Royal College of Nursing

SAFE STAFFING SAVES LIVES

NURSING UNDER UNSUSTAINABLE PRESSURES: STAFFING FOR SAFE AND EFFECTIVE CARE IN THE UK

Acknowledgements

We would like to thank all the members who responded to the last shift survey.

Report authors

Adriana Castro-Ayala, Antonia Borneo, Jessica Holden, Emily Maynard, Paul Oakley and Helen Tamburello.

Contributions from: Amy Dharymple, Victoria Jayne, John Knape, Shelley Lovesay, Monomita Raksit and Lisa Turnbull.

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Foreword

Nursing staff in the UK are being asked to keep going in the face of intolerable pressure, with no end in sight, and too often no meaningful recognition or response to their attempts to escalate risks and issues for patient safety.

This is the third time we have asked members to complete a detailed survey about their last shift and the steady deterioration is clear in the pages that follow. The pandemic and its enduring legacy only part explain today's situation.

Health and care services across the UK are buckling under the mounting pressure. Yet no government in the UK has a credible, costed long-term workforce strategy.

Despite being best placed to do so, governments across the UK do not consistently, transparently and openly ensure the collection and public reporting of sufficient reliable, meaningful data to understand staffing levels and impact on workforce and patient care.

Governments across the UK should be doing everything in their power to demonstrate that they have a firm grasp on workforce requirements to meet population need, and supply, as part of ongoing service planning. It should not be the responsibility of the health and care workforce to capture, report and present data back to the system. And the law must mean that those ministers can be held to account for the planning and the levels of staffing in service.

The contents of this report are part of the new and growing evidence base making the case for effective legislation across the UK, including what enforceable levels and skill of staffing should be in place across care settings.

The results here speak for themselves. The risk to patients, to services and to health and care staff, is simply unacceptable. The complacency from governments across the UK is unacceptable.

Our members are nursing under unsustainable pressure, and governments are risking lives by failing to take urgent action. Together, we are determined to use our position as the leading voice of nursing to be the greatest champion of high-quality patient care.

Pat Cullen
RCN General Secretary & Chief Executive

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> The government is not supporting basic working conditions – there is no way that I will stay in this job long term. It is simply not worth the stress or the low pay."
>
> *Staff nurse, NHS adult acute ward, England*

> I feel that I am always chasing my tail. I am becoming increasingly exhausted and do not think I can keep this up long term. Pay does not reflect this nor make it worthwhile. I wonder on a daily basis why I ever came into nursing."
>
> *Community staff nurse, NHS, Northern Ireland*

> Patient safety is compromised. Higher number of incidents as patients needing support often cannot get it with their named worker. Lots of agency staff, poor continuity, patients feeling unsupported. Permanent staff have such high caseloads that they cannot support patients as they need it. Due to this staff morale is low."
>
> *Registered nurse, NHS mental health community setting, England*

> Staff have been tired. Frustrated that they are doing the job of two or more staff and only getting paid as one. Incidents have occurred with patient care."
>
> *Community learning disabilities registered nurse, independent sector, England*

> Frustrated that we are expected to still provide the same service and care with a reduced number of staff. I feel I am not able to appropriately supervise and support junior members of the team. I feel I'm pulled from pillar to post, trying to juggle everything. Some shifts are relentless with no time for breaks. We are not able to care for patients as we would like yet the expectation is still there."
>
> *Registered nurse, NHS hospital, adult acute ward, England*

About the RCN's last shift survey

In March 2022, we invited nursing and midwifery staff from across the UK to tell us about their experiences of the last time they were at work. The survey provides valuable insight into the realities of staffing levels across the UK, and the impact on our members and the people they are caring for.

Throughout the report we refer to experiences regarding the 'last shift' to mean the last time somebody was at work, although we recognise this is not a universal term across all settings where nursing and midwifery staff work.

The survey was open to all nursing and midwifery staff working in different settings across the UK and we received 20,325 responses. The questions address a number of issues, including adherence to the RCN *Nursing Workforce Standards*, planned and actual staffing levels and how these staffing levels affected patient care and the wellbeing of nursing staff.

We also wanted to know if respondents were able to raise concerns about staffing levels more generally, and how these concerns were addressed, when they did.

The survey also provided respondents with the opportunity to describe in their own words, the impact that staffing levels have had on them and those they care for. Some of these examples are set out within this report.

We have presented data from the 2022 survey, providing comparisons with previous survey iterations in 2017 and 2020, including where responses identifying increased severity of issues is demonstrated.

More information about the respondents' demographics and responses broken down by each UK country can be found in the appendices from page 56.

Executive summary

The complexity and context of the last two years – including the implications of the UK's departure from the European Union and the ongoing consequences of the COVID-19 global pandemic, has highlighted and exacerbated the existing, long-standing issues with health and care workforce supply in the UK, and the impact of this on patient care.

It is widely understood that having the right number of appropriately qualified, competent and experienced nurses protects both the public and the nursing profession. For many years, nursing staff working in all settings across the UK have been shouting about the research evidence base, drawing attention to the impact of growing staff shortages and rising demand on their ability to deliver care that is safe and effective.

The impact of these pressures on patient safety, care outcomes, staff retention and the wellbeing of nursing staff is now beyond concerning. In 2021, the RCN published *Nursing Workforce Standards* which set out what is required for planning staffing levels for safe and effective care across all settings in the UK. They are intended for use by local, regional and national leaders, and by service and professional regulators, as the benchmark for workforce planning quality. We have presented our findings through the lens of the importance of these standards.

Going into the COVID-19 pandemic in January 2020, 73% of nursing staff surveyed by the RCN said that staffing levels on their last shift were not sufficient to meet all the needs of the patients safely and effectively. In 2022, this has risen to 83%.

This year, as set out in the detail of this report, there is an increase in people reporting that in their professional judgement staffing levels are compromising care, that there are not enough registered nurses on shift, that they are seeing increased patient acuity, care that they describe as 'poor' or 'very poor', and they do not have enough time to provide the level of care they would have liked.

Across the UK, nursing staff working in health and care systems have nowhere near sufficient staffing to provide safe and effective care. The survey data presented demonstrates the increasingly damaging impact policy decisions are having on both patients and professionals. Nursing staff who responded to this survey are united in their message that poor staffing levels are preventing the provision of safe and effective care.

This picture varies in all settings but is concerning across the board. In all NHS care settings, 84% of respondents reported that staffing levels were not sufficient compared to 69% working in independent sectors.

Key UK level findings from the 2022 last shift survey data

- Only 25% of shifts had the full number of planned registered nurses on shift.
- Three-quarters of respondents reported a shortfall of at least one registered nurse on their shift (75%, compared to 58% in 2020). The majority were working with 50-74% of the planned number of registered nurses for that shift.
- Only 28% of respondents said that the nursing skill mix (the number and educational experience of nurses working in clinical settings) was appropriate to meet the needs and dependency of patients safely and effectively. 69% of respondents said it was not appropriate.
- Only around one in five (18%) respondents agreed they had enough time to provide the level of care they would like.
- Only around half of respondents said that students held supernumerary status (52%), 39% said they did not. Supernumerary status means that education standards require that they are not to be counted in workforce numbers while learning, due to the risk to student and patients of them being counted as clinical staff.
- 62% reported that patient care was compromised on their last shift (compared to 57% in 2020 and 53% in 2017).
- Four in five respondents (81%) felt that patient care being compromised was due to not having enough registered nurses on the shift.
- 43% of respondents said that due to lack of time they had to leave necessary care undone, up from 38% in 2020, and 36% in 2017.
- One in five (21%) said they felt unable to raise their concerns.
- Even on shifts where 100% of planned registered nurses were present, around one in three (31%) respondents reported necessary care being left undone due to a lack of time.
- Half of respondents (51%) felt “demoralised”. Only 16% felt “fulfilled”.
- Almost two thirds of respondents (61%) were unable to take the breaks that they were supposed to take.
- Almost two thirds of respondents worked additional time (63%). Of these, almost eight in 10 (77%) were unpaid for these additional hours.
- 87% of Black respondents who worked within the NHS reported working unpaid additional time compared with 77% respondents from a White British background.

These findings present a clear picture of unsustainable staffing levels in health and care services in the UK, in which it is not possible for patient safety to be protected. We see nursing staff working unpaid hours to deliver for their patients, and too many telling us they are unable to report concerns.

These results support the existing evidence that staffing levels, particularly in relation to the proportion of planned registered nurse numbers filled for a shift, impact directly on quality of care and patient safety. Moreover, results indicate that even the full

complement of planned registered nurses is often not sufficient to provide safe and effective care. This suggests that services are not able to plan effectively to meet the needs of patients, possibly due to the knowledge that overall available workforce supply cannot match what is really required.

Staffing for safe and effective care is dependent on robust policy and investment by governments. As a minimum, every country in the UK must have government accountability for the health and care workforce enshrined in legislation. This must include a government funded health and care workforce plan, which ensures that the health and care workforce is equipped with the numbers and skills to provide safe and effective care to meet population demand and is adhering to the workforce standards published by the RCN (2021). Without this, the current unsustainable pressures remain unresolved, with patients and staff continuing to pay an unacceptable price.

> “Recently, our insufficient staffing meant that patient care, health and wellbeing suffered – unquestionably. There have been scenarios where nurses who are from different DN teams have been visiting our patients for a number of visits due to skill-mix/staffing numbers issues, and on some occasions this has meant that for instance, required dressings such as compression bandaging have not been re-requested and so patients have gone on to be without that therapy. Subtle signs of deteriorating health have been missed until patients are acutely and sometimes critically unwell, and so patient visits have not been forward planned correctly due to communication breakdown, leading to omissions of care entirely.”
>
> *Community staff nurse, NHS, Scotland*

> “In terms of our staff, one nursing staff member had a breakdown while at work a few weeks ago due to the burden of anxiety and physical strain she was experiencing relating to our poor staffing – that staff member had as yet not been able to return to work as they are not psychologically well enough to do so. I personally am feeling for the first time in my six-year career as a registered nurse that I may not be able to continue – I absolutely love my job, but I’m so heartbroken by the fact that I know I can’t provide care as I would like to right now, that I’m no longer sure that I can carry on myself without physically and mentally burning out myself. I’m worried about the future for myself, my colleagues and most of all for my patients and their loved ones.”
>
> *Community staff nurse, NHS, Scotland*

Staffing levels

We asked those with knowledge of both planned and actual staffing levels to tell us how many staff were on their last shift, and how this compared to the planned numbers.[1] This is known as the planned 'establishment' and should reflect the appropriate numbers and mix of skilled staff to meet the needs of patients in that service, and the expected severity of patients' illness or condition (known as 'acuity'). The RCN *Nursing Workforce Standards* state that when calculating the nursing workforce, consideration needs to be applied which allows for the management of planned and unplanned absence, for example study leave, annual leave or sickness. If the staffing levels are underestimated, this can result in an establishment that cannot meet day-to-day staffing requirements and care can be compromised.

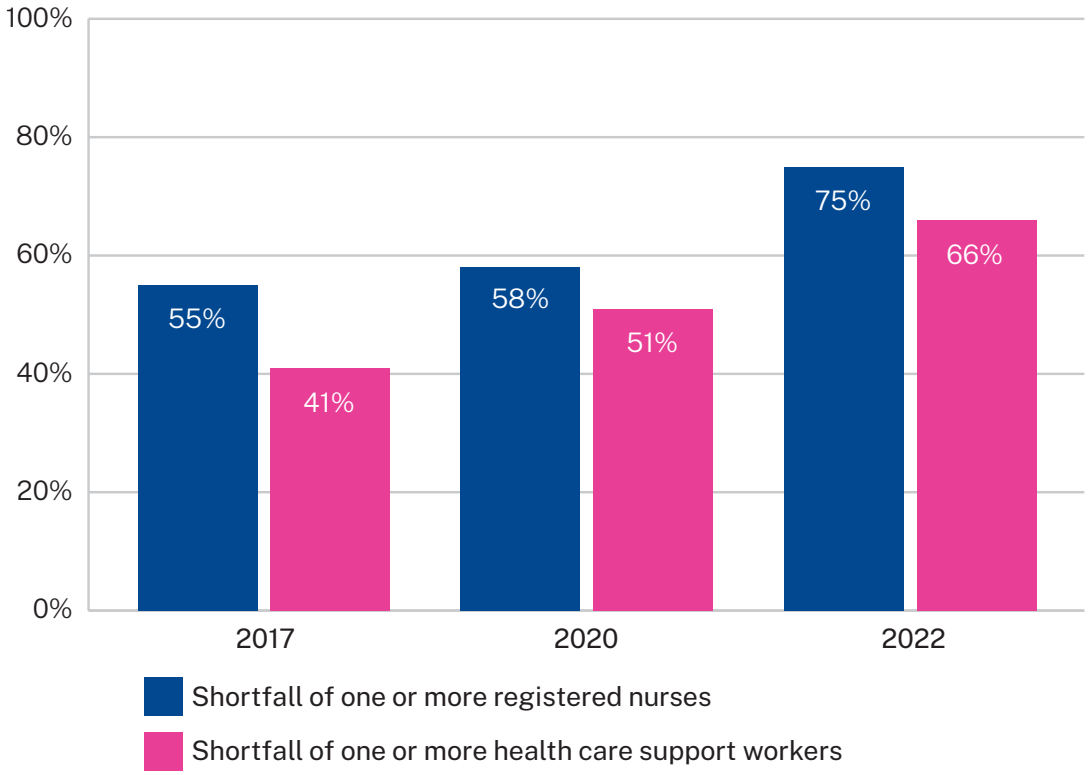
Mounting evidence shows the increased risk that comes with lower registered nurse staffing levels and higher numbers of patients per registered nurse. For example, increased risk of death during admission to hospital (Lasater et al., 2021, Griffiths et al., 2019, and Ball et al., 2018). In comparison, a higher proportion of registered nurses in hospitals is associated with lower mortality rates, higher patient ratings of their care and fewer adverse care outcomes (Aiken et al., 2017).

The RCN *Nursing Workforce Standards* clearly state the nursing workforce falling below 80% for a department or team should be an exception and be escalated quickly. Overall, across the UK, only 25% of shifts had 100% of the planned registered nurses on shift. Therefore, three-quarters (75%) of respondents reported a shortfall of at least one registered nurse on their shift. This compares to 58% in 2020 and 55% in 2017, demonstrating a considerable increase in reported shortfall.

The majority of shifts reported in 2022 worked with 50-74% of the planned registered nurses, which is below the 80% threshold stipulated by the *Nursing Workforce Standards*. As shown in Figure 1 opposite, this reported staffing shortfall was not limited to registered nurses. Only 34% of shifts reported had 100% of the planned health care support workers, with almost seven in 10 (66%) shifts had a shortfall of at least one health care support worker.

1 We analysed responses from those who gave both planned and actual numbers of staff on each shift.

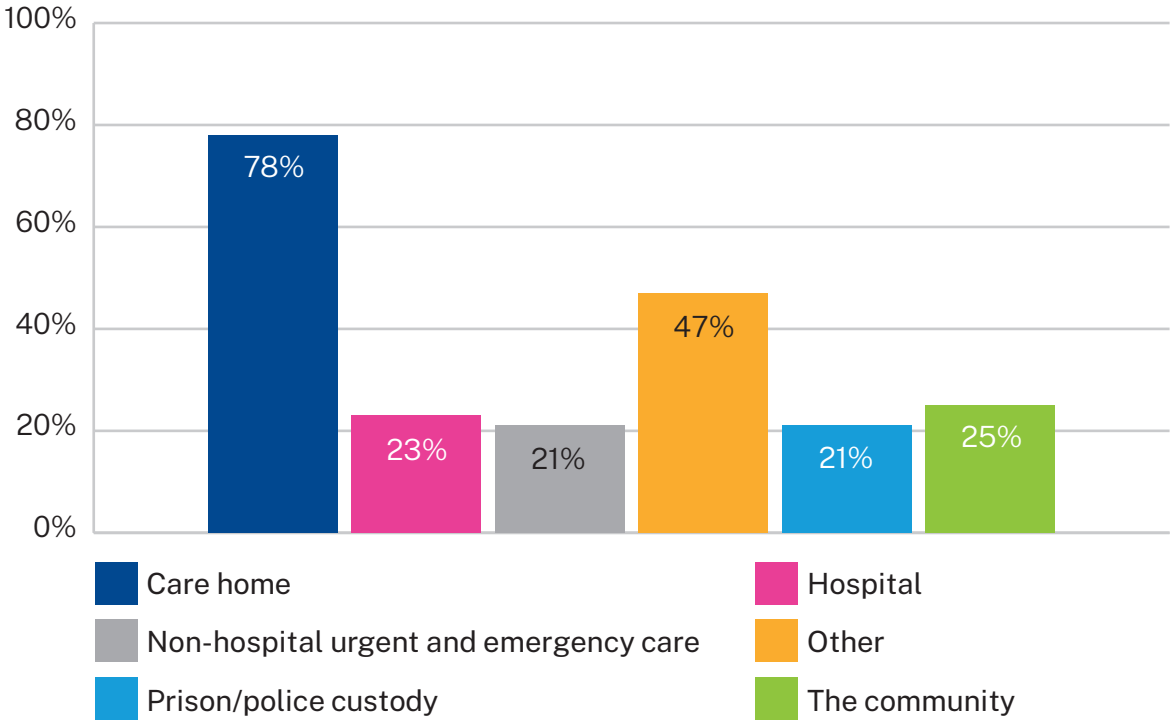
Figure 1: shortfall of nursing staff – 2017, 2020 and 2022



Results shown in Figure 2 overleaf also demonstrate variation across care settings, where respondents have reported that they have 100% or more of the planned registered nurses on their last shift.

> Patients are not able to get the same degree of care. My caseload was doubled and I was expected to do the work of two nurses as well as support a newly qualified nurse on shift. There was only myself and a newly qualified nurse on shift to care for 30 patients. It's not physically possible to do this. I subsequently found out that senior hospital management were aware of the unsafe staffing levels of all wards within the hospital the day before. All wards were short of trained staff.
>
> Only one staff nurse position was escalated to agency and that was for a surgical floater. This is not acceptable. Senior hospital management seem to be more concerned about budgets than patient safety and I feel that they don't care about staff wellbeing and we are not appreciated at all. Feel demoralised and I could leave the profession as there is no job satisfaction and I am unable to provide safe and effective care for my patients."
>
> *Registered nurse, NHS hospital, older people's ward, Scotland*

Figure 2: shifts with 100% or more of the planned registered nurses by broad care setting



Our findings show that nursing staff are working with staffing levels below what is acceptable and unsafe staffing levels are no longer an exception but instead becoming the norm.

> One day I walked into my shift, and I was told everyone who was supposed to be on that same shift had phoned in sick and I was on my own on the entire floor. We only managed to get staff to come in and cover three hours later. I can't describe how I felt at the end of that shift, emotional, physically and the feeling of letting the service users down for not meeting their needs, and no breaks. With COVID-19 this has been the new normal in the health sector, inadequate staffing.
>
> Are nurses being enslaved in the UK? Well YES. I am expected to do a job for three people each day and I get paid way less than what should be paid one person. Something should be done about the staff shortage and fast otherwise nurses will be forced to leave one by one and the few remaining will die of stress and burnout."
>
> *Registered nurse, independent sector, care home, Scotland*

Reliance on temporary staff

Good workforce planning includes access to a contingent temporary workforce to manage vacancies and to have nurses available to be responsive to patient needs, including the severity of their need. This enables flex in staffing capacity as demand fluctuates. As identified in the RCN *Nursing Workforce Standards*, bank and agency work provide services and nursing staff with flexibility on both an individual and an organisational level. The findings here demonstrate a clear over-reliance in some settings which does not adhere to what is required to staff for safe and effective care.

