RCN INSTITUTE OF NURSING EXCELLENCE

NURSING WORKFORCE ACADEMY

NURSING PRACTICE ACADEMY

Registered Nurse-to-Patient Ratios: A synthesis of current guidance in the UK

Royal College of Nursing

Contents

Foreword by Professor Jane Ball

Fifteen years ago, whilst working at the Royal College of Nursing (RCN) as a policy adviser, I wrote the RCN's guidance on Safe Nurse Staffing in the UK. It was well supported in all four UK countries and welcomed by chief nurses and RCN stewards alike. It was published as the events at Mid Staffordshire were coming to light. Not for the first time, insufficient nurse staffing had been identified as a key factor in the compromised care that had fatal consequences for many patients.

It was a proud moment for me to think this guidance might help raise awareness of the critical role that nurse staffing plays in patient safety. Not only raise awareness, but that the new RCN guidance could help improve decision making around planning nurse staffing, in every service and every part of the UK. By promoting the use of both planning tools and professional judgement, within a context of specialty-specific guidance, nurse staffing establishments could be sufficient (allowing for predictable absence levels) to ensure there are always enough staff on duty to provide safe and effective care. I left the RCN to return to the world of research, to build the evidence on the difference that nurse staffing makes to patient care.

In the subsequent years we've seen the importance of nurse staffing recognised in all four UK countries. In England, NICE was commissioned to produce nurse staffing guidelines for each setting, starting with adult inpatient (published in 2014). In 2016, Wales became the first country in the UK to have legislation on nurse staffing levels, making explicit the legal duty of health boards to calculate and maintain appropriate levels of nurse staffing, and to report their compliance. This was followed by Scotland's Health and Care (Staffing) Act 2019, enacted in April 2024, which placed legal duties on both health care providers and on the Scottish government. Providers have a duty to ensure there are always suitably qualified staff working in the right numbers to ensure safe and effective care. Scottish government have a duty to ensure an adequate supply of staff to enable employers to achieve safe staffing levels, including registered nurses, midwives, allied health professionals and doctors.

The 2014 *Delivering Care* policy in Northern Ireland put forward a framework for planning nurse staffing, which included 'normative ranges' and in 2020 a commitment was made to develop safe staffing legislation for nursing. A consultation was undertaken in 2024 (Nursing and Midwifery Task Group, 2020).

Given such legislative progress we might expect that the dangers of insufficient nurse staffing in the UK to have been significantly reduced. Certainly, there has been some progress made. For example, in England, seven years after safe staffing policies were introduced following the Francis Inquiry (2013), 94% of directors of nursing said that trust board awareness of staffing as an issue had improved, and nationally the number of registered nurses (RNs) employed increased (Ball et al., 2019; Ball and Saville, 2020). However, the number of patients treated in this period also increased. Thus, average staffing levels did not significantly improve: 1:4 trusts reported routinely having wards staffed at the NICE defined 'hazard' level, of one registered nurse (RN)to every eight patients (or worse). Analysis of 2024 data found only one in 12 hospitals were fully implementing the safety measures brought in after the Francis Inquiry (2013).

Although committed to improving nurse staffing levels and making use of the NICE endorsed planning tools such as the Safer Nursing Care Tool (SNCT), national shortages meant trusts were unable to recruit the RNs they needed. The bottom line, policy guidance and the willingness of employers is not enough, if there are not nurses available to fill posts, or resources to employ them.

In 2019, the Westminster government pledged to tackle the nursing workforce supply crisis in England by increasing RNs in the NHS by 50,000 by 2024. N50k (as the policy was termed) was a short-term intervention to what has been a long-term problem: failure to adequately plan and invest to ensure a skilled nursing workforce of sufficient scale to meet the nation's needs. The target was met by March 2024 – primarily through a massive recruitment drive to attract nurses from other countries.

However, the following year, health services across the country introduced recruitment freezes, and we heard reports of the much sought after new graduate nurses not being able to secure jobs. Following a successful petition by the RCN, a response by central government responded to the crisis offering a graduate job offer guarantee. The financial restriction on health and care services continues to impact on the nursing workforce, with many areas running short staffed.

