ‘Informational needs of surgical patients following discharge.’ *Applied Nursing Research* 13, 12–18.





done to connect empirical evidence with patient experiences to find combination approaches that are meaningful to patients and professionals.

Organisations like the RCN could spend more time in contact with patients and their representative groups, developing understanding of the various issues and finding joint areas of activity and research. It was agreed that both patients and professional groups like the RCN could benefit from strategic alliances such as this which continue to put patients at the centre of policy discussions.

In concluding the discussions, it was felt important that patients have a voice in this debate and help develop meaningful measures that strike very clear chords with the patient experience. Their input could also open up understanding of the 'black hole' between inputs/outputs on one hand and outcomes on the other.

"...lots of things happen in that 'black hole' that we don't know enough about. That isn't right."

## Conclusions



## Participant organisations

Commission for Patient and Public Involvement

Health Link

MS Trust

The National Association for Patient Participation

Parkinson's Disease Society

The Prostate Cancer Charity

The Stroke Association

Which?