However, this must be carefully managed, as an over reliance on temporary staff is associated with an increase in clinical risk as they may require a level of orientation and supervision that substantive staff – already under pressure – may find difficult to provide. When the proportion of temporary staff becomes too great, this impacts the quality of care provided as temporary staff are less likely to know the service, the patients well, or the local geography, and therefore less able to efficiently and effectively meet the needs of patients.

Nearly half (47%) of respondents said that on their last shift they had at least one or more agency or bank nurses working, compared to 37% in 2020 and 42% in 2017.

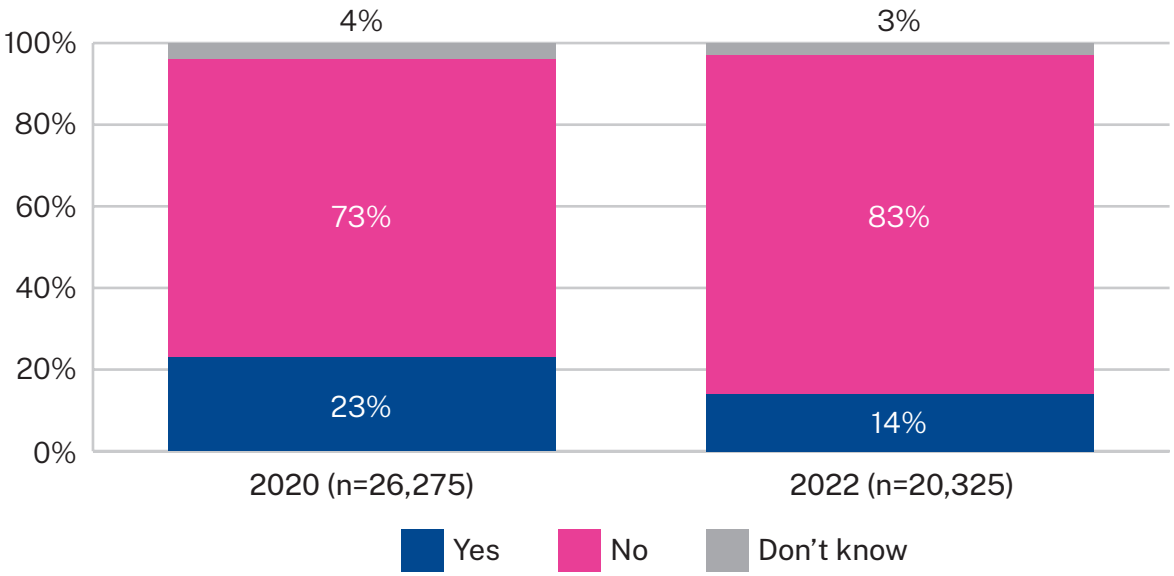
Respondents working in the NHS were more likely to report that temporary staff members were utilised (48%) than respondents in independent sectors (33%).

13% of respondents working in a care home said that 100% of the registered nurses on their last shift were agency or bank nurses. This finding indicates temporary staff are not only being used to cover unplanned situations, but also bank and agency nursing staff are being planned as an integral part of the workforce. This presents a risk to the quality and safety of care, since temporary staff, despite their best efforts, will not have the same level of familiarity with the service or patients as permanent staff, which could lead to mistakes being made more easily. It also demonstrates that care homes often struggle to recruit and retain permanent nursing staff, particularly in light of different wages, working conditions and lack of professional development.

Sufficient staffing levels to meet the needs and dependency of patients

83% of respondents said that the staffing levels on their last shift were not sufficient to meet all the needs and dependency of the patients safely and effectively (compared to 73% in 2020).

Figure 3: sufficient staffing levels to meet the needs and dependency of patients, 2020 and 2022



Respondents working in the NHS were more likely to report that staffing levels were not sufficient (84%) than those working in independent sectors (69%).

Figure 4 opposite shows reporting of sufficient staffing levels also varied by care setting.

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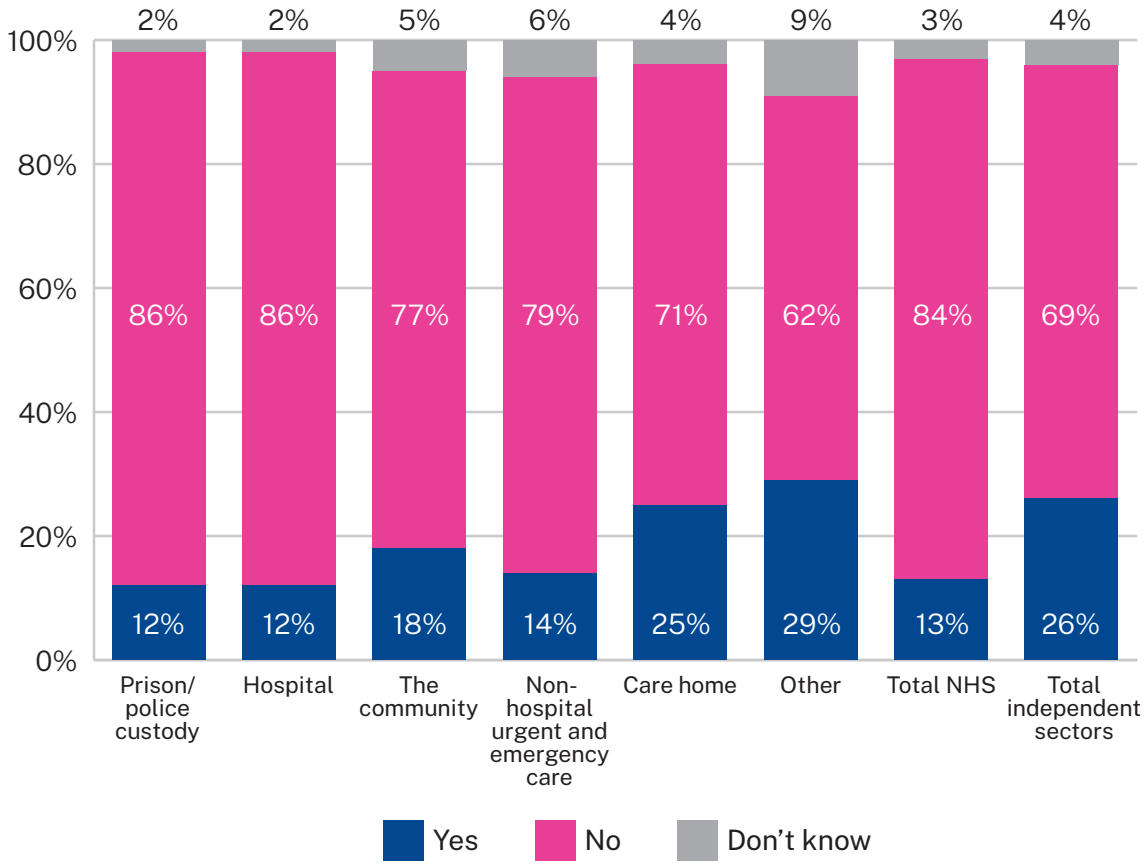
Figure 4: sufficient staffing levels to meet the needs and dependency of patients, by care setting and NHS/independent sectors



Results also show a clear link between the levels of planned registered nurses on their last shift with reported ability to meet the needs of patients safely and effectively. When there were between 25-49% of planned registered nurses on shift, 97% of respondents reported that staffing levels were not sufficient.

When 100% of planned registered nurses were on shift, 58% of respondents reported that staffing levels were not sufficient to meet patient's needs. This indicates that while higher staffing levels are linked with being better able to meet patients' needs, the full planned establishment is still not sufficient.

The overwhelming majority of respondents, across all settings, reported that the actual staffing levels on their last shift were not sufficient to meet patient need. This is the case even when 100% of the planned establishment of nurses are on shift, suggesting that workforce establishments are not being planned based on service demand or patient need.

These staffing gaps are in direct contradiction of the RCN *Nursing Workforce Standards*, which state that registered nurse and nursing support worker establishments should be set based on service demand and the needs of people using services, placing additional pressure on nursing staff and putting patient safety at risk.

> I have worked in several settings throughout my nursing career and been working for the NHS for 25 years, there have always been staffing issues and the ratio of staff to patients has never been good, it is a constant battle trying to provide the best care you can, some days are good and some are bad, it's stressful, hard work and at times you think that leaving the profession would be better for your mental health but when it's all you've known and on good days you love the job you can't just leave!
>
> You leave work some days and could cry and feel demoralised cause you can't always give the time to patients that you would like or they deserve, nursing is not for the faint hearted it definitely hard work and stressful!"
>
> *NHS community staff nurse, England*

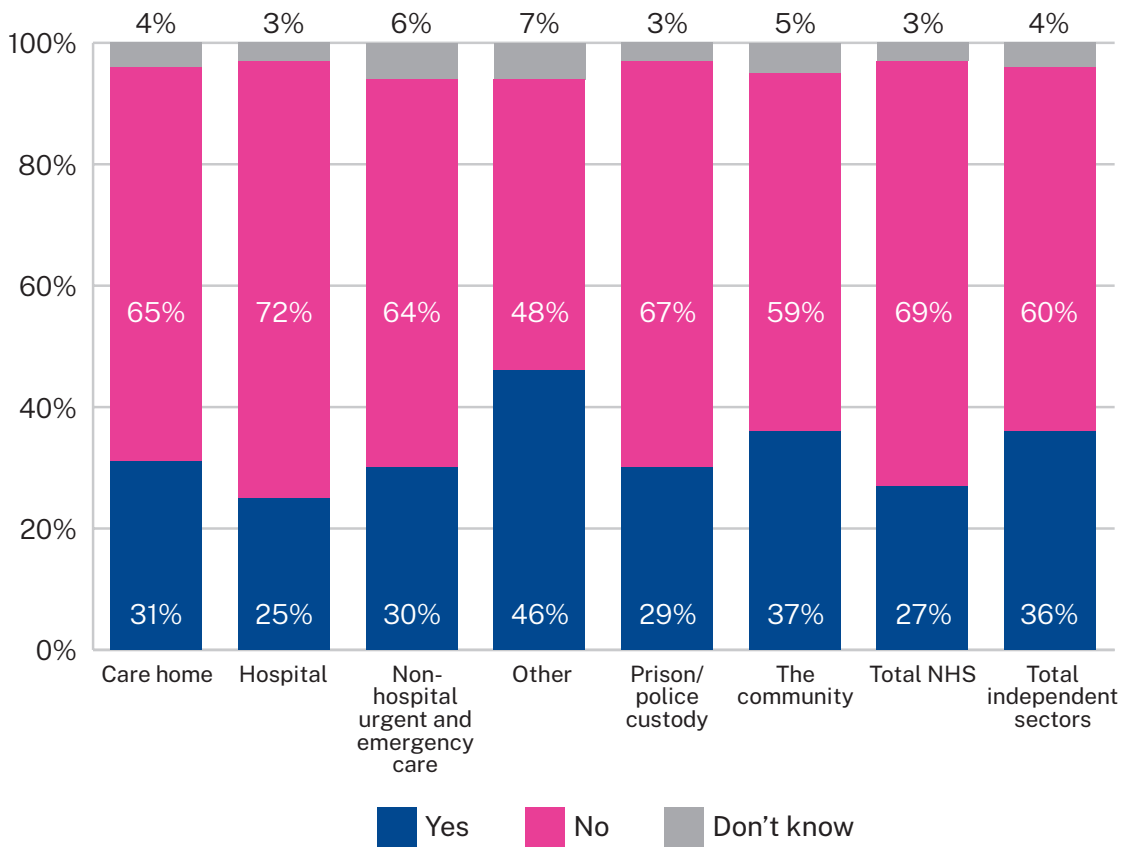
Skill mix

Beyond staffing numbers, the spread of skills across the nursing team as well as the balance between registered nurses and health care support workers needs to be planned in order to meet the needs and dependency of the people being cared for. This is referred to as the "skill mix". As with temporary staffing, skill mix is another example of where "who" is just as important a consideration as "how many". The education level, practical training, skills, and experience that nursing staff hold need to be considered when determining how many staff are needed, and when setting the skill mix.

Only 28% of respondents said that skill mix was appropriate to meet patients' needs safely and effectively. 69% of respondents said skill mix was not appropriate. This varied by care setting, as shown in Figure 5 opposite.

Responses by staff group were similar, with 64% of health care support workers reported that the skill mix was not appropriate, compared to 70% of registered nurses.

Figure 5: was the skill mix appropriate to meet the needs and dependency of the patients/service users safely and effectively?



Respondents working in the NHS were more likely to report that the skill mix was not appropriate (69%) than those working in independent sectors (60%). Those working in a hospital were more likely to report that the skill mix was not appropriate (72%) compared to those working in the community (59%).

Around half (51%) of those with 100% of planned nurses working the shift reported that the skill mix was appropriate. Of those reporting less than 50% of their planned registered nurses, only 12% said that the skill mix was appropriate. This demonstrates a clear link between planned number of registered nurses and assessment that the skill mix was appropriate.

Supernumerary status of lead nurses and students

The RCN *Nursing Workforce Standards* state that each team or service that delivers nursing care will have a registered lead nurse. Supernumerary status means that the student or lead nurse must not be counted in the numbers of nursing staff providing direct care to patients.

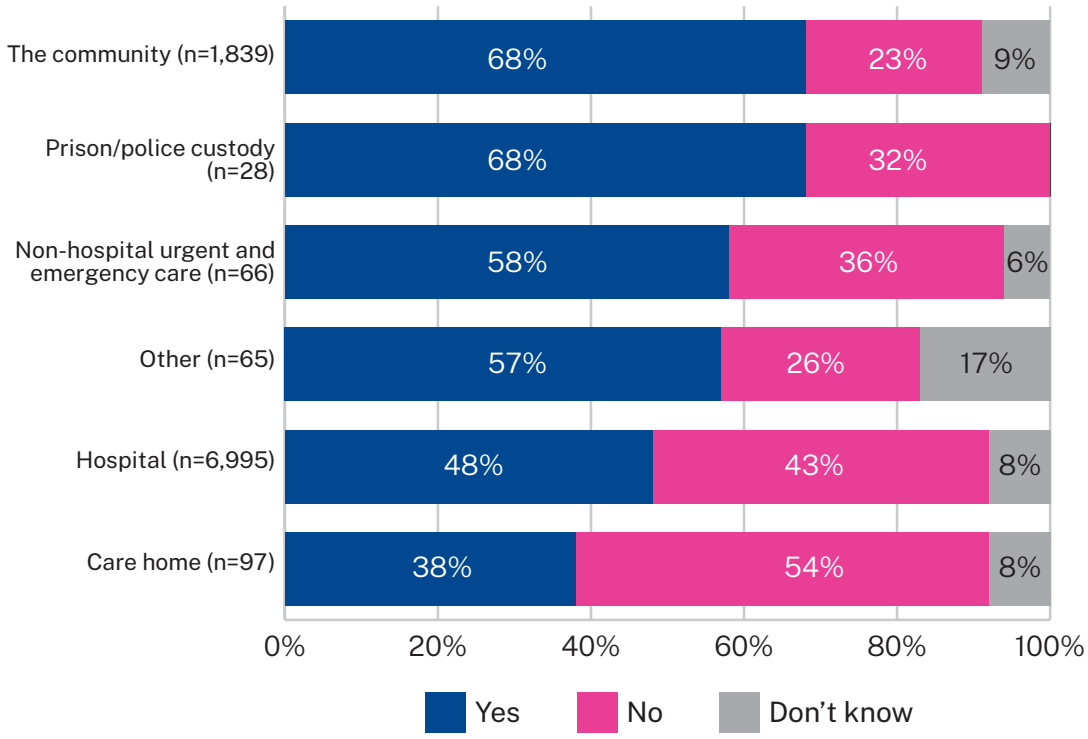
The RCN is clear that the role of the senior nurse should be protected, as they need space and dedicated time to be able to manage the team, make decisions and deal with situations that may arise, and therefore should not be counted within the staffing numbers for that shift.

Only around one in four respondents told us the lead nurse held supernumerary status on their last shift (22% in the NHS and 23% in independent sectors). This is concerning as it means that the lead nurse on shift is not able to help reduce their team's workload when service delivery is too much, identify risks and resolve them as they themselves are included in the staffing numbers. Good practice in leadership comes from having the time and resource to lead. Our survey responses show that this is challenging and can be hard to achieve across multiple workplace settings, especially when staffing levels are not safe.

All students undertaking pre-registration nursing and midwifery programmes are required to have supernumerary status by the Nursing and Midwifery Council (NMC) while on clinical practice placements. This means that they must be additional to the workforce requirement and staff on duty on each shift, and not counted as part of the workforce. As a result of staffing shortages students are often having to assist registered nurses and health care support workers when they are supposed to be actively learning, putting both the student and patients at risk (NMC, 2019).

Only 52% of respondents said that students learning on the shift held supernumerary status. 39% said they did not have this status, and 8% reported not knowing. This was similar for respondents working in the NHS and independent sectors but varied across care settings.

Figure 6: supernumerary status of students by care setting



Respondents were also more likely to report that students held supernumerary status when there was a higher percentage of planned registered nurses on shift. Of those reporting 100% of the planned registered nurses being on shift, 64% reported that students held supernumerary status.

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However, of those reporting that 25-49% of the planned registered nurses were on shift, only 47% reported that students held supernumerary status. This finding suggests that when there is a shortage of registered nurses, students are more likely to be counted in the registered nurse numbers, which is not acceptable – in terms of risk to the student and to patients.

> "As a student nurse, when staffing levels have been bad I have been expected to fill the gap of a nurse. As the ward was short staffed there was very little support while doing this and I felt very overwhelmed. This is not a one off/every once in a while situation. I almost dropped out due to stress and had to start taking sleeping tablets due to being too anxious to sleep after shifts."
>
> *Student nurse, NHS hospital, adult acute ward, Scotland*

We can see from the results presented in this chapter the nature of pressures that nursing staff across the UK are forced to work under. The nursing shortfall described here has grown steadily worse with each iteration of this survey. While the shortfall of just one registered nurse has an impact on care quality and safety for patients, this also increases the pressures on nursing staff who are on shift. The vast majority of respondents across all NHS and independent sector settings are saying clearly that staffing levels are not sufficient to meet patients' needs.

The fact that so many shifts are running on half to three-quarters of the planned nursing establishment demonstrates clearly what RCN members have been consistently describing about current pressures, and as set out in the next chapter, relates directly to quality and safety of patient care.

We are concerned to see in the survey data that even shifts fully staffed according to the planned establishment are not deemed by experts as sufficient to meet patients' needs. This reveals a potential issue with effective workforce planning, potentially due to the known constraints in overall supply, recruitment and retention of the nursing workforce. This means that the true workforce shortage is also not transparent, and that the extent of the pressure is potentially masked to the service, and to policy makers.

The data also reveals an alarming reliance on temporary staff, reaching 100% of service staffing in some independent sector services, presenting considerable risk to staff and patients, and is perhaps a clear gauge of the insufficiency of current nursing workforce supply.

Staffing is not only about 'numbers' but the right blend of skill and experience is also crucial to safe and effective health and care services. Yet this survey data sets out that a significant majority of respondents experience that skill mix is not sufficient. A registered nurse cannot be replaced by an unregistered staff member and nor can an individual, inappropriately substituted in this way, be held to the same level of responsibility and accountability. We consider it unsafe due to the significant difference in education, training and experience. Nursing students who are yet to qualify and the lead nurse too,

must not be counted in staffing numbers and we are concerned that these responses demonstrate the opposite. Unfortunately, each time we have conducted this survey of members the responses demonstrate increasing levels of unsafe practice and risk.