The benefits expected from the various guidance and systems put in place have not been realised. We need a new and enforceable solution to what has become an intractable chronic problem. A solution that goes beyond guidance and examples of best practice and one that cannot be ignored in times of financial difficulty (which are a constant in public sector health and social care driven by increased demand and restricted capacity). We cannot allow patients to pay the price for repeated administrations not understanding the value of RNs in the care of people at every stage of life (and death). Recognising the safety critical role of RNs, the RCN is thus fully committed to campaigning for the introduction of mandated minimum nurse staffing levels.

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Workforce policies that ensure sufficient nurses are present can radically transform care quality, the working lives of nursing staff and improve the nursing labour market (Aiken et al., 2023). Research from Australia demonstrates that minimum nurse-to-patient ratio policies are a feasible approach to improve nurse staffing and patient outcomes, to reduce readmissions, shorten lengths of stay and overall offer a good return on investment (McHugh, 2021). Better nurse staffing was associated with 24% lower odds of nurses experiencing high burnout and 27% lower odds of job dissatisfaction (Lasater et al., 2025). In California, minimum nurse-to-patient ratio legislation implemented in 2004 has had a sustained positive impact on nurse staffing, including lower levels of burnout, greater job satisfaction and better retention of nursing staff, compared to other states (Muir et al., 2025).

Safe registered nurse staffing levels are associated with improved retention and staff satisfaction, which supports conditions for nursing to thrive (Dall'ora and Griffiths, 2025).

Nurses value being part of care services which ensure patients receive quality care, which minimise risk to patients and staff, reduce the occurrence of adverse events, and demonstrate effectiveness and efficiency.

As a Royal College and the world's largest representative professional body, the RCN is committed to a multi-year programme of work to ensure that we treat the issue of nurse staffing with the care and diligence we know it deserves. Decisions on minimum nurse-patient ratios should be taken carefully, using evidence and taking account of the expertise of our most experienced and knowledgeable practitioners. The international recruitment drive in England, succeeded in increasing national numbers of RNs and filling many vacancies in acute hospitals. However, the benefit of number increases was not applied equally across the country, or across health and care settings. The net national growth in RNs has had minimal impact on shortages in mental health, community and learning disabilities. In addition, many more experienced nurses have since left the NHS (and nursing), as sustained improvement in working conditions has not been realised in many areas.

This resource represents a critical stage in our commitment to making safe staffing an embedded reality across nursing, rather than an aspiration. It aims to provide a comprehensive review of the legislative foundations and frameworks across the four UK nations and a summary of current UK guidance on safe staffing , along with guidance from across nurse staffing care settings.

We hope this resource will prove helpful to RNs, policy makers and providers and inform decision making for workforce planning as well as provide an overview of current approaches. The identification of gaps in the evidence is also important to highlight further areas for research and evidence informed guidance. Where legislation exists, it is essential to understand if the implementation is effective. We can then make explicit the gaps in knowledge and in policy guidance, and work collaboratively to fill them, and where legislation is not being measured for impact, identify priorities for data capture.

Our surveys of members and their descriptions of severely compromised care show levels are routinely falling well below what any of us would regard as acceptable. This has to change. Guidance alone is not enough; we need enforceable minimum registered nurse staffing levels to protect both patients and staff from harm.

We trust that this document is not only another step towards that destination but is useful in its own right – so that better use can be made of existing guidance.

Professor Jane Ball

Director, RCN Institute of Nursing Excellence

Introduction

Nursing is a safety critical profession. The work of RNs consists of many specialised and complex interventions, interwoven skilful expertise and surveillance (Stalpers et al., 2025). Across diverse settings, nursing presence and vigilance is critical to the safety of people, the prevention of avoidable harm and the management of risks. The RCN published a literature review (Tamburello et al., 2023) regarding the impact of staffing levels on safe and effective patient care and produced a position summary that highlighted consequences and costs of insufficient staffing.

Evidence on the impact of nursing staffing on patient and nurse outcomes includes:

- each additional patient per registered nurse was associated with the patient having to stay longer in hospital, as well as being: 12% more likely to die in hospital; 7% more likely to die after 60 days; 7% more likely to be readmitted after 60 days (Lasater et al., 2021)
- decreasing the workload of a registered nurse by one patient was associated with 7% fewer patients returning to hospital within a week, 30-day mortality rates decreased by 7% and patients left hospital 3% faster (Aiken et al., 2014)
- for every additional patient a registered nurse was caring for, the odds of a patient dying within 30 days of admission increased by 7%. (Aiken et al., 2014)
- for every 10% increase of missed care by registered nurses, the chance of a patient dying within 30 days of admission increased by 16%. (Ball et al., 2018)
- nurses working in hospitals with fewer registered nurses per patient were more likely to report higher levels of burnout, intent to leave their job, lower qualities of care and give their hospital an unfavourable patient safety grade (Lasater et al., 2021)
- nursing homes with high levels of registered nurses had the lowest rehospitalisation and emergency department visit rates (Yang, 2021).