This data presents a range of signals that staffing levels are not safe, with the pressures and risks mounting every time we ask nursing staff at the frontline how things really are.

> “I have been struggling with ongoing staff shortages for a long time and still trying to manage a hectic caseload with relentless new referrals (palliative care). My sleep pattern has been disrupted. I am experiencing numerous stress symptoms and highly anxious and feel psychologically and emotionally damaged. I am trying to rebuild for returning to work.”
>
> *Clinical nurse specialist, NHS hospital, Northern Ireland*

> “Tired, mentally and physically drained, emotional due to low staffing levels. Expected to do same amount of work with far fewer staff. At times 50% less staff. Staff always get moved to help other areas and leaves us running short. I regularly carry three phones at present – patients have started to notice this and ask about why I need three phones. But I can’t turn around and say it’s because there’s no other staff to answer them.
>
> Every shift just now is a marathon that feels like you are never near the finishing line.”
>
> *Sister, NHS hospital, Scotland*

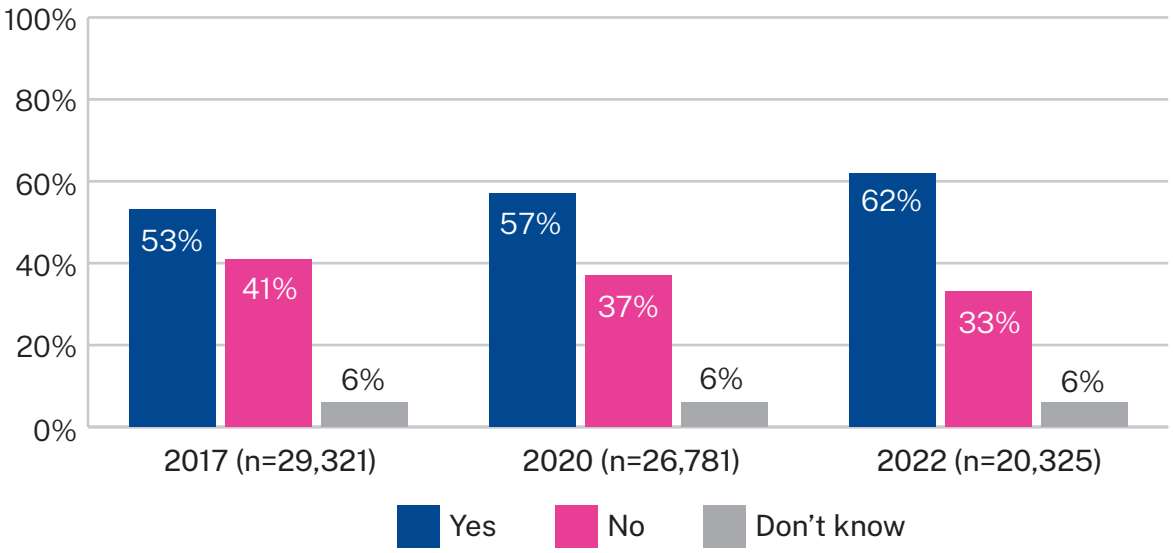
Impact of staffing levels on patient care

A strong and growing body of evidence that shows that the patient outcomes affected the most by registered nurse staffing numbers are mortality, care quality, missed care and adverse events (for example, infection, pressure ulcers, medication errors). There is also evidence of a positive association between an appropriately planned nursing skills mix and patient safety outcomes (Sworn and Booth, 2019). We asked respondents how the staffing levels reported affected patient care.

Care compromised

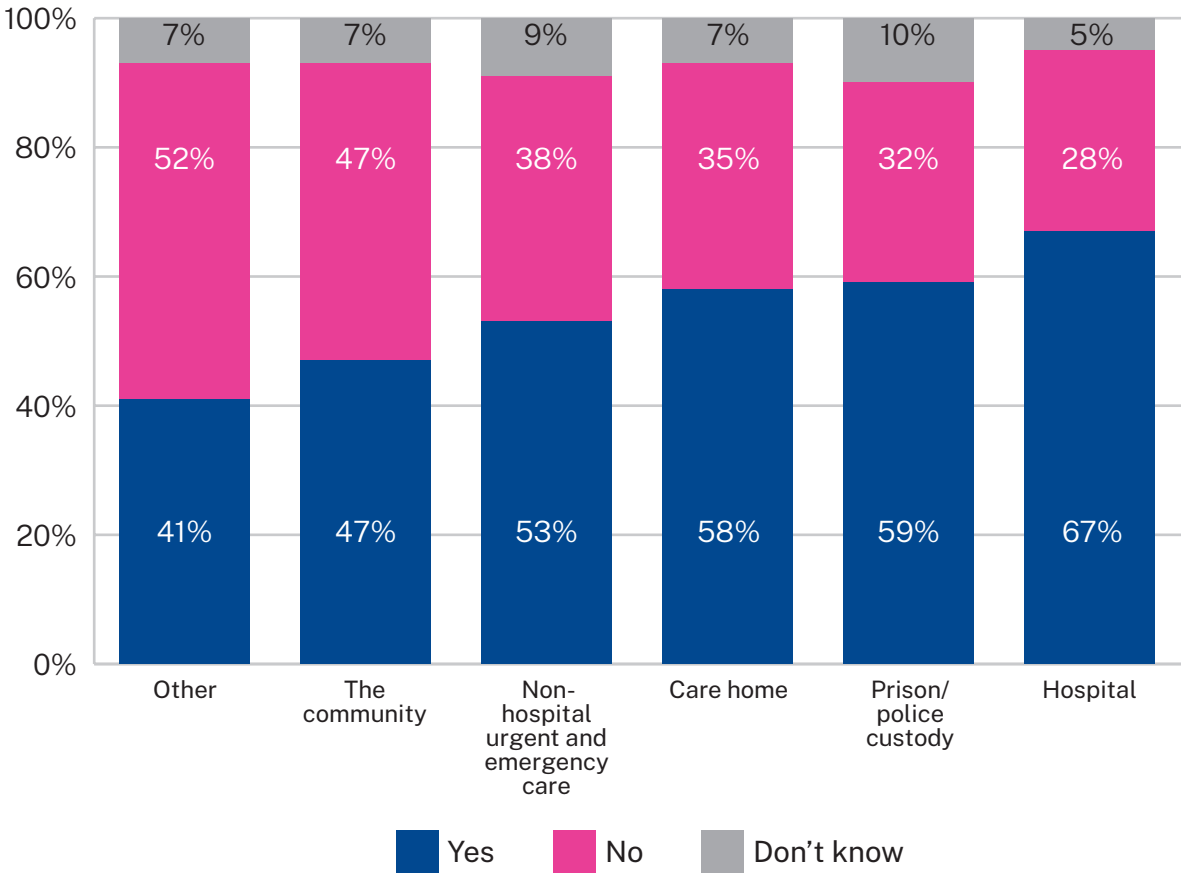
62% of respondents felt that patient care was compromised on their last shift (compared to 57% in 2020 and 53% in 2017). Across the UK, only a third (33%) said care was not compromised (down from 37% in 2020 and 41% in 2017). Responses varied by UK country, details of which can be found in Appendix 2.

Figure 7: care compromised – 2017, 2020 and 2022



Respondents working in the NHS were more likely to report that care was compromised (63%) than those working in independent sectors (51%). There were also differences between settings (as shown in Figure 8 overleaf); respondents working in hospitals were most likely to say that care had been compromised (67%), compared to 47% of those working in the community.

Figure 8: care compromised by care setting

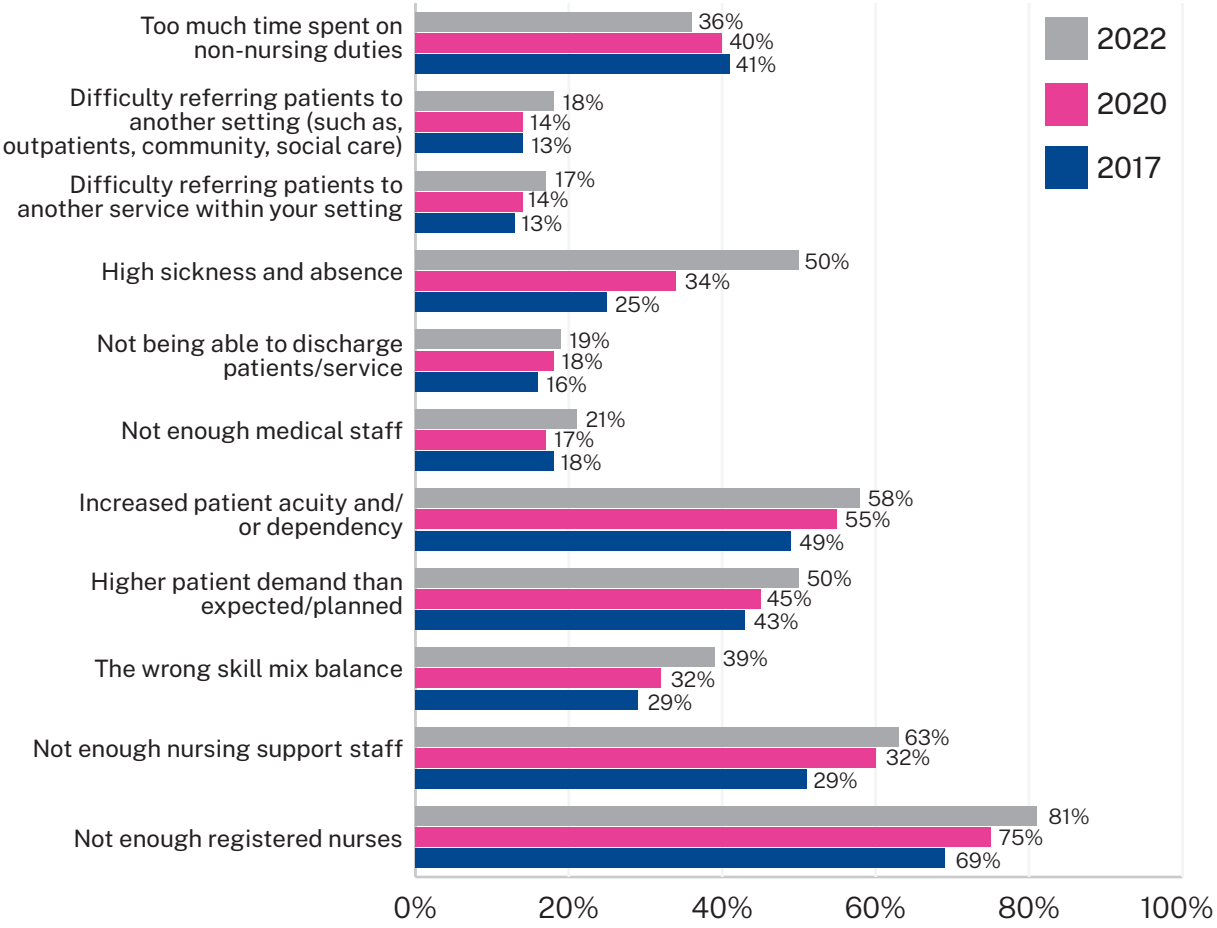


On shifts where there were fewer registered nurses than planned, respondents were more likely to report that care was compromised. Where there were 100% of the planned registered nurses on shift, 44% reported that care was compromised. However, when there were 25-49% of planned registered nurses on shift, 77% of respondents said that care was compromised. This demonstrates a clear link between staffing levels and care quality.

Respondents were asked, in their professional judgement, what they felt had the most significant impact on their or their team's ability to deliver high quality care. We explored these reasons given by those respondents who said that care had been compromised, shown in Figure 9 opposite.

Four in five (81%) of respondents felt that not having enough registered nurses on shift impacted on their team's ability to deliver high quality care (compared to 75% in 2020 and 69% in 2017).

Figure 9: reasons that impacted the ability to deliver high quality care – 2017, 2020 and 2022



Over one-third (35%) of those who reported being on shift with 100% of their planned registered nurses said they felt care had been compromised because of not having enough registered nurses. This suggests that even the planned number of registered nurses for these shifts was not sufficient for the delivery of safe and effective care.

Reports of compromised care increases to 93% for respondents where there were 50-74% of their planned registered nurses on their last shift.

Reasons for care being compromised also varied between the NHS and independent sectors (as shown in Figure 10 overleaf).

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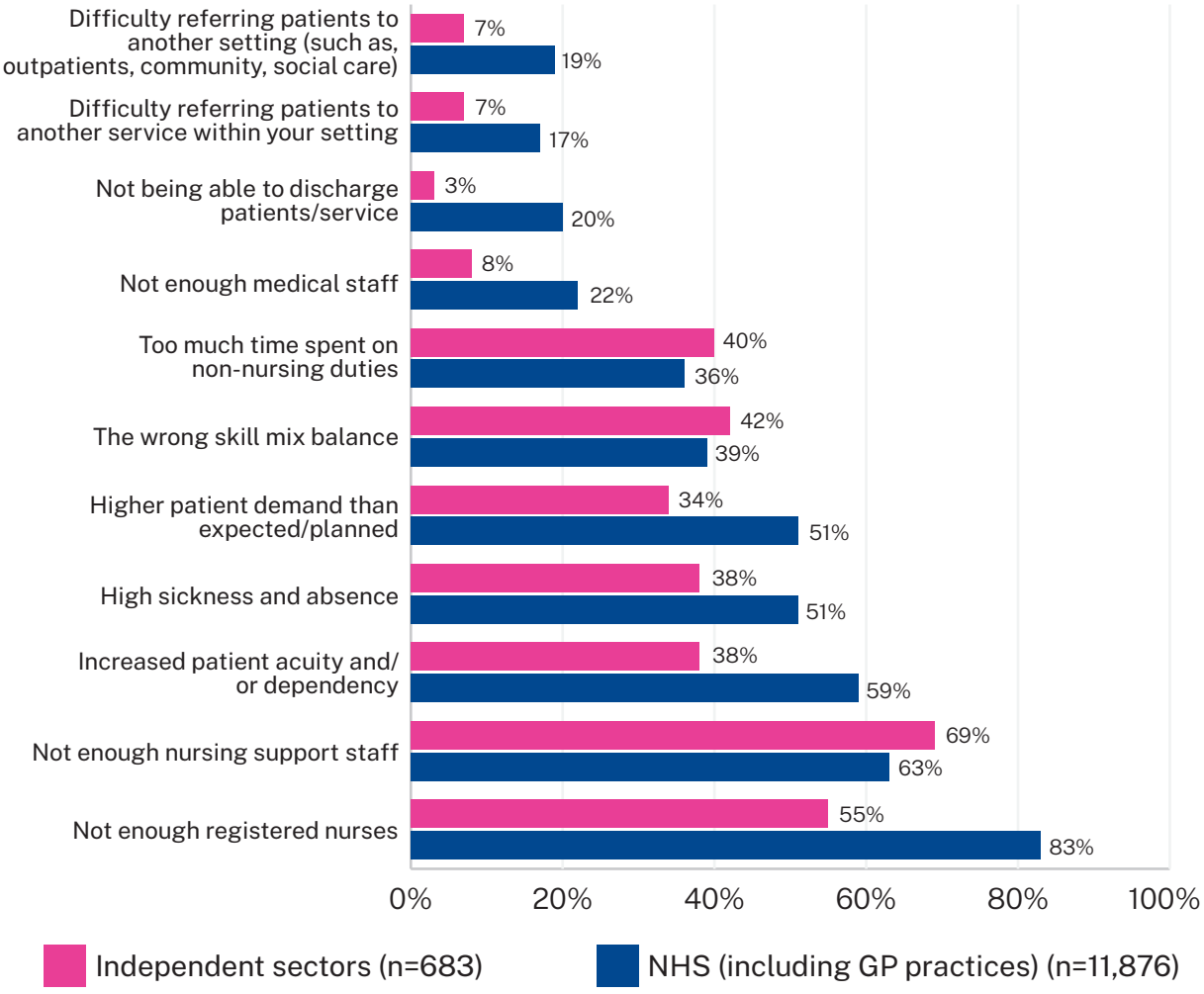
Figure 10: reasons that impacted the ability to deliver high quality care – NHS and independent sectors



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> As a critical care nurse who worked throughout the pandemic under immensely challenging conditions, where staffing levels were at an all-time crisis and continue to be today... I ended up facing crippling anxiety and got diagnosed with PTSD due to worries surrounding unsafe staffing levels/compromised patient care due to inexperienced staff and/or unsafe patient to staff ratios.
>
> Myself and my colleagues are mentally, physically and emotionally exhausted/burnt out which has resulted in, and continues to result in, many leaving the profession causing a continued domino effect. If these issues are not addressed, more and more nurses will leave the profession due to burn out, and patient care will continue to be compromised. The care we are expected to give has to be recognised in the pay we receive."
>
> *Registered nurse, NHS hospital, Scotland*

Care left undone or taking place in inappropriate environments

Across the UK, around two in five (43%, up from 38% in 2020 and 36% in 2017) respondents said that due to lack of time on their last shift they had to leave necessary care undone. Almost one in four (23%) said that clinical care took place in an inappropriate environment (up from 21% in 2020) when we first asked this question.

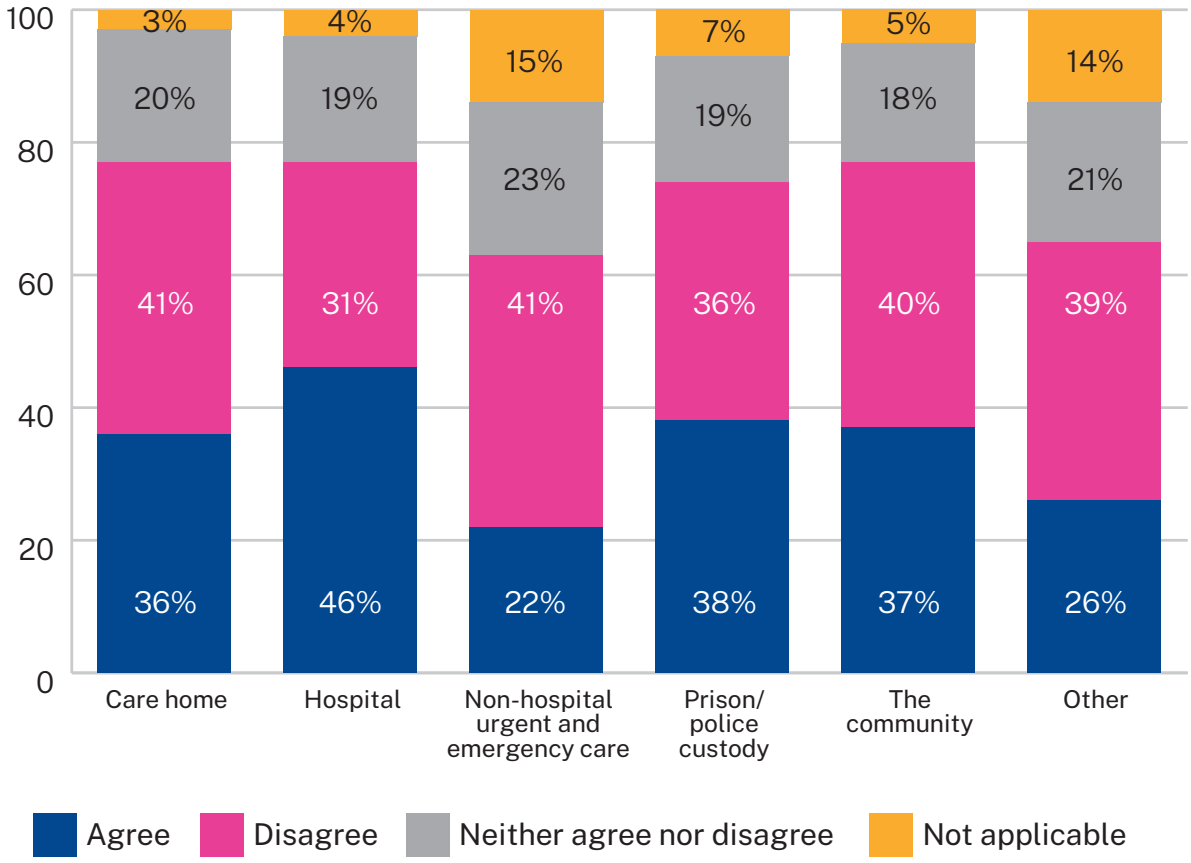
43% of NHS respondents reported having to leave necessary care undone due to a lack of time, and 24% said clinical care took place in an inappropriate environment compared to 33% and 14%, for those working in independent sectors, respectively.

Approximately 27% of respondents working in a hospital reported clinical care taking place in an inappropriate environment, such as waiting rooms and corridors, compared to 14% in the community, 13% in non-hospital urgent and emergency care and 12% in care home settings. Out of 146 responses from nursing staff working in prison or policy custody setting, 46 (32%) told us that during their last shift care took place in an inappropriate environment.

> When I was working in the COVID-19 area I felt every day I was delivering substandard care. One nurse to anything up to 20 patients, some very ill needing Cpap/aerosolation of oxygen, you could be with an ill patient for a long time (up to an hour or more) and not cast eyes on any other of your patients.
>
> Despite asking for help/raising concerns I neither got help nor were my concerns treated with respect. Due to lack of space I had to treat and triage patients in corridors and rooms designed for other uses. This lack of privacy and respect left me feeling helpless and totally demoralised."
>
> *Registered nurse, NHS hospital, A&E/urgent and emergency care, Northern Ireland*

More than two in five (46%) respondents working in a hospital said necessary care had been left undone due to a lack of time. Necessary care left undone was reported at 37% for those working in community settings and 22% in non-hospital urgent and emergency care, (such as, call centres, walk-in centres, home visits, etc.). Figure 11 shows the variation in findings across care settings.

Figure 11: necessary care left undone due to lack of time by care setting



Even on shifts where 100% of planned registered nurses were present, around one in three (31%) respondents reported necessary care being left undone due to a lack of time on their last shift. This again suggests that even the planned establishment of registered nurses for these shifts was not sufficient to allow registered nurses the time to deliver the care that was needed.

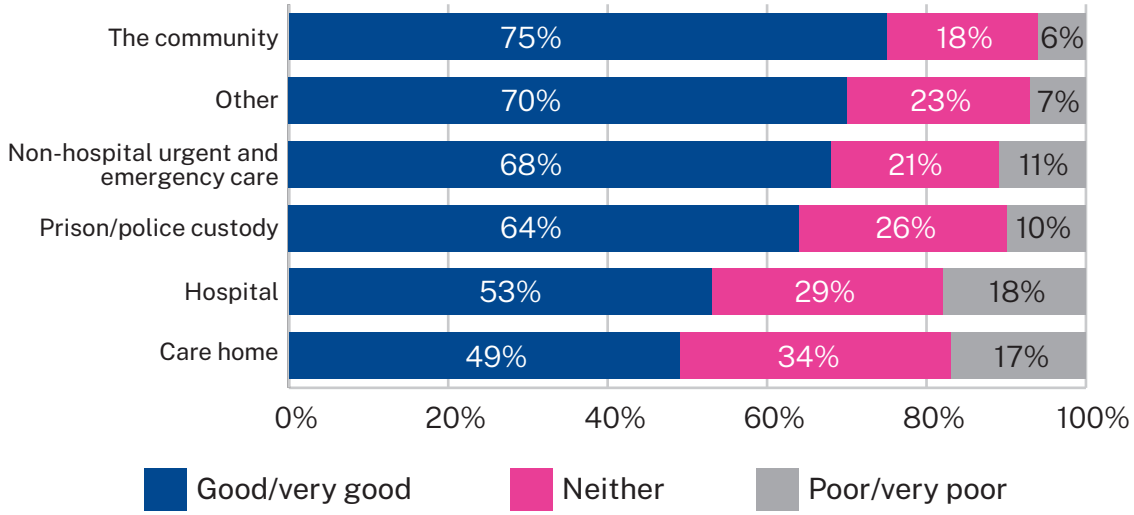
> Missed meds for patients who have been seen outside on ambulances, deterioration of a patient in the waiting area that went unnoticed, insufficient skin care and toileting. It's unacceptable, I wouldn't want my family cared for here. We are doing our best but it's just not good enough."
>
> *Sister, NHS A&E department, Wales*

Quality of care

We asked respondents to rate the overall quality of care on their last shift. Almost six in 10 (58%, compared to 61% in 2020 and 68% in 2017) rated it as either good or very good. Over a quarter (27%, compared to 26% in 2020 and 23% in 2017) reported it was neither good nor poor. Around one in eight (15%, compared to 12% in 2020 and 9% in 2017) told us it was poor or very poor. Ratings varied across care settings, show in Figure 12.

> As nurses we continue to push to provide a high quality of care. Without enough staff to do this, nurses are working above and beyond, with increased patient numbers, less breaks and longer shifts. All unpaid. Nurses are exhausted and burnt out.
>
> The pandemic has taken a two-year toll on ICU nurses and there is no sign of that changing as staffing numbers continue to fall as capacity grows. Levels of sickness are very high and include much more psychological illnesses than previously seen. PTSD, depression, stress and anxiety seem commonplace."
>
> *Sister, NHS hospital, Scotland*

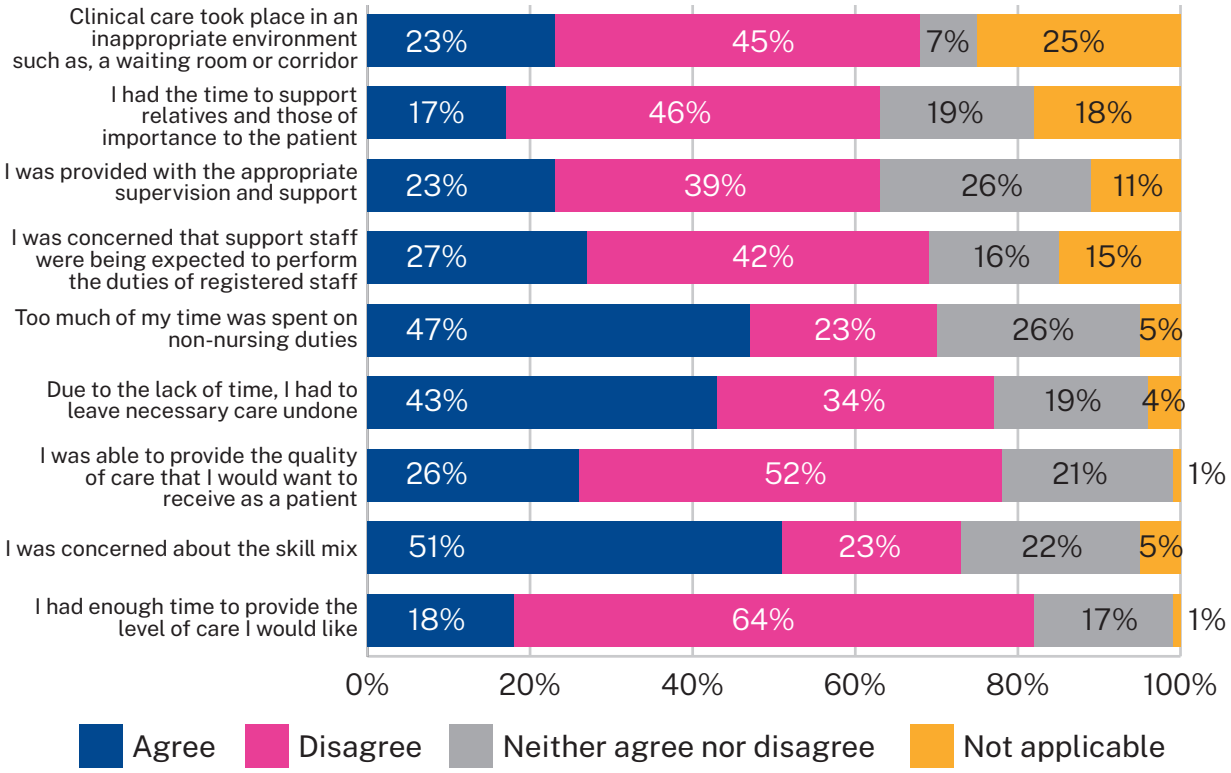
Figure 12: quality of care rating by care setting



There was also a difference in responses depending on the percentage of planned registered nurses on shift. Of the respondents reporting 100% of the planned registered nurses being on shift, 71% rated quality of care as good or very good. However, of those reporting 25-49% of the planned registered nurses being on shift, only 46% rated quality of care as good or very good. Adding to existing research evidence, these findings clearly demonstrate the link between having a full establishment of registered nurses and being able to provide higher quality care for patients.

Figure 13 shows to what extent respondents agreed or disagreed with a series of statements regarding their experiences during their last shift at work and its impact on their ability to provide safe, quality care and some of the reasons why.

Figure 13: impact of staffing levels on patient care

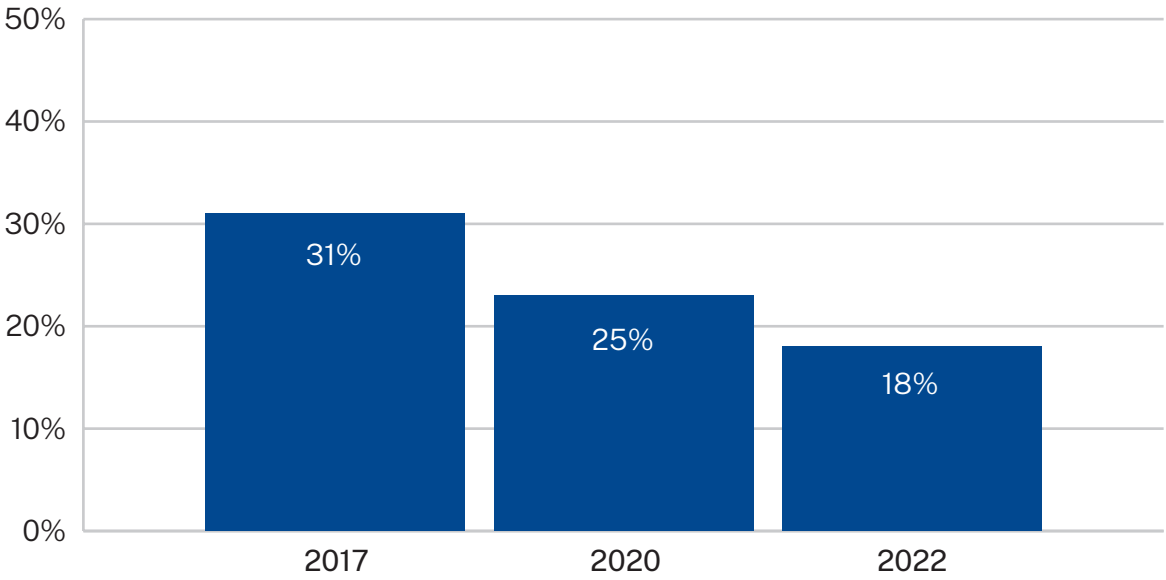


> I have been left feeling demoralised and chronically stressed due to the immense workload placed upon me. Priority of care throughout my career has been used in the sense of prioritising the work I do according to the highest risks being managed first but with the assurance that all of the fundamentals of care are maintained thoroughly.
>
> I feel priority of care has now changed to managing high risks first but without the assurance that the fundamentals of care are maintained. Life as a nurse feels like one huge risk that will also feels like an "accident waiting to happen."
>
> *Sister, NHS hospital, Wales*

Enough time to provide the level of care respondent would like

Across the UK, nearly two thirds of respondents disagreed (64%) with the statement that they had enough time to provide the level of care they would have liked, while only 18% of respondents (around one in five) agreed that they did. These findings show a significant decline in comparison to 2017 and 2020 data, as shown in Figure 14 below.

Figure 14: respondents who reported that they had enough time to provide the level of care they would like – 2017, 2020 and 2022



For those working within the NHS, around one in six (17%) said that on their last shift they had sufficient time to provide the level of care they would have liked. This was one in four (26%) for those working in independent sectors.

For those working in a hospital only about one in seven (16%) said they had enough time to provide the level of care they would have liked, which is lower than the proportions of those working in non-hospital urgent and emergency care settings (27%), community settings (22%) and care homes (21%).

Of those who reported working on shifts with 100% of the planned registered nurses present, only 34% of respondents said they had enough time to provide the quality of care they would like; again, suggesting that even the planned number of registered nurses is not sufficient to provide the best quality of care for patients.

The proportion reporting that they had time to provide the level of care they would like on their last shift fell to just 8% when only between 50-74% of the planned registered nurses were on shift.

> I am embarrassed at not being able to carry out the care I would expect for myself. I want to do more but end up using my own spare time to catch up on admin, etc. Patient demand is too high for the current staffing levels. I am considering emigrating to a country which provides better health care and have already begun my application."
>
> *Community staff nurse, NHS, Scotland*

Skill mix concerns

Overall, more than a half (51%) were concerned about the skill mix (up from 46% in 2020). The same proportion of respondents working within the NHS reported this as a concern compared to 45% of respondents working in independent sectors.

When the number of registered nurses on shift was reported as between 50%-75% of what was planned, the proportion of respondents saying the skill mix concerning them increased to 60%.

Concerns about skill mix were more likely to be reported by respondents working in a hospital (55%) and care home (53%) setting than in a community setting (39%).

> Inappropriate skill mix for the procedures being performed has become commonplace in my dep't. As a band 5 nurse with experience I am often left scrubbed and dependent on circulating staff covering from other hospitals or specialties who do not have the appropriate specialty knowledge which adds extra stress to the scrub team and at times delays intra-operative progress.
>
> I fear one day harm will be caused to a patient due to a delay in bringing in additional equipment because the circulating team don't have the specialist knowledge and experience for my specialty should an unforeseeable situation arise in theatre."
>
> *Registered nurse, NHS hospital, England*

Time spent on non-nursing duties

Overall, 47% of respondents said that too much time on their last shift was being spent on non-nursing duties, for example non-nursing administrative work.

This was more likely the case for respondents working in care homes (57%), community settings (51%), prison/policy custody (49%), and hospitals (45%).

> We have had occasions when staff have been off with COVID-19, or we've just been low on staff, where patients have been unable to make appointments, and nurses are covering duties that aren't part of their skill set, just to hit targets."
>
> *Registered nurse, general practice, England*

> We do not have adequate administrative support and waste time completing tasks that are not nursing."
>
> *Clinical nurse specialist, NHS community health care centre, England*

Time to support relatives and other individuals of importance

A lack of time affects other areas of care, such as providing support for relatives and other individuals of importance to the patient.

Overall, only 17% reported having time on their last shift to support the patient's family and friends. For those in independent sectors, around one in four (23%) said they had time to provide this type of support. This dropped to 15% for respondents working in hospitals and to 21% for those employed in care home settings.

Even when 100% of the planned registered nurses were on shift, only approximately one in four (27%) of respondents said they had sufficient time to provide support to family and friends of their patients on their last shift. However, when the shift was operating with 75–99% of planned registered nurses, only 17% of respondents said they had sufficient time.

> I had a dying patient during a COVID-19 outbreak and due to staffing levels, I couldn't spend as much time with my patient or their family who were present as I normally would but I was the only staff nurse on to look after 55 residents in a care home."
>
> *Registered nurse, independent sector care home, Scotland*

Appropriate support and supervision

Overall, 23% agreed that they were provided appropriate supervision and support during their last shift, but this percentage fell to 17% when the respondent reported working in a care home setting, and to 21% in a hospital setting. However, 31% of respondents working in non-hospital urgent and emergency care and 30% community settings reported better access to appropriate supervision and support.

> Frustrated that we are expected to still provide the same service and care with a reduced number of staff. I feel I am not able to appropriately supervise and support junior members of the team. I feel I'm pulled from pillar to post, trying to juggle everything. Some shifts are relentless with no time for breaks. We are not able to care for patients as we would like yet the expectation is still there."
>
> *Registered nurse, NHS hospital, adult acute ward, England*

We have seen in this chapter that respondents have been absolutely clear that the single greatest contributor to compromised care is having insufficient registered nurse staffing levels. Over time, we have seen a consistent increase in respondents reporting compromised care, with a growing emphasis on there being insufficient numbers of registered nurses and support staff. NHS respondents reported particular concern about the former, and independent sectors about the latter.

Our analysis of survey data demonstrates a link between reported staffing levels with compromised care concerns. We also see a slight increase in the proportion of respondents telling us that they had to leave necessary care undone due to time constraints, with almost half of hospital staff citing this concern. This risk speaks for itself – and is something many of our members speak about having severe anxiety around, given that it compromises their ability to deliver the care their professional expertise enables.

The percentage of respondents citing staff sickness absence has increased by 16% since 2020 and doubled since 2017. Hospitals, care homes and prisons report the highest level of concern, presenting clear and particular risks to vulnerable patient populations.

From the responses, we can observe how low staffing levels deprive registered nurses of good quality interactions with their patients, families, and relatives. It is concerning to hear nursing staff expressing that poor staffing levels and lack of time hinder their ability to provide the quality and level of care they would like to receive as patients or to support relatives and other individuals of importance to the patient, which is also an important element of the holistic care that nursing practice provides.

Impact of staffing levels on nursing staff

Wellbeing after last shift

More than half of respondents (59%, up from 54% in 2020 and 53% in 2017) felt "upset or sad" that they could not provide the level of care they wanted and only 31% (down from 38% in 2020 and 43% in 2017) felt satisfied with the care they had provided and the job they had done.

Only 16% (down from 21% in 2020 and 26% in 2017) of respondents felt fulfilled after their last shift, and more than three times as many (51%, up from 43% in 2020 and 45% in 2017) felt demoralised. Over half (54%, up from 47% in 2020 and 46% in 2017) felt exhausted and negative, compared to under a third (30%, down from 36% in 2020 and 40% in 2017) who felt exhausted but positive.