A substantial body of evidence, collated over many decades, supports a critical connection between RN staffing levels and both patient and nursing wellbeing outcomes.

It is critical that the right nursing staff with the right skills are present at the right time and place, and are paid appropriately for the work they do. However, our members consistently tell us that this does not happen; 83% of nursing staff surveyed by the RCN stated that staffing levels on their last shift were not sufficient to meet all the needs of the patients safely and effectively (Royal College of Nursing (2022) Nursing under unsustainable pressures: staffing for safe and effective care in the UK).

In December 2023, the RCN brought together senior nurse leaders from across the UK to hear from international workforce experts, assess the evidence and agree our collective vision for the future (access RCN Safe Staffing summit videos).

Two further events were facilitated in 2024: a UK senior workforce managers' event in March and a follow-up summit for senior nurse leaders from across the UK in May. This was then followed by the Mona Grey Lecture at Congress 2024 which focused on ratios to support dissemination to wider membership. At Congress 2025 the revised Nursing Workforce Standards were launched, which stated : '*Establishments should be set in such a way as to ensure that nurse staffing can always exceed the critical minimum staffing levels (defined by registered nurse-to-patient ratio). Where a registered nurse-to-patient ratio has been set (through legislation or evidence-based guidance supported by professional consensus), employers must ensure that establishments are sufficient to always exceed the minimal level.*' (Standard 2d).

The RCN endorses enforceable minimum RN-to-patient ratios, ensuring staffing levels do not fall to dangerously low levels and helping protect patients and nursing staff from avoidable harm. Minimums are exactly that – a minimum that should always be exceeded – not a target. For the optimum level of RN staffing to be achieved baseline staffing levels (i.e. the 'nursing establishment') need to be sufficient across all providers to meet predicted levels of demand without compromise to care quality.

Minimum ratios are an evidence-based failsafe; they do not replace effective workforce planning (using workload assessment tools and professional judgment). They prevent dangerously low levels from being reached. Establishment setting – that is, planning the total number of permanent nursing staff that make up the 'establishment' employed to provide a particular service - should be determined using the best available guidance, for example, NICE guidelines, and meeting the RCN's Nursing Workforce Standards | Publications | Royal College of Nursing.

Members have also stated the importance of attending to settings where there is little nurse staffing guidance, and no specific reference made to a ratio, so it is also important to highlight these as areas where more research and guidance are urgently needed.

About this resource

This resource makes explicit the information that is available (or not available) on registered nurse-to-patient ratios identified in staffing guidelines for different specialties. Where a nurse-to-patient ratio has been identified in published guidance, it may be valuable for staff and managers to refer to as part of discussion on what nurse staffing levels should be, in a meaningful way. There needs to be clarity on exactly what the ratio is, whether it refers to the absolute minimum required to avoid harm, an average, a range, or an optimal level for good quality care. Decision makers also need to be aware of the methodology and underpinning evidence that has been used to generate the guidance, and consider other factors (some of which will relate to the local context) that are likely to impact on nurse staffing need.

We have set out the information that we have collated according to clinical settings, and endeavour to make explicit which parts of the UK guidance it applies to or stems from. However, we acknowledge the real expertise and knowledge on nurse staffing guidance, and what is currently in use (or planned) lies with nurses and leaders in each country, working in different fields.

This is a beginning point of what we intend to be a live and evolving resource. We would encourage you to also be involved in its development by letting us know what needs adding or updating.

What do we mean by ratios?

Registered nurse-to-patient ratios refer to the average number of patients per RN for a specific shift or work period. Ratios will look different depending on clinical settings and contexts (see page 10).

Safety critical, optimal standards, and benchmark averages

A key point to note before considering using ratios referred to in current guidelines, is that they are set at different levels, depending on the intention of the guidance. In some guidance (such as the NICE adult inpatient setting guidance), the ratios referred to (1:8 RN: patients, excluding the nurse in charge) is the hazard level – a safety critical line which must not be crossed, as there is evidence of significantly increased risks (such as risk of avoidable hospital mortality). It is therefore an absolute minimum.