Figure 15: respondents who answered agree to the impact of staffing levels on nursing staff statements – 2017, 2020 and 2022

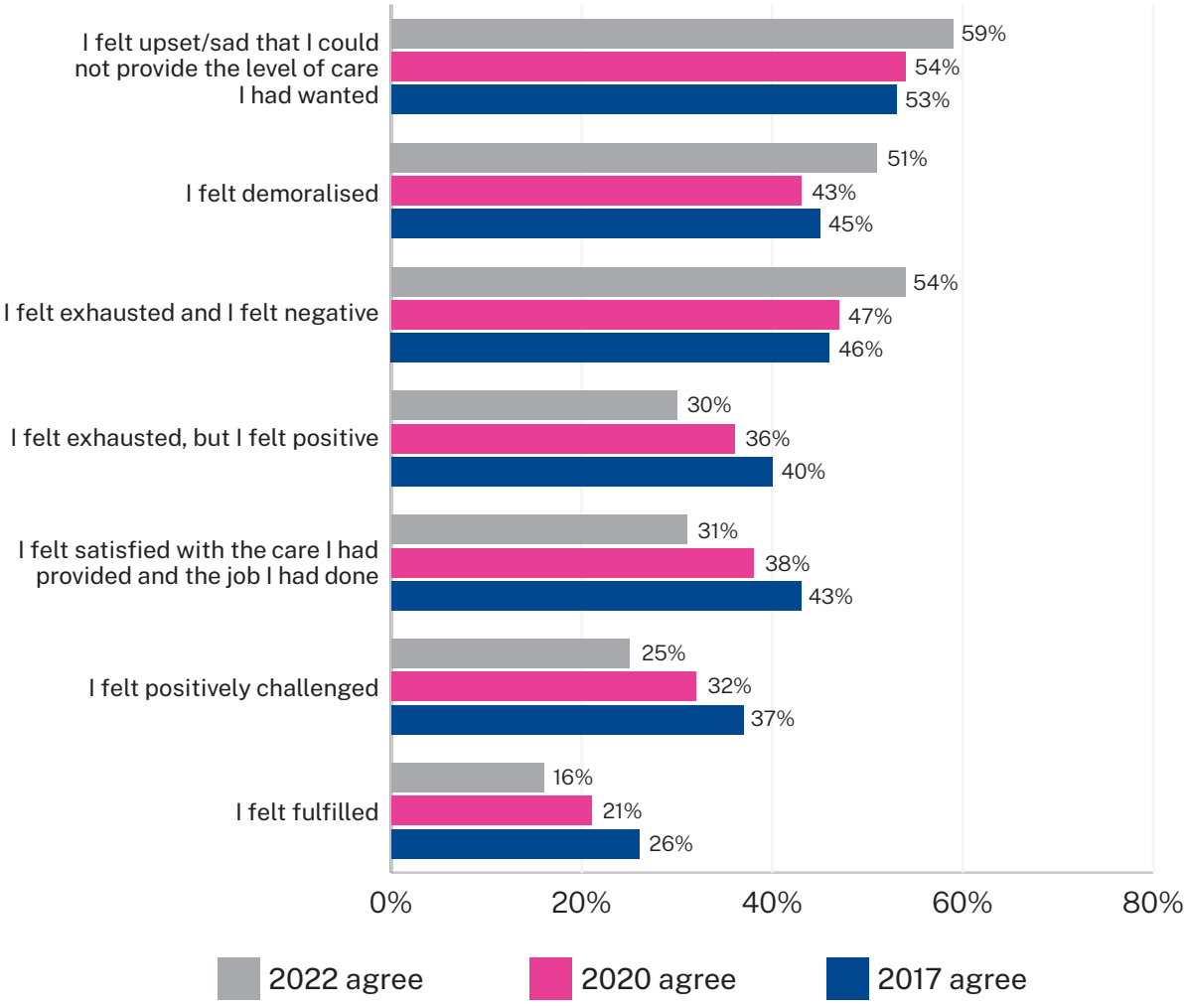


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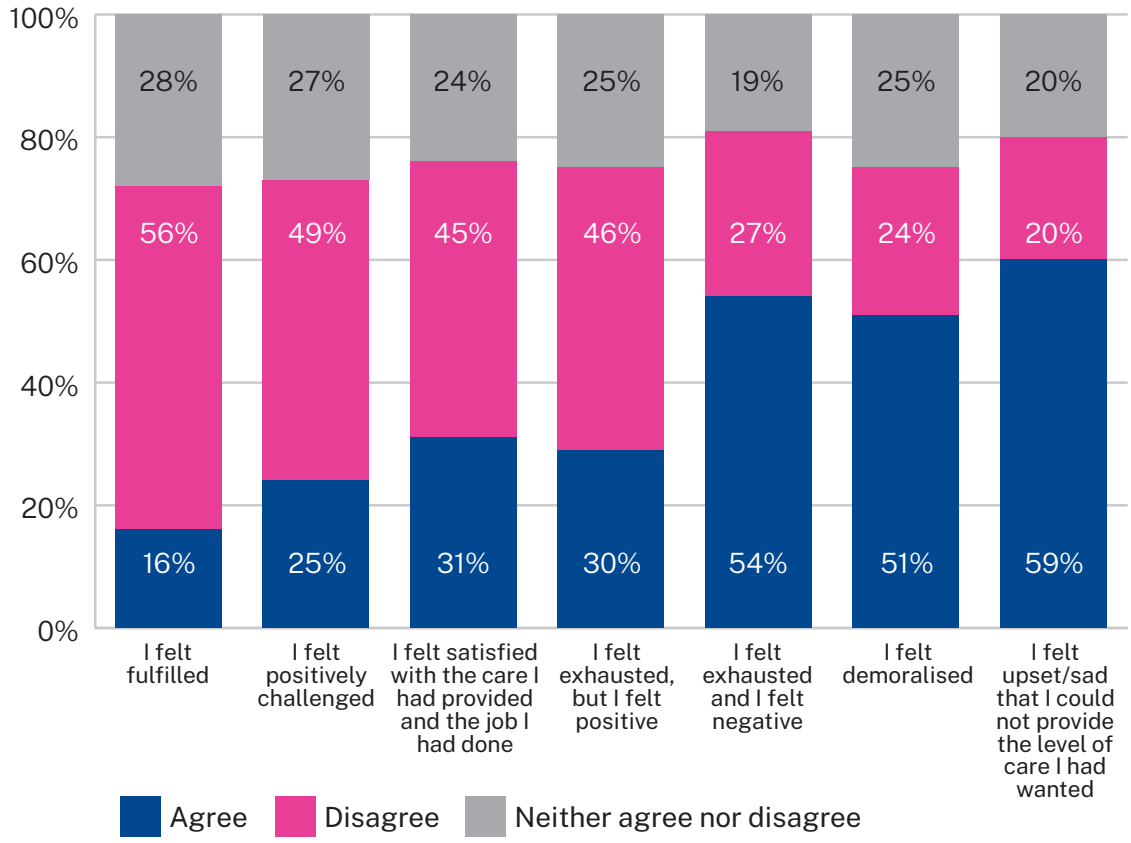
Figure 16: impact of staffing levels on nursing staff, 2022



Across all settings 51% of respondents agreed with the statement "I felt demoralised". Isolating those just working in hospitals, the proportion agreeing with the statement increases to 57%.

> Low staffing levels constitutes physical, mental and emotional exhaustion or burn out. It affects not only the safe and efficient provision of service from health care staff but also the standards and quality of care received by patients. It demoralises staff firstly, by draining their physical strength from the doubled workload and increased patient acuity and demand.
>
> Secondly, it causes stress and anxiety for staff with the uncertainty of adequate staffing levels, safety of patients, lack of or inadequate source of support and the looming sense that no one has control over it. Finally it dampens your spirit and hope, which then affects your attitude and behaviour especially on how you deal with staff and patients. Your kindness and patience is truly stretched to the limit, sadly staff are already on the brink."
>
> *Sister, NHS hospital, adult acute ward, England*

> “I had to leave my last role as a ward sister as the staffing levels were so unsafe. As a senior member of staff I felt patient care was compromised and I was unable to support my team. The pressure was immense and in the end my mental health took a hit and I made the decision to leave before I became more unwell. I could not sleep at night for worrying about my job, my staff and most of all my patients.”
>
> *Practice nurse, NHS GP practice, England*

Feeling appropriately prepared and working within scope of practice

The RCN *Nursing Workforce Standards* state that nursing staff must be appropriately prepared and work within their scope of practice for the people who use service, their families, and the population they are working with. This includes having access to education, training and support to ensure that the nursing workforce has the knowledge, skills and competencies required to deliver evidence-based, safe, person-centred care that is of high quality.

Just under a third (32%) of respondents said they were not appropriately prepared and were working within their scope of practice for the people they were caring for during their shift. Respondents working in independent sectors were more likely to say that they were prepared and working within the scope of their practice (73%) compared to those working in the NHS (64%). Further, respondents in community settings (73%) and care homes (70%) were more likely to say they were prepared and working within the scope of their practice than those working in hospitals (62%) and prison/police custody (61%).

Responses also varied between staff groups; just over half (56%) of health care support workers said yes, compared to 66% of registered nurses.

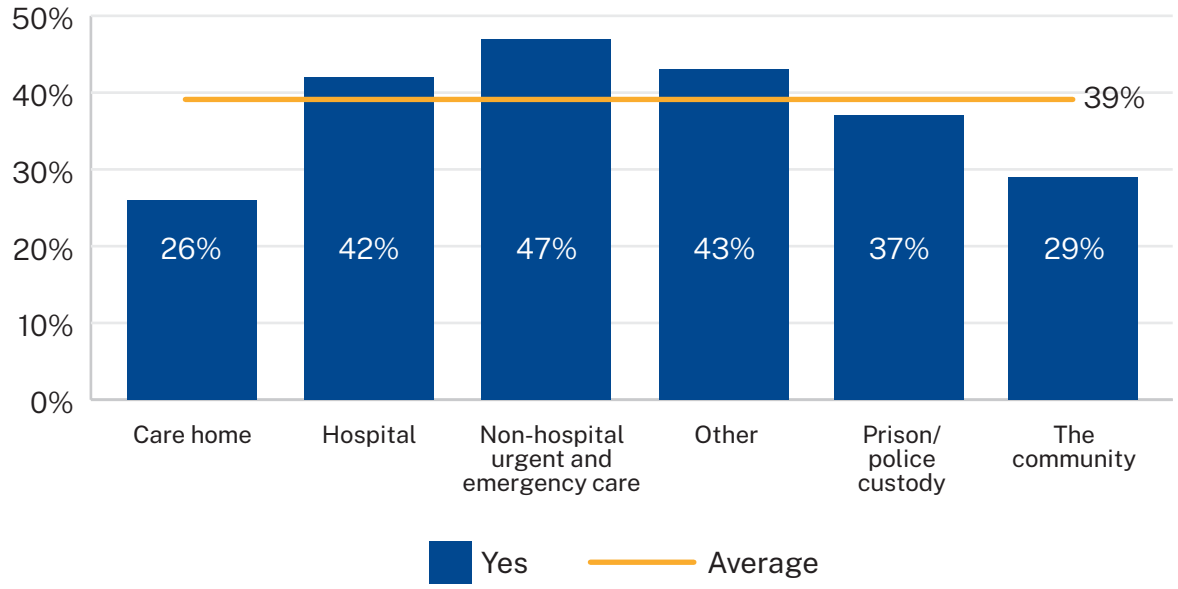
When there were 100% of the planned registered nurses on shift, 77% of respondents said yes, they felt prepared and working within the scope of their practice. When there were only 25-49% of the planned registered nurses on shift, only 47% said yes. This demonstrates a link between percentage of planned registered nurses being on shift and whether respondents felt appropriately prepared for and were working within scope of practice.

Taking breaks and working additional hours

Almost two-thirds (61%) of respondents reported not being able to take the breaks that they were supposed to take. There were also differences across care settings, as shown in Figure 17: those working in care homes were least likely to have taken a break on their last shift, at just 26%. Those working in independent sectors (66%) were more likely to have forgone their scheduled break, with 61% missing their break within NHS settings.

> Lack of appropriate staff to provide care means no breaks at times and staff caring for patients that they are not qualified to care for."
>
> *Staff nurse, NHS hospital, Scotland*

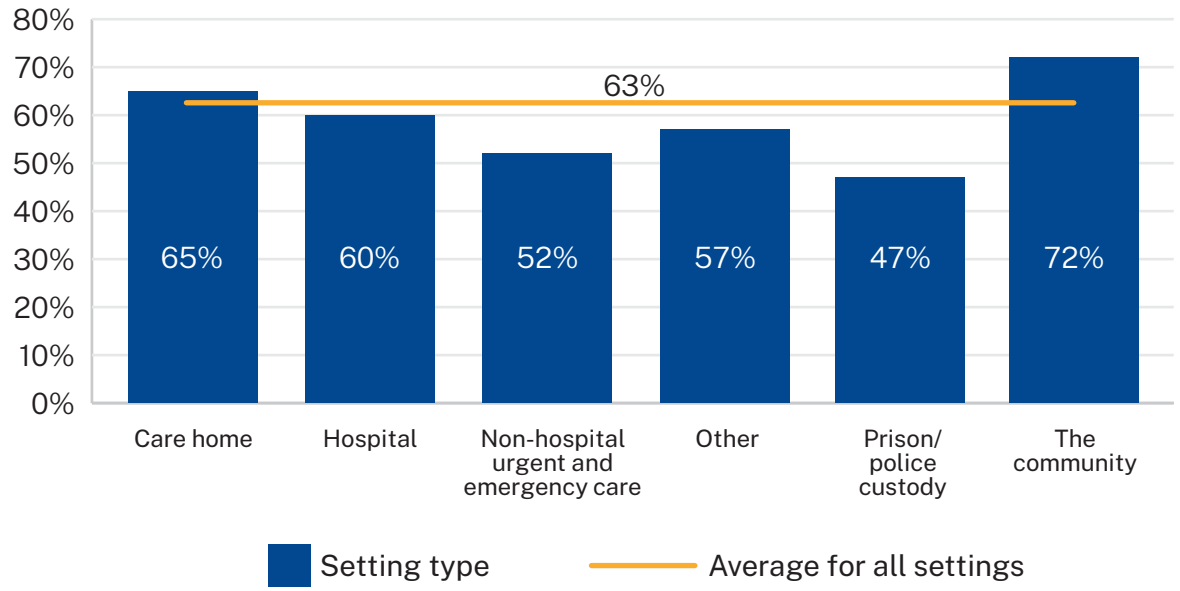
Figure 17: ability to take breaks by care setting



Almost two-thirds (63%) of respondents worked additional time, and almost eight in 10 (77% down from 90% in 2020 and 91% in 2017) were unpaid for working these additional hours.

Figure 18 overleaf shows that those working in the community were most likely to have worked additional time on their last shift (72%) while those working in a prison/police custody are least likely (47%).

Figure 18: working additional hours



Of the 12,730 respondents who said they worked additional time, most respondents worked between half an hour and an hour beyond their scheduled hours (as shown in Figure 19 opposite). 12% worked two or more hours on top of their planned shift.

> Lack of staff means unmanageable patient lists. A lack of staff on evening and night service means a pressure not to hand over visits. I feel tired and mentally drained over the workload. There is no time for team meetings, supervision or to complete online training, check emails and do admin. I rarely take a break. I rarely complete all my documenting during my shift which means I have to complete it at home. I can claim this time but it's not a choice and it impacts on my home and family life.
>
> My anxiety and stress levels have been higher than ever. There is no time to feel we do the job for patients we should be. We are constantly rushing in and out and only really doing what we have time for. I don't think this helps with my personal development and learning. Mandatory training gets booked and then often cancelled so it's not up to date and no time is given to us to complete e-learning."
>
> *NHS community staff nurse, England*

> I have worked up to an extra 20 unpaid hours a week for weeks on end at times to try to cover my workload. It has taken a huge toll on my physical and mental health. I now resent the career I was once passionate about. I have sacrificed so much time with my daughter to ensure my patients have their basic needs met for fear of them dying if I didn't.
>
> I am aware the government do not care to staff services nor of our wellbeing. I want to leave nursing, despite having worked so hard for my career and to help others. I am angry at the complete lack of regard and respect for health and social care workers from the government. I would advise others to stay away – it's exploitation of our goodwill and kindness."
>
> *Senior nurse, community children and young people's service, England*

Figure 19: amount of additional time worked on last shift

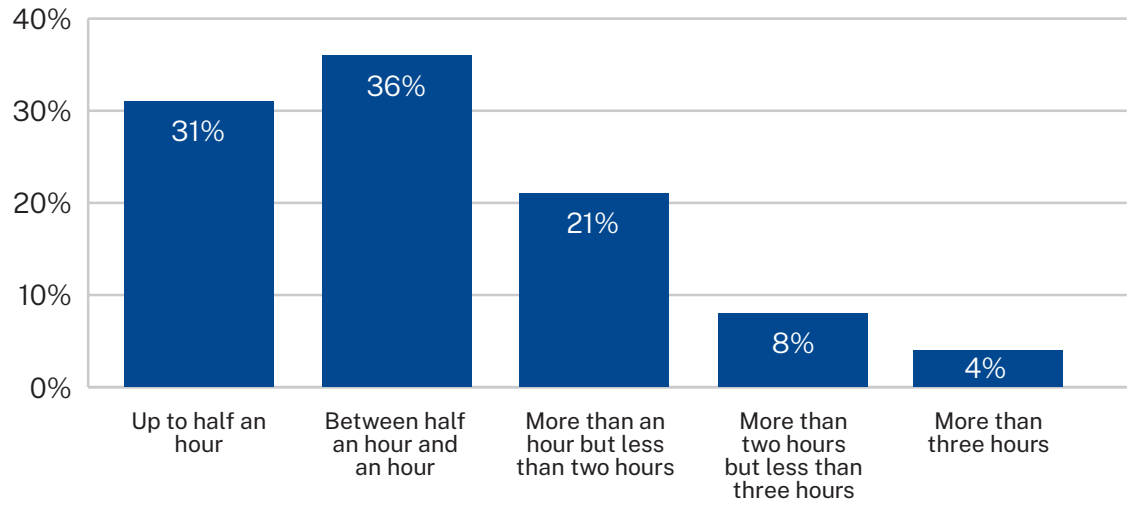
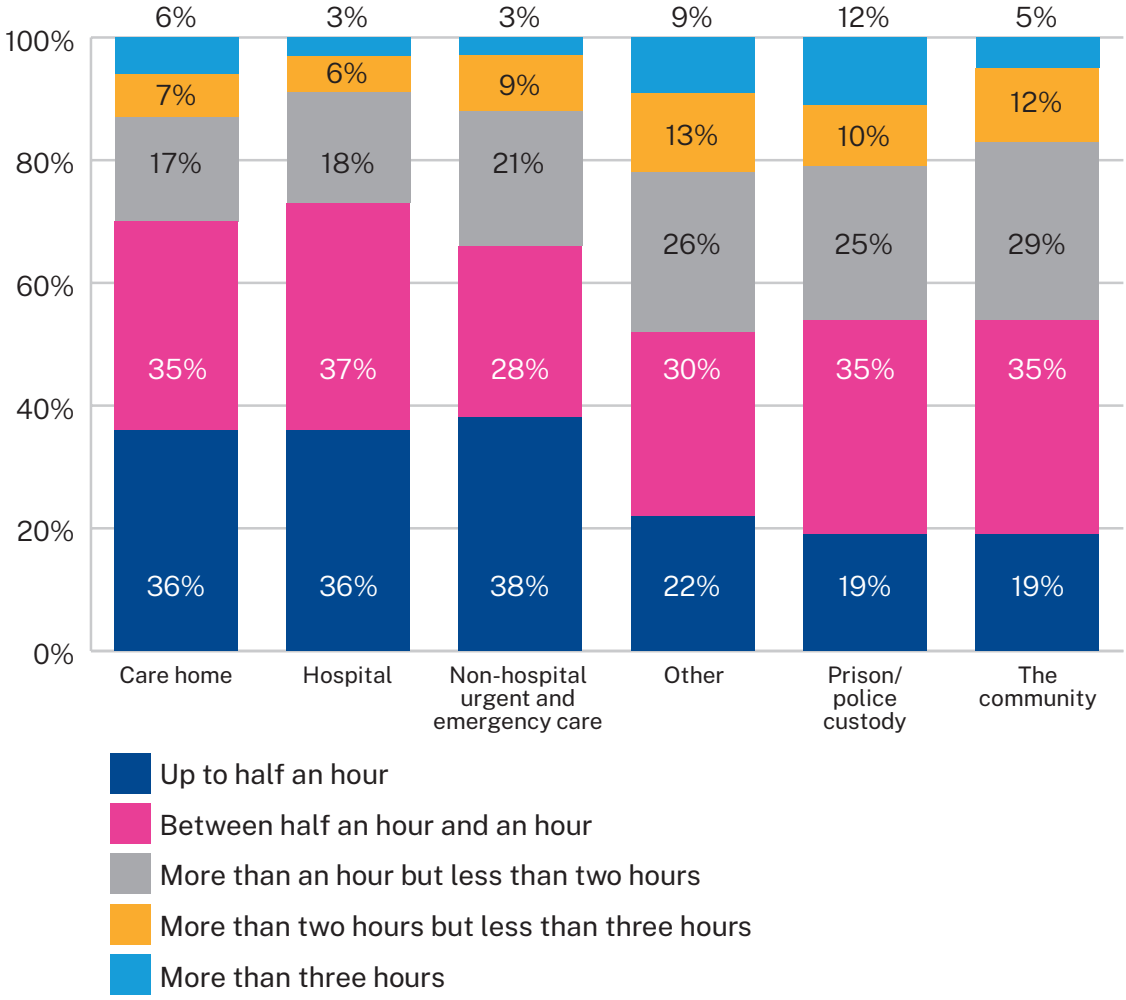


Figure 20: amount of additional time worked by care setting



Of the 12,730 respondents, only 11% reported that they were paid for extra time worked, and 12% were given the time back and 77% (around three in four) were not paid for the additional time they worked (as shown in Figure 21 opposite).