Meanwhile in other cases the ratio set represents what is seen as the level required to maintain safety and deliver optimal care effectively. Some guidance sits between the two. The level set is a norm or benchmark and refers to what is expected to be the typical or average level required. However, creating staffing schedules at the 'mean' requirement comes with risks: half of the shifts will require more than the average (Griffiths, 2020). So, staffing to the average means that typically – on any given shift, the level of staffing achieved will be less than deemed safe for patients and staff.

As nurses and managers seek to make use of existing guidance (much of which is outlined in this resource) the complexity of this issue demands clarity in what the standard is, its purpose, along with evidence and knowledge about how it was arrived at.

A substantial body of evidence, collated over many decades, supports a critical connection between RN staffing levels and both patient and nursing outcomes (Dall'Ora et al., 2022; Blume et al., 2021). Extensive international and UK research, including large-scale longitudinal studies, indicate that lower nurse staffing levels are linked with heightened risks of adverse patient events, preventable complications, and increased in-hospital mortality. Inadequate nurse staffing is also a primary driver of clinician burnout, workplace injury, and diminished job satisfaction. Having carefully reviewed the evidence, and listened to experts, nurses and nursing leaders (across the UK and from around the world), we are confident that the RCN position – to campaign for the enforced nurse-to-patient ratios, to ensure minimum levels are always exceeded - is well supported by evidence and expertise, as well as expert consensus.

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Ratios across settings

a) Registered nurse-to-patient ratio

Most typically used in inpatient settings, where the number of patients and nurses is more clearly defined, at its simplest, this is a straightforward calculation of how many patients there are relative to number of registered nurses. So, if there are 24 patients and four RNs on a ward, the ratio of RN: patients is 1:6. However, in many guidelines the ratio stipulated is explicit that the nurse in charge is excluded from the ratio – on the basis that they should not have individual patients assigned to them. In which case, to achieve a 1:6 ratio, a ward with 24 patients would need a nurse in charge (not 'counted in the numbers' in terms of patient loads) plus four RNs, totalling five RNs per shift.

Where guidance (or legislation in other parts of the world) uses ratios, it may refer to the average nurse-to-patient ratios to be achieved. As in the example above, the overall ratio required for the ward may be 1:6 but patients may be distributed differently between staff, depending on their acuity/dependency. For example, some RNs have responsibility for eight patients whilst others only have four, but the average achieved remains 1:6.

In other cases, a stipulated ratio may be more specifically referring to the maximum number of patients allocated to each nurse ie, no nurse can care for more than six patients.

b) Registered nurse: population

This is the number of registered nurses required for a population (WTE) whole time equivalent.

Examples

- A minimum of one dedicated WTE designated nurse looked after children for a population of 70,000. Therefore, a population of 280,000 people needs four WTE registered nurses (with the appropriate skills). (see Safeguarding Children and Young People: Roles and competencies for health care staff).
- One WTE health visitor per 250 children under five years old.* (https://bit.ly/3xmhlfR).
- There should be a minimum of one qualified school nurse for each secondary school and its cluster of primary schools.

c) Caseloads

This is the number of cases for which a registered nurse should be responsible. This may be a 'case load' that they have responsibility for over a period of time. Or it may be expressed as a limit on the amount of home visits or consultations that can safely be facilitated in their working hours that day or night. Since working hours vary, this is more helpfully expressed as a minimum time per client or patient.

Examples

- Named nurse for looked after children with a maximum caseload should be of no more than 50.
- The Queen's Institute of Community Nursing (QICN) workforce standards state a district nurse should not have more than nine to 10 visits per day and a wider caseload cap of 150 people (see District Nursing).

Beyond ratios

- Nurse staffing (and the planned or achieved nurse-to-patient ratio) may need to be higher than set out in guidance, depending on acuity and other factors assessed by professional judgement.
- In most settings, a supervisory registered nurse in charge (enhanced level or above) is required in addition to the planned levels, to ensure clinical leadership and safety Levels of nursing | Royal College of Nursing.
- The nursing support workforce is an integral part of the nursing team, and it is important that there are funded establishments (and actual workforce) that, where necessary includes these roles to support and/or assist the registered nurses. This is in addition to the ratio provided for the registered nurse.
- Guidance and ratios should be considered alongside the RCN Nursing Workforce Standards.

An overview of UK legislation and frameworks within the four UK countries

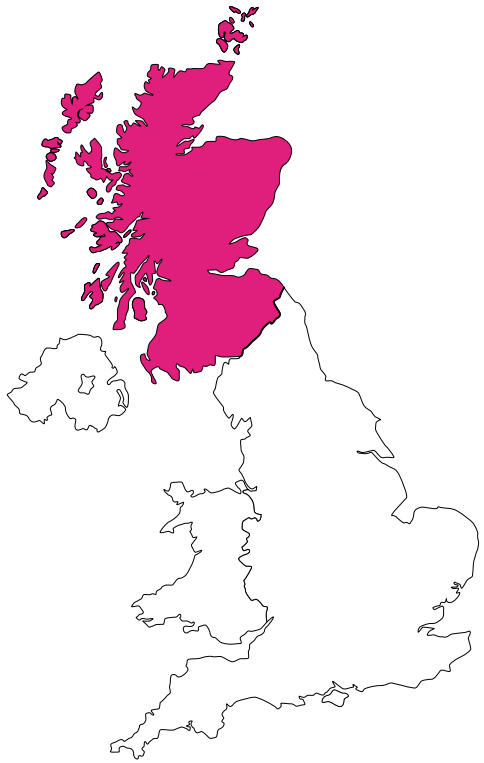
Legislation on safe nurse staffing differs across the four UK countries. We present an overview here and further indepth information is available on the RCN websites: England, Scotland, Wales, Northern Ireland

Scotland has mandatory safe staffing legislation for nurses, requiring employers to use approved tools and methodologies to ensure sufficient staffing for safe patient care (Health and Care (Staffing) (Scotland) Act 2019 and the Nurse Staffing Levels (Wales) Act 2016) places a duty on organisations to ensure there are sufficient nurses to care sensitively in every setting and a focused duty to apply evidence-based tools and a triangulated methodology, which is a statutory requirement, to set staffing levels in medical, surgical and children's inpatient services.

England and Northern Ireland currently do not have national legislation for mandatory safe staffing numbers, relying instead on guidance and a combination of evidence-based tools, professional judgment, and outcomes.
In all four nations, using acuity tools is a key component of determining staffing needs, either mandated by law or through professional guidance.

Scotland

The Health and Care (Staffing) (Scotland) Act 2019, which came into force in April 2024 established a mandatory framework for appropriate staffing levels in health and care settings. Instead of prescribing staff-to-patient ratios, the legislation uses a flexible, evidence-based approach to determine safe staffing levels that can be adapted to local circumstances and patient needs, including the use of a professional judgement tool and specialty-specific staffing level tools to inform establishments, but does not mandate safe staffing levels. When deciding the number and skill mix of staff required, health boards must also take account of the service type, local context, the number and needs of the patients and appropriate clinical advice. Health boards are required to have arrangements for the real-time assessment of staffing levels to ensure services are responsive to changing clinical need and to have a process for escalating risks.



Implementation is supported by Healthcare Improvement Scotland and the Care Inspectorate, who are responsible for monitoring compliance and developing staffing methodologies.

The Act applies to both health and social care in all care settings. It places a legal duty on the NHS and care providers to ensure that there are always sufficient suitably qualified and competent staff available and mandates the Scottish government to take all reasonable steps to ensure an adequate supply of registered nurses, midwives, and medical professionals. The Act includes measures for providers to identify staffing risks in real-time and for the Scottish government to report annually to parliament on its progress.

The legislation includes eight guiding principles that must be considered when determining staffing arrangements:

- prioritising improved standards and outcomes for service users
- considering the individual needs, characteristics, and circumstances of patients and care users
- respecting the dignity and rights of service users
- considering views of both staff and service users
- ensuring the wellbeing of staff, recognising its impact on the quality of care
- promoting transparency and open communication with staff and service users about staffing decisions
- allocating staff effectively and efficiently
- promoting multidisciplinary services.