These findings suggest that not only a significant number of nursing staff are working more than their contracted hours but also exceeding the recommended working time regulations that exist to protect patients from clinical errors resulting from cumulative fatigue.

Patient safety and quality of care is compromised when nursing staff have to work longer shifts. Fatigue can also result in health problems for staff and even 'burnout', impacting upon staff retention and on the existing shortage.

The RCN *Nursing Workforce Standards* state that rostering patterns should consider best practices on safe shift working to protect their ability to provide safe and effective care. The Health and Safety Executive (2006) recommends the avoidance of shifts that are longer than eight hours where the work is safety critical and physically and mentally demanding, which clearly applies to nursing as a safety critical profession.

Figure 21: renumeration for additional time worked

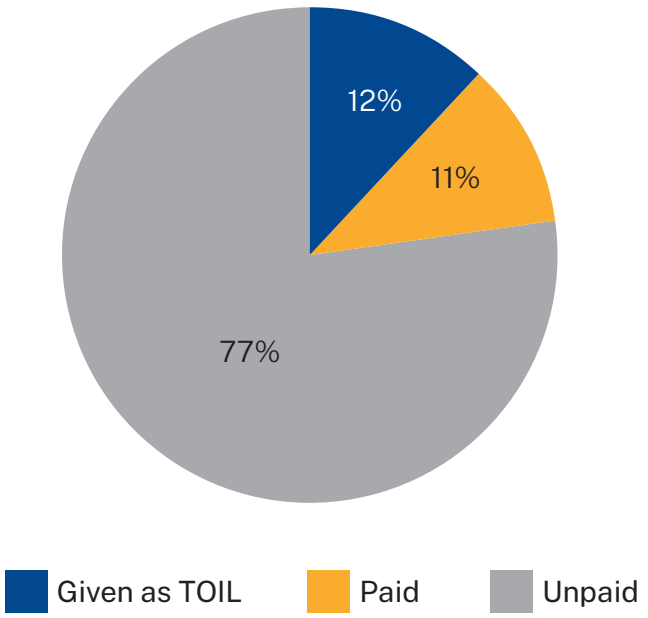


Figure 22 below shows that those working in the community were most likely to be working additional time unpaid (53%), with those working in prison/police custody were least likely to have worked unpaid additional time (27%).

Figure 22: working additional hours unpaid by care setting

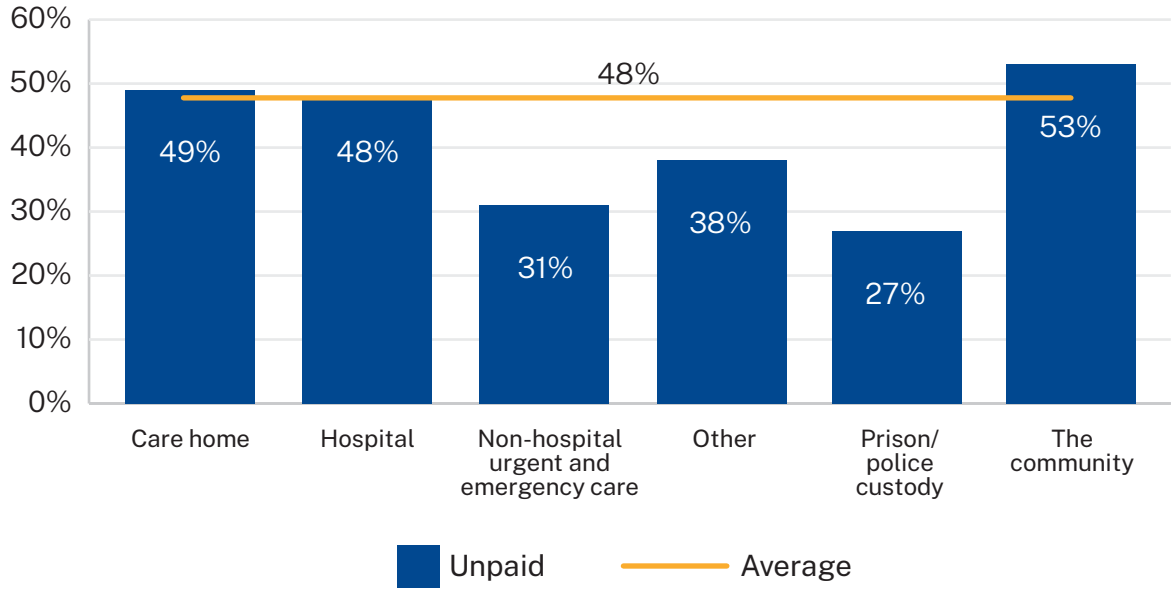
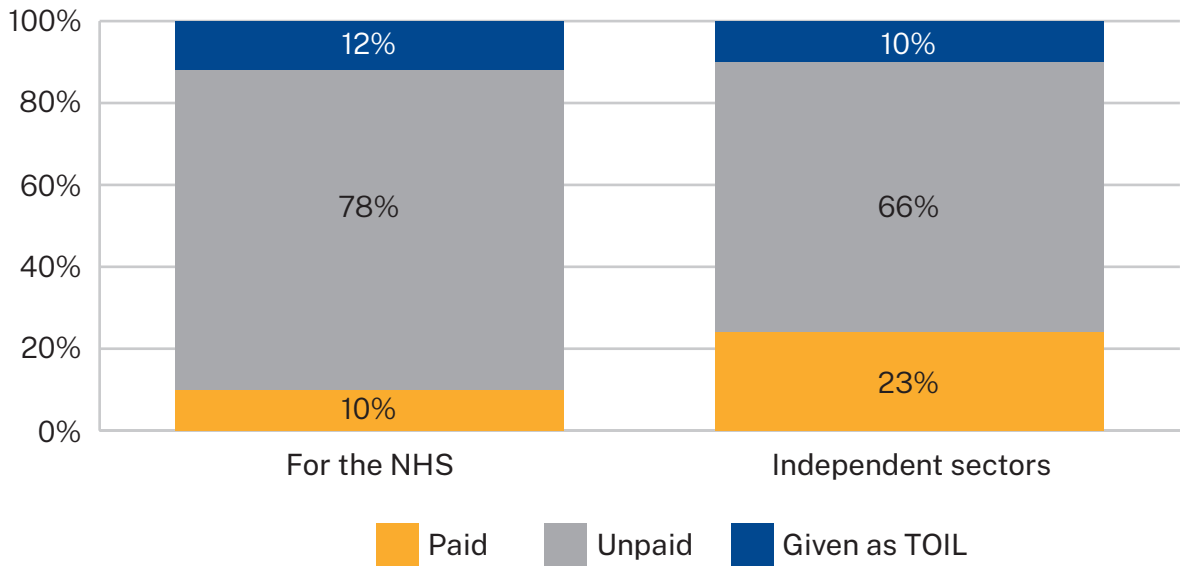


Figure 23 shows that only 10% of respondents in the NHS got paid for working additional time, while only 23% of those working in independent sectors did.

Figure 23: renumeration for additional time worked



Responses to these set of questions also showed variation when analysed at country level and a summary of these findings can be found in **Appendix 2**.

Raising concerns

It is vital that all nursing staff feel able and supported to raise concerns relating to staffing levels or patient care being compromised. Staff being supported to raise concerns is about safeguarding and protecting both staff and patients, supporting learning from a situation and making improvements, and reporting into systems to enable assessment and response to issues.

As the RCN's *Nursing Workforce Standards* state, nursing staff should be encouraged to report any incidents where the safety of patients and the quality of the service provided has been compromised (RCN, 2021). This creates 'psychologically safe' environments where individuals are enabled to raise concerns without the fear of detriment and enables a learning culture that guarantees the safety of patients and other staff members.

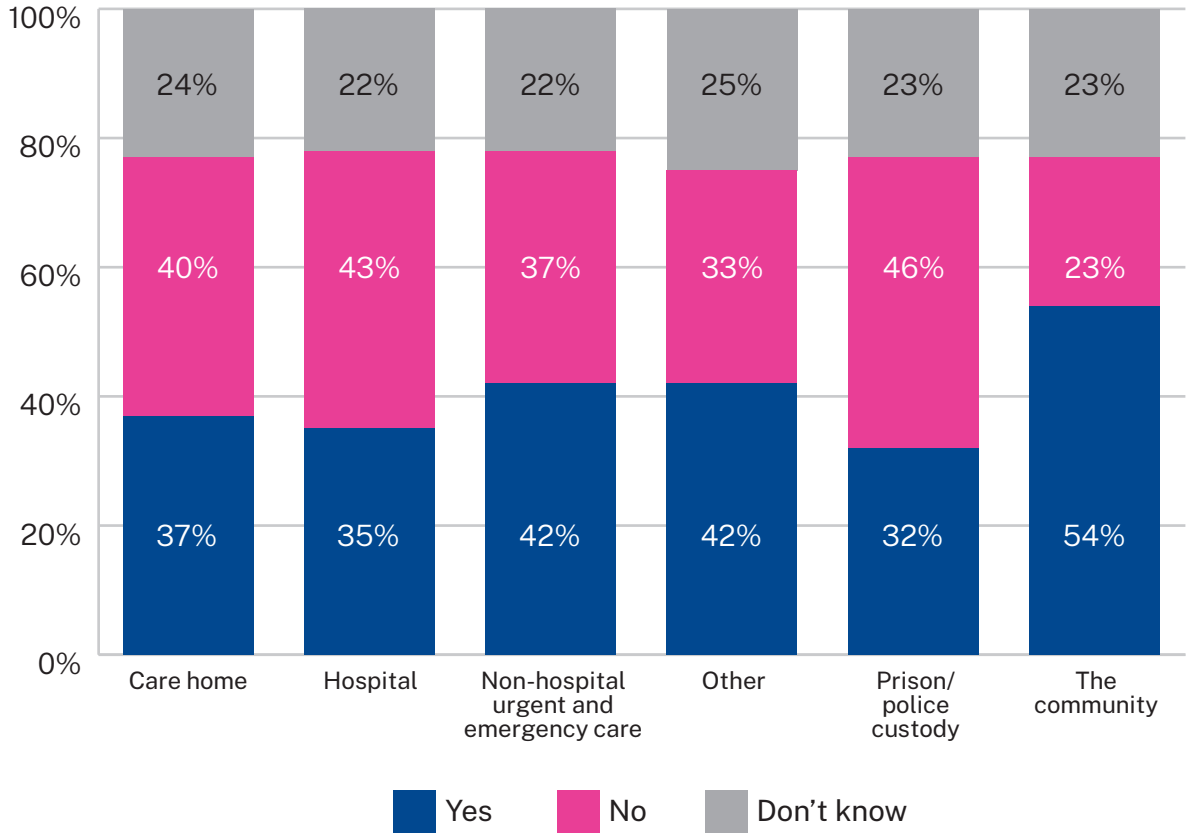
Fewer than three quarters (73%) of respondents told us that they had been able to do this. One in five (21%) said they felt unable to raise their concerns. Responses were similar for respondents working both in and out of the NHS and across care settings.

Of those who did raise concerns, just over a third (37%) of respondents were able to say that action had been taken to address the issue. A similar number (41%) said no action had been taken. One in five (22%) did not know if any action had been taken.

Respondents working in independent sectors were slightly more likely (41%) to report that action had been taken to address the concerns they raised, than those working in the NHS (37%).

Figure 24 shows there is a slight variation across care settings, with those working in non-hospital urgent and emergency care most likely to report action being taken (42%).

Figure 24: When you raised a concern, was any action taken to try to address the issue?



> The growing pressures from ward charge nurses, senior managers, bed managers and the heads of the departments, to get patients 'in and out' of theatres and discharged out of hospital is overwhelming. More and more nurses are talking leave of absences and sick days because of the pressure to meet the increasing demands and the toxic environment that has been created by more senior members of staff.
>
> Concerns between staff are just whispers and hushed talks in clean utility rooms, because everyone is too scared to come forward and raise a concern. In the past, those brave few who have come forward with concerns have been meet with an insincere "I'm sorry you feel that way" and "we acknowledge your struggles and are trying our best to help". However, nothing changes and we carry on, doing our job, feeling anxious, unheard, exhausted, underpaid and waiting for something to change."
>
> *Staff nurse, NHS hospital, Scotland*

We see in this chapter many indications that the reliance on the goodwill and resilience of nursing staff has a cost. Reports of negative experiences have increased, and positive experiences decreased, across the board.

The majority of respondents are working additional time on a shift, which even if paid, signals that there is not enough nursing workforce to deliver planned care. The majority of respondents working additional time were in community services, which are particularly hidden in terms of increasing workload.

With so few reporting being paid for extra time worked, this trend is particularly concerning, given the significant number of respondents raising concerns around insufficient pay for nursing work. This is particularly stark for NHS nursing staff, who are less likely to be paid for their additional hours of work. Furthermore, there is a safety issue in that so many registered nurses are working past their contracted hours, as this may also present a detrimental impact on the quality of care they are able to provide, as a safety critical profession.

The RCN *Nursing Workforce Standards* state that the nursing workforce should be recognised and valued through fair pay, terms and conditions (RCN, 2021). Further, working conditions should support the health, safety and wellbeing of the nursing workforce. The conditions described through the findings in this survey show the clear impact on physical and emotional wellbeing of nursing staff, who despite this, continue to go above and beyond to care for patients. However, working under these conditions is not safe or sustainable and without intervention will only lead to higher levels of burnout.

We are absolutely clear that every member of nursing staff must be supported to raise any safety concern. We are extremely concerned one in five of respondents were not supported to raise a concern, and that less than half of those who reported a concern were aware of any action being taken as a result. This is a clear failure of health and care systems which must be rectified as a matter of urgency.

Impact of staffing levels and experiences – variation across different nursing staff groups

The RCN believes that all nursing staff should be treated with dignity and respect and that their contributions must be valued, irrespective of their ethnicity or background. This includes ensuring that no one is underpaid or unpaid for their work.

The RCN encourages and values diversity within the nursing workforce and the recruitment and retention of individuals from different backgrounds and characteristics. This requires structural and cultural change to ensure that fair and equitable workplaces support and foster a diverse workforce.

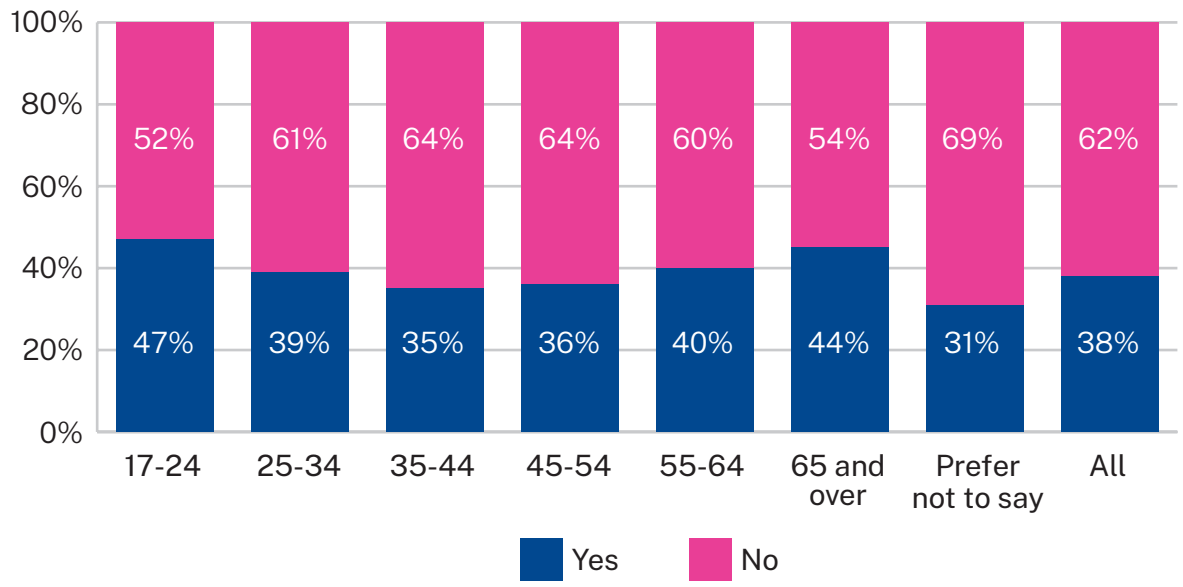
We therefore explored the impact of staffing levels on respondents' wellbeing and identified differences worth noting among certain populations, which are supported by sample size large enough to enable comparisons.

Taking breaks

We asked respondents whether they were able to take the breaks they were supposed to take during their last shift/day at work.

Regarding respondent age, those aged 17–24 (48%) and 65 and over (45%) were more likely to be able to take their breaks compared with 35% and 36% among those aged 34–44 and 45–54, respectively (as shown in Figure 25).

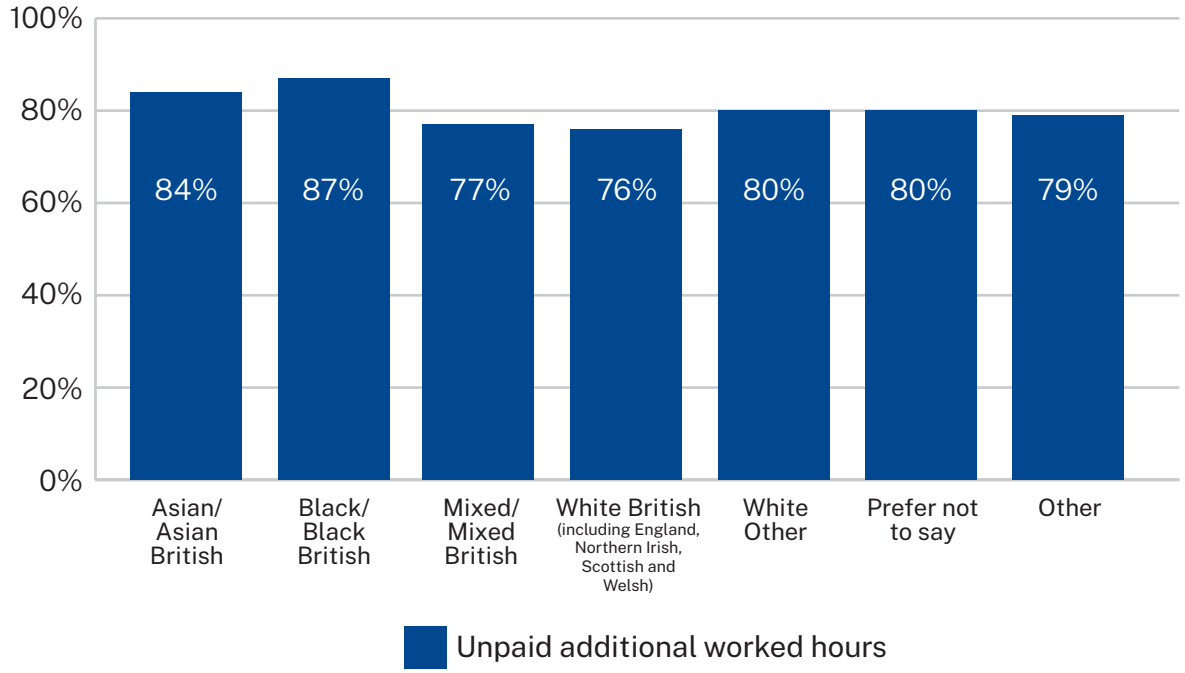
Figure 25: ability to take breaks by age group



Remuneration of additional time worked

Respondents were asked if they worked any additional time on their last shift and, if so, whether that additional time had been paid, unpaid or given as time off in lieu (TOIL). In total, 11,611 respondents reported working additional time during their last shift. Method of remuneration varied. Figure 26 shows that overall, those from Asian (84%), Black (85%) and White Other (80%) backgrounds were more likely to be unpaid for their additional work than respondents from a mixed background (77%) and 76% of White British respondents.

Figure 26: unpaid hours of additional time worked by ethnicity



Within the NHS specifically, there is a marked difference as approximately 87% of Black respondents reported working unpaid additional time compared with 77% respondents from a White British background.

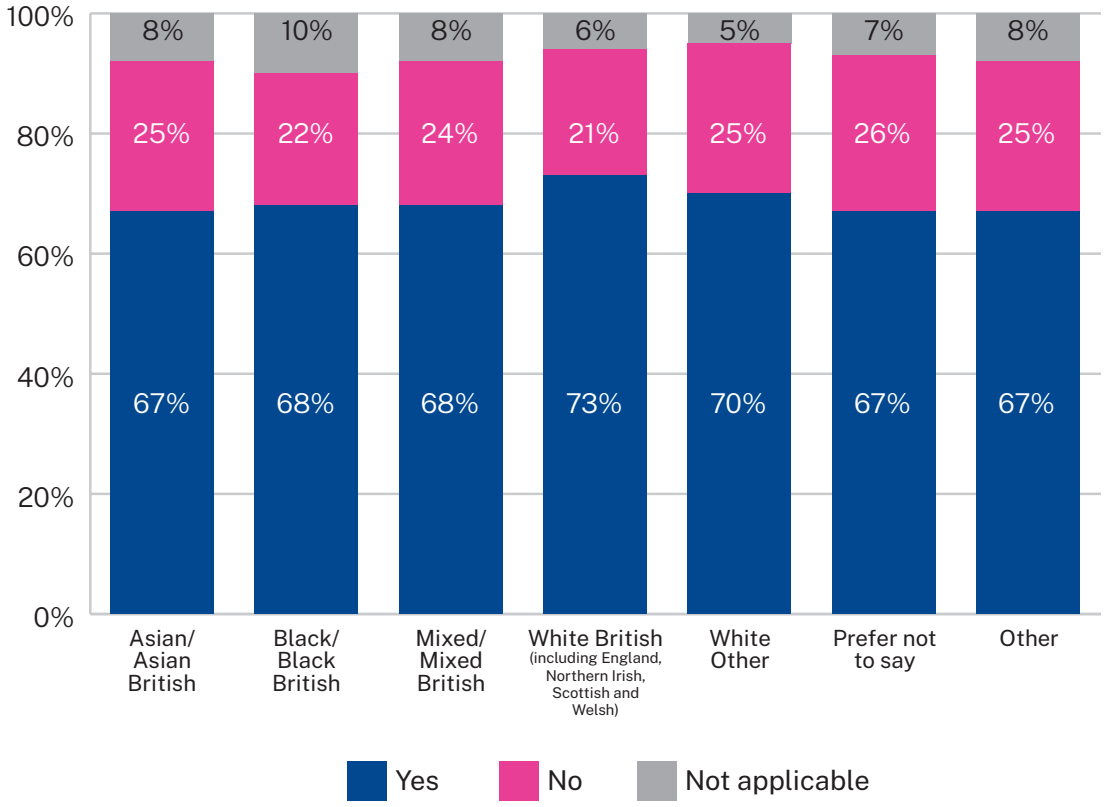
Respondents from an Asian background were more likely to work additional unpaid hours when working in a care home (94%) than in a hospital (84%) or a community setting (87%).

Raising concerns

Respondents were asked if they had been able to raise concerns during their last shift if there was not enough staff or if patient care was compromised. Overall, 73% respondents from a White British background (n = 14,207) reported the ability to raise their concerns, whereas only 63% of Asian respondents (n = 769) and 68% of Black respondents (n = 750) reported the same (as shown in Figure 27).

Overall, respondents from ethnic backgrounds other than White British were less likely to raise concerns. This suggests that for certain individuals, their workplaces are not providing inclusive, safe spaces where concerns can be communicated safely.

Figure 27: ability to raise concerns by ethnic group



Of those who raised concerns, 44% of White Other respondents indicated that their concerns had not been addressed compared with 38% of respondents from Asian backgrounds who expressed the same.

Nursing is a diverse profession. However, responses to this survey also show a significant level of variation in the working experiences of certain groups. As we see in the data, ethnic minority staff are less likely to be paid for additional hours worked, and less able to raise safety concerns in the workplace. These differences in the value attached to the same work, and safety provisions, suggest discrimination and a source of income inequality.

These findings are supported by a body of evidence that suggests inequalities within the nursing profession persist for individuals, particularly from ethnic minority backgrounds (RCN, 2020a and NHS RHO, 2022). Urgent work is needed to address these inequalities and ensure the working rights of all individuals, irrespective of their background, are respected.

We also see nursing staff in particular age groups forgoing their breaks, suggesting a cohort of staff who are taking on disproportionate responsibility within their shift.

This apparent variation in experience for nursing staff must be addressed, as any form of direct or indirect discrimination is not acceptable within health and care systems.

RCN *Nursing Workforce Standards* and executive nurses

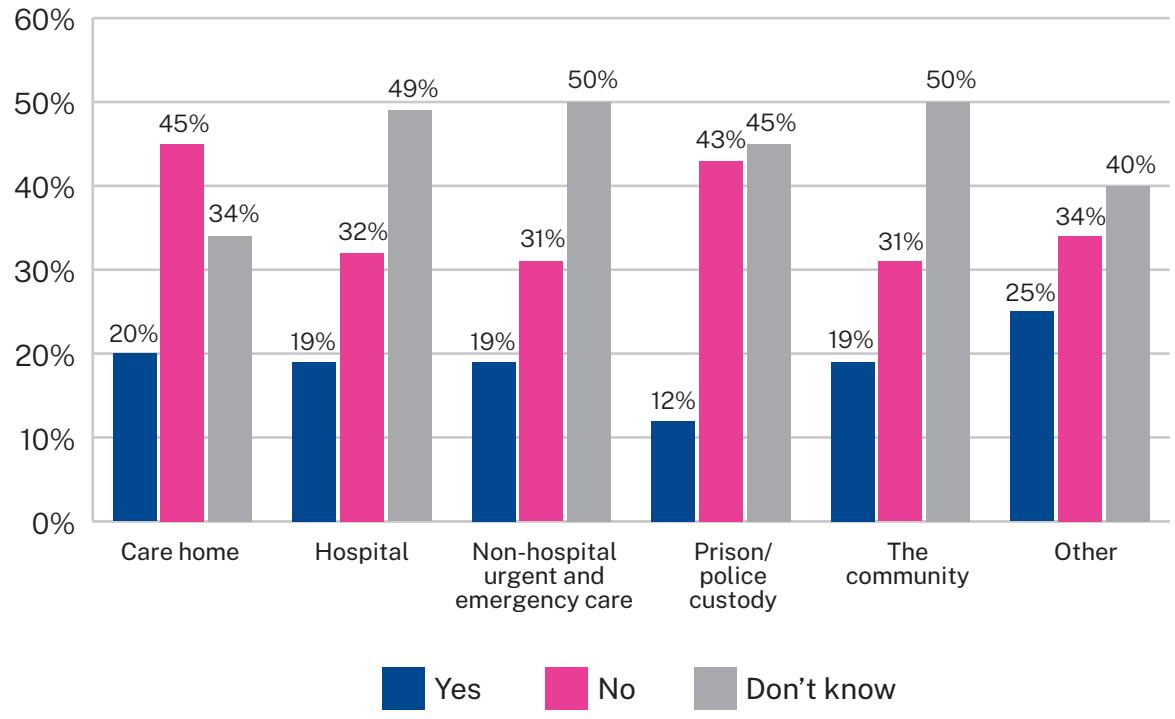
The RCN published the *Nursing Workforce Standards* in 2021 to set out what must happen within workplaces to ensure the delivery of safe and effective care. They set out what we want to see from those who fund, plan, commission, design, review and provide services which require a nursing workforce (RCN, 2021).

They can also be used to help all nursing staff understand what they should expect to be in place to enable them to do their jobs safely and effectively. Across all UK respondents:

- 45% said they were aware of the *Nursing Workforce Standards* before completing the survey
- of those who said they were aware of the *Nursing Workforce Standards* (45%), just under one in five (19%) said that the *Nursing Workforce Standards* were being used in their workplace
- just over one in five (22%) of respondents working in independent sectors said that the *Nursing Workforce Standards* were being used in their workplace
- just under one in five (19%) of respondents working in the NHS said they were being used in their workplace.

Figure 28 sets out whether respondents across each care setting were aware of the *Nursing Workforce Standards* before completing the survey.

Figure 28: use of RCN *Nursing Workforce Standards* in the workplace



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Executive nurses' views on workforce planning

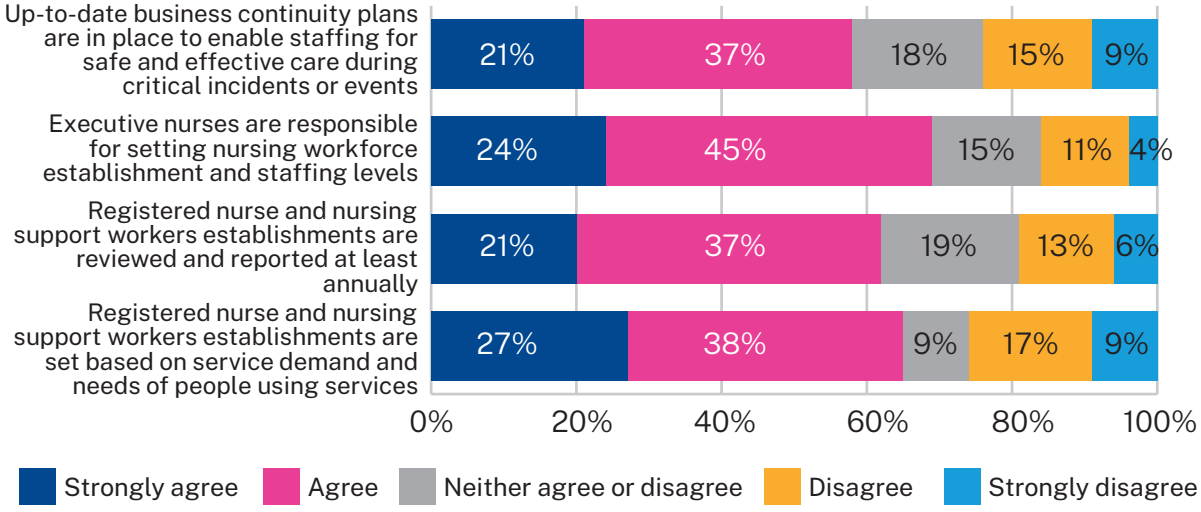
We asked executive nurse respondents (n=117) to what extent they agree or disagree with a series of statements relating to workforce planning. An executive nurse is defined as a registered nurse who holds executive responsibility on the corporate board and is usually responsible for assuring the board regarding nursing workforce issues. 'Executive nurses have a pivotal and transformational role in an organisation. They navigate a complex set of stakeholders and partners in the service of organisational values and must use their influence at board level to guide nursing priorities for their organisation' (RCN, 2021).

Across the UK, around one in four (26%) executive nurses disagreed with the statement that 'registered nurses and nursing support workers' establishments are set based on service demand and needs of people using services' but almost two in three (65%) executive nurses agreed with this statement.

Of the 101 executive nurses working in the NHS, 29% disagreed with this statement compared to 13% in working in independent sectors. Furthermore, around one in five (19%) executive nurses did not agree that 'registered nurse and nursing support workers establishments are reviewed and reported at least annually'. We asked respondents whether they agreed that executive nurses are responsible for setting nursing workforce establishments and staffing levels. Overall, around two in three (69%) agreed that executive nurses are responsible.

Finally, a total of one in four (25%) respondents did not agree that there were 'up-to-date business continuity plans in place to enable staffing for safe and effective care during critical incidents or events'. The proportion who did not agree increased to 28% for those respondents working in a hospital.

Figure 29: responsibility and accountability



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The RCN's *Nursing Workforce Standards* have been designed to support a safe and effective nursing workforce. Although these standards do not define specific models or tools of nursing workforce planning, they should be followed and used alongside established practice or setting specific guidance. Our standards state that executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the board are accountable, and that there must be corporate accountability for registered nurse and nursing support workers establishments based on service demand and the needs of people using services, reviewed and reported regularly and at least annually. This requires corporate board level accountability.

It is, therefore, concerning to hear that a significant number of the executive nurses, particularly in the NHS, are reporting service and workforce planning which contradicts the *Nursing Workforce Standards*.

Urgent action needed and next steps

In addition to the survey findings presented here, the NMC reported on their register for the period 1 April 2021 to 31 March 2022 (NMC, 2022). The register has grown by around 26,000 in the last year. Most of the growth is generated by registered nurses. There were over 48,000 first-time joiners in the last year, which is almost 14,000 more than the previous year. Of those, almost half (47%) were from outside the European Economic Area (EEA), which demonstrates a heavy reliance on international recruitment to fill domestic workforce gaps. There has been an increase in recruitment from countries on the World Health Organization's Support and Safeguards List (2020), including Ghana and Nigeria, which are listed in the top five countries of training outside of the EEA for people joining the UK register.

However, the number of people leaving the register has increased this year, to over 27,000, having fallen steadily over recent years. The leavers survey data covers the period January 2021 to December 2021. The most common factors for leaving included retirement, change of circumstances, too much pressure and negative workplace culture. The number of professionals on the register aged 56 and above increased by 4.2% to a total of 161,055. This means that one in five of those on the register are aged 56 or above and almost one in 10 are over 60 and are therefore approaching retirement age.

The data set out in this report paints a telling picture of the desperate situation facing nursing staff across all health and care settings in the UK, and of the need for urgent action to prevent further risk and damage to the health and safety of patients and nursing staff.

The RCN will make immediate use of this detailed evidence and the voices of the nursing staff contained in this report. We will bring their experiences and arguments to the attention of politicians, policymakers, regulators and employers.

As the professional body and trade union for nursing we will be demanding change on behalf of our members and will set out the short, medium and long-term solutions at the disposal of each.

The role of governments across the UK

Over the past two years, RCN members have worked to influence the UK Government, Scottish Government, Welsh Parliament and the Northern Ireland Assembly, with the aim of securing staffing for safe and effective care across all health and care settings. This includes the necessity of securing legal accountability for provision of this, including government funded strategy to meet population needs in each country. We will deploy this evidence in our lobbying and influencing work. We expect and need to see the following in every part of the UK.

- There must be government accountability for nursing workforce planning and supply in law.
- Governments should adopt and apply the RCN *Nursing Workforce Standards*.

- Governments must publish independently verifiable assessment of health and care nursing workforce requirements to meet the needs of the population and address health inequalities.
- There must be fully funded government health and care workforce plans to ensure long-term nursing supply, retention and recruitment to meet the needs of the population.
- Fair, effective and inclusive UK systems that ensure clear routes for appropriately trained international registered nurses to join the UK nursing workforce.
- Fit for the future regulation of nursing workforce.
- The nursing workforce should be recognised and valued through fair pay, terms and conditions.
- The nursing workforce will be treated with dignity, respect, and enabled to raise concerns without fear of detriment, and to have concerns responded to.
- Nursing health and safety supported and protected by employers.
- A chief nursing officer in every government to drive policy making.
- UK and global health policy recognises and promotes nursing leadership and the essential role of nursing within health and care systems.

In May 2021, we published the first UK overarching *Nursing Workforce Standards* (RCN, 2021). These standards were developed through review of current research literature and in collaboration with expert reference groups contributing professional expertise.

These standards promote excellence in safe staffing and apply across all areas of nursing and all sectors within the UK. They are designed to support a safe and effective nursing workforce alongside each nation's legislation, and we expect all workplaces, and health and care systems, to adopt and apply them.

What we expect of employers

Under the Health and Safety at Work Act and the Health and Safety at Work Order (Northern Ireland) employers have responsibility for the health and safety of staff and others who may be affected by the work activity, including patients and the public. Employers should continue to implement health, safety and wellbeing measures, undertake and regularly review risk assessments (where required) to support and protect staff.

It is paramount that employers actively promote a culture of safety. A safe organisation is one in which staff are both welcomed and encouraged to report incidents, near misses and concerns. Staff should feel able to be candid about mistakes and to talk openly about error. It is unacceptable for any nursing staff to be asked to cover up any risk, inappropriate behaviour or action. Staff need to know that the organisation will focus on system learning, not individual blame and believe they are psychologically safe when raising concerns or putting forward ideas for improvement. Organisations must have effective procedures in place to allow nursing staff – including students – and their representatives to raise any concerns in relation to equipment, policies and processes at the earliest opportunity. Nursing staff should feel able to raise their concerns without

detriment and should receive timely feedback on their concerns. This could include concerns relating to unsustainable pressures in the workplace as well as equipment, policies and processes for managing COVID-19.

Employment terms and working conditions for registered nurses and nursing support workers should enable health, safety and wellbeing and equality at work. This is essential for both recruitment and retention of nursing workforce. Registered nurses and nursing support workers should be supported through fair workplace procedures as well as access to clinical supervision, continuing professional development (CPD) and opportunities for career progression. There must be sufficient dedicated funding of CPD and uptake improved for all registered nurses and nursing support workers, in all health and care settings, alongside pay progression and career development opportunities. Funding of CPD must be based on modelling on future service and population-based need. Fair and equitable pay, terms and working conditions can only be achieved by engaging directly with the nursing workforce, through the RCN and recognised trade unions and professional organisations.

We believe that the nursing profession should reflect the make-up of the UK's society in terms of gender, socio-economic background and ethnicity, amongst other characteristics. This requires structural issues within our undervalued profession to be addressed. At every stage of their career, from pre-registration education experiences through to the end of their careers, nurses from ethnic minority backgrounds experience the cumulative impact of both subtle and covert disadvantage. Employers must properly acknowledge and address the problem of structural racism within health and care settings and the impact it has on ethnic minority staff and patients. Structural racism must be taken seriously through demonstrable action to improve our understanding of the depth and complexity of the issue and better support staff who face discrimination at various points of delivering care.

The RCN fully expects employers to adhere to all their legal statutory and contractual obligations to protect the health, safety and wellbeing of staff in the workplace. A fundamental and integral component of that is safe workforce planning. If employers fail to comply with their legal obligations, the RCN will not hesitate to challenge locally, nationally and via the appropriate regulators.

The role of regulators

Health care professionals and service regulators across the UK have a clear role to play in strengthening support and insights around systemic staffing issues in all settings. As bodies dedicated to upholding quality of care, and owners of rich and nuanced data, there is significant potential for all health care regulatory systems to share intelligence and learning. They are also well placed to make use of their powers and duties to advocate for the nursing profession and challenge governments across the UK to take accountability for resolving issues outside the control of individuals and services.

The role of the Royal College of Nursing

Based on the *Nursing Workforce Standards*, we have established new UK-wide RCN principles for staffing for safe and effective care. These are the foundations for our leadership and activity in this domain, and we also expect these principles to underpin all decision making by policy makers and employers (RCN, 2022). It is in this context that the RCN is also seeking delegated authority from the NMC, our professional regulator, for the right to set standards for our profession, and for this to include enforceable standards when it comes to staffing for safe and effective care.

In addition, the RCN has committed to developing further resources and tools for members. We are seeking to refine and develop our positions on the uses of evidence-based workforce planning tools, nurse staffing numerical algorithms such as ratios and ranges and safety indicators.

We will always support members to raise concerns. Members can escalate a concern either verbally or in writing and employers have a duty to respond. If they do not, the RCN can help escalate concerns. The RCN's *Raising and Escalating Concerns* toolkit (2020b) includes a step-by-step guide on how to raise a concern. Additionally, we have produced a series of template letters for members to copy and paste into their local reporting system to help raise a concern swiftly.

The RCN has also developed a toolkit for safety representatives, to recognise and support them in their legislated right to carry out workplace safety inspections, examine health and safety-related data and be consulted on any changes that impact on the health and safety of our members (RCN, 2020c). This enables safety representatives to identify and negotiate workplace improvements which not only benefit members but the patients they care for. This work is part of the wider RCN Organising Programme, developing the approach to making positive change happen in the workplace, where members identify the issues, come together with colleagues and bring about solutions on their own terms.

Fair Pay for Nursing campaign

RCN members continue to fight for fair pay for nursing staff, in recognition of their level of responsibility and skill, and as the only action governments can take which has an immediate impact on nursing recruitment and retention. Nursing is the largest safety-critical profession in health care, playing a vital role in patient safety.

The campaign involves:

- recognising that salaries of nursing professionals has consistently fallen behind the cost of living and must now rise significantly to reflect that
- valuing the qualifications, skills, responsibilities and experience demonstrated every day by nursing staff
- ensuring that nursing is seen as an attractive, rewarding profession to tackle the tens of thousands of unfilled nursing posts.

Ultimately, the *Fair Pay for Nursing* campaign involves providing safe and effective care for all people of the UK. Members across the UK voted in ballots on the NHS pay

awards made for 2021-22. A significant number made clear that the fight for fair pay will continue as the 2022-23 pay awards arrive. When governments across the UK make pay awards this year, RCN members will once again have their say on whether these are acceptable or not and will undoubtedly have the profession's ability to recruit and retain staff front of mind.

The campaign aims to secure a pay increase that is 5% higher than the cost of living. Costs have been spiralling at an unaffordable rate and are set to continue rising. For example, inflation – the way we measure how quickly prices are rising – stood at 7.5% in December 2021.

The RCN's submission to the Pay Review Body applies to all nursing staff covered by NHS Agenda for Change terms, as part of a one-year deal that applies equally to all NHS pay bands. We are clear that there must be parity of pay and other terms and conditions for all nursing staff, regardless of employer. After years of underinvestment the government must act urgently to protect patient care by protecting the profession. We are clear that funding our health and care system is a political choice, and that there must be parity of pay and other terms and conditions for all nursing staff, regardless of employer.

Despite this, nursing remains understaffed and undervalued. After years of underinvestment governments must act urgently to protect patient care by protecting and enabling our profession.

Appendix 1 – Respondent demographic data

Profile of staffing survey respondents

There were 20,325 total responses to the survey. Not all respondents answered every question. The number of respondents for each question is in brackets above each table. Percentages are rounded to the nearest full number so the total may not equal 100%

Respondents by country (n=18,598)

England (n=14,600)	79%
Northern Ireland (n=581)	3%
Scotland (n=2,358)	13%
Wales (n=974)	5%
Outside UK (n=85)	0%

Respondents by place of work (n=20,325)

For the NHS, including GP practices	93%
In independent sectors	7%

Respondents by broad setting (n=20,325)

Care home	3%
Hospital	71%
Non-hospital urgent and emergency care[2]	2%
Prison/police custody	1%
The community[3]	22%
Other	1%

Was your last shift in a role you've been redeployed to due to the COVID-19 pandemic? (n=20,325)

Yes	3%
No	97%

Respondents by registration type (n=18,658)

Are you a registered nurse?

Yes	88%
No	12%

Respondents by work pattern (n=20,325)

Agency	2%
Bank	8%
Permanent	85%
Student/trainee	4%
Temporary	1%

2 Such as, call centre, walk in centre, home visits, etc.

3 Such as, general practice, district nursing team, hospice, school nurse, etc.

Appendix 2 – Survey findings presented by country

Please note that not all respondents answered every question.

Staffing levels

Planned vs. actual staffing (RNs)	England (n=11,234)	Scotland (n=1,933)	Wales (n=728)	Northern Ireland (n=435)	Outside UK (n=73)
0-24%	1%	1%	0%	1%	4%
25-49%	6%	5%	5%	5%	1%
50-74%	43%	46%	39%	39%	34%
75-99%	26%	26%	24%	29%	27%
100%+	25%	23%	32%	26%	33%

Planned vs. actual staffing (HCAs)	England (n=9,838)	Scotland (n=1,750)	Wales (n=680)	Northern Ireland (n=380)	Outside UK (n=66)
0-24%	9%	9%	8%	12%	9%
25-49%	8%	9%	8%	8%	2%
50-74%	36%	36%	37%	37%	30%
75-99%	14%	12%	15%	10%	15%
100%+	33%	34%	33%	34%	44%

	England (n=11,252)	Scotland (n=1,938)	Wales (n=728)	Northern Ireland (n=437)	Outside UK (n=73)
Shortfall of one or more registered nurses	75%	77%	68%	74%	67%
Shortfall of one or more health care support workers	67%	66%	67%	66%	56%
Shortfall of one or more nursing associates	50%	–	–	–	–

In your professional judgement, was the actual number of nursing staff sufficient to meet all the needs and dependency of the patients/service users safely and effectively?

Country	Yes	No	Don't know
England (n=14,600)	14%	83%	3%
Northern Ireland (n=581)	13%	83%	4%
Outside UK (n=85)	24%	72%	5%
Scotland (n=2,358)	12%	86%	2%
Wales (n=974)	12%	84%	3%
Total (n=20,325)	14%	83%	3%

In your professional judgement, was the skill mix appropriate to meet the needs and dependency of the patients/service users safely and effectively?

Country	Yes	No	Don't know
England (n=14,600)	28%	68%	4%
Northern Ireland (n=581)	24%	73%	4%
Outside UK (n=85)	33%	64%	4%
Scotland (n=2,358)	24%	73%	2%
Wales (n=974)	28%	69%	3%
Total (n=20,325)	28%	69%	3%

Did the sister/charge nurse/senior charge nurse/ward manager hold supernumerary/ supervisory* status throughout your whole shift? *Supernumerary/supervisory status – not counted in the registered nurse numbers providing direct care to patients for that shift

Country	Yes	No	Don't know
England (n=14,600)	23%	69%	8%
Northern Ireland (n=581)	26%	64%	10%
Outside UK (n=85)	14%	81%	5%
Scotland (n=2,358)	20%	72%	8%
Wales (n=974)	22%	70%	8%
Total (n=20,325)	22%	69%	9%

Did all of the students on your shift hold supernumerary status* throughout your whole shift?
***Supernumerary/supervisory status - not counted in the registered nurse numbers providing direct care to patients for that shift**

Country	Yes	No	Don't know
England (n=6,491)	53%	38%	9%
Northern Ireland (n=246)	48%	46%	6%
Outside UK (n=33)	64%	36%	0%
Scotland (n=1,097)	47%	46%	7%
Wales (n=425)	52%	40%	8%
Total (n=9,090)	52%	39%	8%

Impact of staffing levels on patient care

Do you feel patient care was compromised during your last shift/day at work?

Country	Yes	No	Don't know
England (n=14,600)	62%	32%	6%
Northern Ireland (n=581)	58%	35%	7%
Outside UK (n=85)	58%	40%	2%
Scotland (n=2,358)	69%	27%	4%
Wales (n=974)	63%	32%	5%
Total (n=20,325)	62%	33%	6%

Reason care was compromised by country

Care compromised reason	England (n=9,047)	Scotland (n=1616)	Wales (n=615)	Northern Ireland (n=339)	Outside UK (n=49)	Total (n=12,599)
Not enough registered nurses	81%	84%	78%	83%	78%	81%
Not enough nursing support staff	64%	62%	68%	59%	63%	63%
Increased patient acuity and/or dependency	58%	57%	59%	60%	59%	58%
High sickness and absence	50%	56%	46%	56%	57%	50%
Higher patient demand than expected/planned	51%	47%	47%	56%	53%	50%
The wrong skill mix balance	39%	41%	35%	42%	47%	39%
Too much time spent on non-nursing duties	37%	33%	34%	45%	43%	36%
Not enough medical staff	22%	20%	18%	23%	29%	21%
Not being able to discharge patients/ service	20%	19%	20%	20%	27%	19%
Difficulty referring patients to another setting (such as, outpatients, community, social care)	17%	16%	18%	17%	20%	18%
Difficulty referring patients to another service within your setting	18%	18%	17%	21%	31%	17%

Thinking about your last shift/day at work, how would you rate the overall quality of care provided?

Country	Good/very good	Neither	Poor/very poor
England (n=14,600)	58%	27%	15%
Northern Ireland (n=581)	64%	24%	12%
Outside UK (n=85)	54%	22%	24%
Scotland (n=2,358)	54%	28%	18%
Wales (n=974)	56%	30%	14%
Total (n=20,325)	58%	27%	15%

To what extent do you agree or disagree with the following

I had enough time to provide the level of care I would like

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	17%	65%	17%	1%
Northern Ireland (n=581)	17%	63%	18%	1%
Scotland (n=2,358)	16%	68%	15%	1%
Wales (n=974)	17%	65%	18%	1%
Outside UK (n=85)	22%	66%	12%	0%
Total (n=20,325)	17%	65%	17%	1%

I was concerned about the skill mix

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	51%	23%	22%	5%
Northern Ireland (n=581)	54%	19%	23%	4%
Scotland (n=2,358)	55%	22%	20%	4%
Wales (n=974)	49%	24%	23%	5%
Outside UK (n=85)	52%	26%	18%	5%
Total (n=20,325)	52%	22%	21%	5%

I was able to provide the quality of care that I would want to receive as a patient

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	26%	52%	21%	1%
Northern Ireland (n=581)	28%	49%	22%	1%
Scotland (n=2,358)	22%	58%	19%	1%
Wales (n=974)	25%	52%	21%	1%
Outside UK (n=85)	31%	54%	15%	0%
Total (n=20,325)	26%	53%	21%	1%

Due to the lack of time, I had to leave necessary care undone

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	43%	33%	19%	4%
Northern Ireland (n=581)	40%	38%	19%	3%
Scotland (n=2,358)	45%	34%	18%	4%
Wales (n=974)	41%	36%	18%	4%
Outside UK (n=85)	44%	39%	16%	1%
Total (n=20,325)	43%	33%	19%	4%

Too much of my time was spent on non-nursing duties

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	47%	23%	26%	5%
Northern Ireland (n=581)	56%	19%	22%	3%
Scotland (n=2,358)	46%	23%	27%	5%
Wales (n=974)	46%	25%	25%	4%
Outside UK (n=85)	49%	27%	19%	5%
Total (n=20,325)	47%	23%	26%	4%

I was concerned that support staff were being expected to perform the duties of registered staff

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	27%	41%	16%	15%
Northern Ireland (n=581)	20%	46%	17%	16%
Scotland (n=2,358)	28%	42%	16%	15%
Wales (n=974)	24%	47%	17%	12%
Outside UK (n=85)	21%	41%	22%	15%
Total (n=20,325)	27%	41%	16%	15%

I was provided with the appropriate supervision and support

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	24%	39%	26%	11%
Northern Ireland (n=581)	20%	40%	28%	11%
Scotland (n=2,358)	18%	43%	26%	12%
Wales (n=974)	21%	40%	29%	10%
Outside UK (n=85)	27%	45%	22%	6%
Total (n=20,325)	23%	40%	26%	11%

I had the time to support relatives and those of importance to the patient

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	17%	46%	19%	17%
Northern Ireland (n=581)	19%	48%	18%	14%
Scotland (n=2,358)	14%	50%	17%	20%
Wales (n=974)	16%	48%	18%	18%
Outside UK (n=85)	27%	38%	21%	14%
Total (n=20,325)	17%	47%	19%	17%

Clinical care took place in an inappropriate environment eg, a waiting room or corridor

Country	Agree	Disagree	Neither agree nor disagree	Not applicable
England (n=14,600)	23%	45%	7%	25%
Northern Ireland (n=581)	25%	43%	7%	25%
Scotland (n=2,358)	22%	45%	6%	27%
Wales (n=974)	23%	43%	6%	27%
Outside UK (n=85)	28%	44%	2%	26%
Total (n=20,325)	23%	45%	7%	25%

Impact of staffing levels on nursing staff

To what extent do you agree or disagree with the following

I felt fulfilled

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	16%	55%	28%
Northern Ireland (n=581)	16%	58%	26%
Scotland (n=2,358)	12%	65%	23%
Wales (n=974)	13%	62%	25%
Outside UK (n=85)	16%	56%	27%
Total (n=20,325)	16%	56%	28%

I felt positively challenged

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	25%	48%	27%
Northern Ireland (n=581)	22%	52%	26%
Scotland (n=2,358)	21%	56%	23%
Wales (n=974)	21%	55%	24%
Outside UK (n=85)	21%	55%	24%
Total (n=20,325)	25%	49%	27%

I felt satisfied with the care I had provided and the job I had done

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	31%	44%	24%
Northern Ireland (n=581)	30%	43%	27%
Scotland (n=2,358)	26%	52%	23%
Wales (n=974)	31%	47%	22%
Outside UK (n=85)	34%	52%	14%
Total (n=20,325)	31%	45%	24%

I felt exhausted, but I felt positive

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	31%	45%	25%
Northern Ireland (n=581)	28%	48%	24%
Scotland (n=2,358)	21%	56%	23%
Wales (n=974)	25%	49%	26%
Outside UK (n=85)	19%	58%	24%
Total (n=20,325)	30%	46%	25%

I felt exhausted and I felt negative

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	54%	27%	19%
Northern Ireland (n=581)	56%	25%	18%
Scotland (n=2,358)	63%	20%	17%
Wales (n=974)	57%	24%	18%
Outside UK (n=85)	64%	27%	9%
Total (n=20,325)	54%	27%	19%

I felt demoralised

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	51%	25%	24%
Northern Ireland (n=581)	52%	22%	25%
Scotland (n=2,358)	59%	19%	21%
Wales (n=974)	53%	22%	25%
Outside UK (n=85)	59%	24%	18%
Total (n=20,325)	51%	24%	25%

I felt upset/sad that I could not provide the level of care I had wanted

	Agree	Disagree	Neither agree nor disagree
England (n=14,600)	59%	20%	20%
Northern Ireland (n=581)	60%	20%	20%
Scotland (n=2,358)	65%	16%	19%
Wales (n=974)	61%	18%	21%
Outside UK (n=85)	58%	25%	18%
Total (n=20,325)	59%	20%	20%

Impact of staffing levels on nursing staff

Did you feel appropriately prepared, and working within your scope of practice for the people you were caring for during this shift?

Country	Yes	No	Don't know
England (n=14,600)	65%	32%	3%
Northern Ireland (n=581)	64%	33%	3%
Outside UK (n=85)	73%	27%	0%
Scotland (n=2,358)	61%	36%	3%
Wales (n=974)	60%	36%	4%
Total (n=20,325)	65%	32%	3%

During your last shift, were you able to take the breaks you were supposed to take?

Country	Yes	No	Don't know
England (n=14,600)	38%	62%	0%
Northern Ireland (n=581)	40%	60%	1%
Outside UK (n=85)	39%	61%	0%
Scotland (n=2,358)	37%	63%	0%
Wales (n=974)	39%	60%	1%
Total (n=20,325)	39%	61%	0%

Did you work any additional minutes/hours on your last shift/day at work?

Country	Yes	No	Don't know
England (n=14,600)	64%	36%	1%
Northern Ireland (n=581)	64%	36%	0%
Outside UK (n=85)	64%	36%	0%
Scotland (n=2,358)	62%	37%	1%
Wales (n=974)	63%	36%	1%
Total (n=20,325)	63%	37%	1%

How much additional time did you work?

Country	Up to half an hour	Between half an hour and an hour	More than an hour but less than 2 hours	More than 2 hours but less than 3 hours	More than 3 hours
England (n=9,292)	30%	36%	21%	8%	4%
Northern Ireland (n=369)	32%	36%	22%	7%	3%
Outside UK (n=54)	26%	20%	31%	13%	9%
Scotland (n=1,454)	35%	37%	19%	6%	3%
Wales (n=615)	28%	40%	21%	8%	3%
Total (n=12,730)	31%	36%	21%	8%	4%

Was this additional time?

Country	Paid	Unpaid	Given as TOIL
England (n=9,292)	11%	77%	12%
Northern Ireland (n=369)	7%	82%	11%
Outside UK (n=54)	15%	61%	24%
Scotland (n=1,454)	7%	83%	9%
Wales (n=615)	11%	70%	20%
Total (n=12,730)	11%	77%	12%

Thinking more generally, if there are not enough staff or if patient care is compromised, have you been able to raise a concern?

Country	Yes	No	Not applicable
England (n=14,600)	73%	21%	6%
Northern Ireland (n=581)	65%	28%	7%
Outside UK (n=85)	69%	21%	9%
Scotland (n=2,358)	69%	25%	6%
Wales (n=974)	71%	24%	5%
Total (20,325)	72%	21%	6%

When you raised a concern, was any action taken to try to address the issue?

Country	Yes	No	Don't know
England (n=10,652)	37%	40%	22%
Northern Ireland (n=380)	37%	40%	23%
Outside UK (n=59)	28%	28%	13%
Scotland (n=1,619)	35%	45%	19%
Wales (n=694)	34%	40%	26%
Total (n=14,608)	36%	39%	22%

RCN *Nursing Workforce Standards*

Were you aware of the RCN *Nursing Workforce Standards* by country (n=20,325)

	England (n=14,600)	Northern Ireland (n=581)	Outside UK (n=85)	Scotland (n=2,358)	Wales (n=974)	Total (n=20,325)
No	56%	52%	58%	55%	50%	55%
Yes	44%	48%	42%	45%	50%	45%

Are the RCN *Nursing Workforce Standards* being used in your workplace by country (n=9,077)

	England (n=6,426)	Northern Ireland (n=279)	Outside UK (n=36)	Scotland (n=1,053)	Wales (n=491)	Total (n=9,077)
Don't know	49%	49%	33%	46%	45%	48%
No	31%	31%	50%	40%	37%	32%
Yes	20%	20%	17%	13%	18%	19%

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Royal College of Nursing
20 Cavendish Square
London
W1G 0RN

www.rcn.org.uk

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