The Act imposes several statutory duties on NHS boards

- Appropriate staffing: An overarching duty to ensure there are always a suitable number of qualified and competent staff.
- Real-time assessment: Establish and maintain arrangements for the real-time assessment of staffing levels to respond to changing patient needs.
- Risk escalation: Put in place clear procedures to identify, escalate, and mitigate staffing-related risks.
- Clinical advice: Seek and consider professional clinical advice when making staffing decisions. The reasons for any decisions that go against this advice must be recorded.
- Adequate time for leaders: Ensure that clinical leaders, such as charge nurses and medical directors, have sufficient time to carry out their staffing and leadership responsibilities.
- Common Staffing Method: Use the Common Staffing Method, a set of approved workload planning tools, in specified clinical areas.
- Training and consultation: Ensure staff receive appropriate training and are encouraged to give feedback on staffing arrangements.
- Agency worker reporting: Report quarterly on the use of high-cost agency staff.

For care service providers

- Care service providers have a duty to ensure they have an appropriate number of suitably qualified and competent staff
- The Care Inspectorate can develop staffing methods and tools for the care sector, which Scottish ministers can then legally require providers to use.

The government has its own responsibilities under the Act which include ensuring registered nurses and midwives are available and submitting an annual report to the Scottish parliament on the operation of the legislation. Health boards, special health boards, and local authorities are required to submit annual reports on their compliance and The Care Inspectorate is responsible for monitoring compliance in the social care sector and can conduct its own reviews of the Act's effectiveness (Chapter 16).

The Act strengthens the position of staff and patients by providing explicit rights and expectations including raising concerns about staffing levels without fear of retribution and entitlement to receive feedback on how those concerns have been addressed and placing the statutory duties on providers.

Evaluation

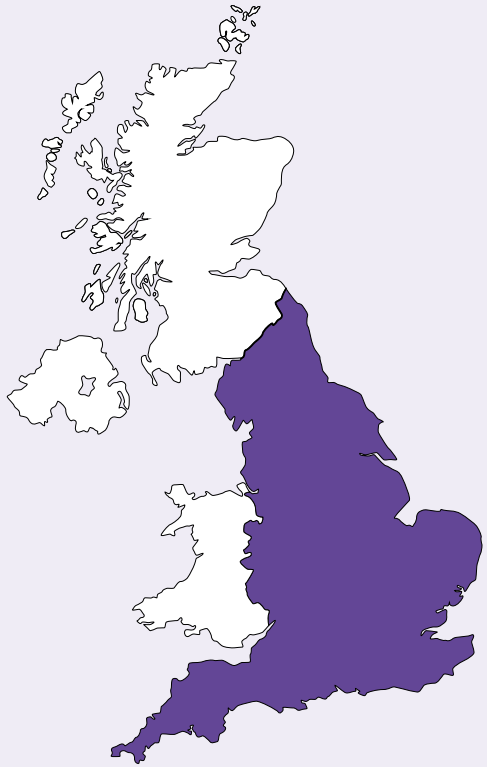
As the Act was implemented in 2024, current reviews have focused on the initial implementation and the systems being put in place, rather than the long-term impact and outcomes, so this is yet to be established. While the Act references the Health and Social Care Standards, evaluating the direct link between the new staffing duties and improvements in patient outcomes, this is acknowledged to be complex. Reporting templates require improved outcomes, as the detail is currently limited, and further revisions have been recommended in the RCN Scotland response to consultation policy document (Royal College of Nursing (2025) Health & Care (Staffing) (Scotland) Act 2019 reporting template | Scotland | Royal College of Nursing).

The challenges are identified both in the RCN report published in May 2025 which details that the number of nurses employed is insufficient to meet the demand to ensure safe and effective nursing care delivery rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Countries-and-regions/Scotland/2025/The-Nursing-Workforce-in-Scotland-2025.pdf

Lake et al's (2025) baseline evaluation of the Act's implementation collected data from a sample of 1,870 RNs and nursing support workers across all regions of Scotland. Only 9% reported that staffing was appropriate for safe, high-quality delivery of care every shift, and only 17% reporting that the quality of care was excellent. 45% of the sample reported an intention to stay in their current job over the next year and from those intending to leave their current job, about half planned to leave the profession through retirement or alternative change.

England

England does not have specific legislation mandating nurse-to-patient ratios, operating under a system of national guidance for NHS trusts and regulatory oversight by the Care Quality Commission (CQC) Regulation 18 which stipulates providers must deploy a sufficient number of suitably qualified, competent, and experienced staff to meet the needs of people using the service and ensure safety. The CQC can take regulatory action if this standard is not met, however it is not a prosecutable offence. The National Quality Board guidance sets the expectation for safe staffing, requiring NHS boards to make local decisions and to have escalation policies for when staffing levels fall short.



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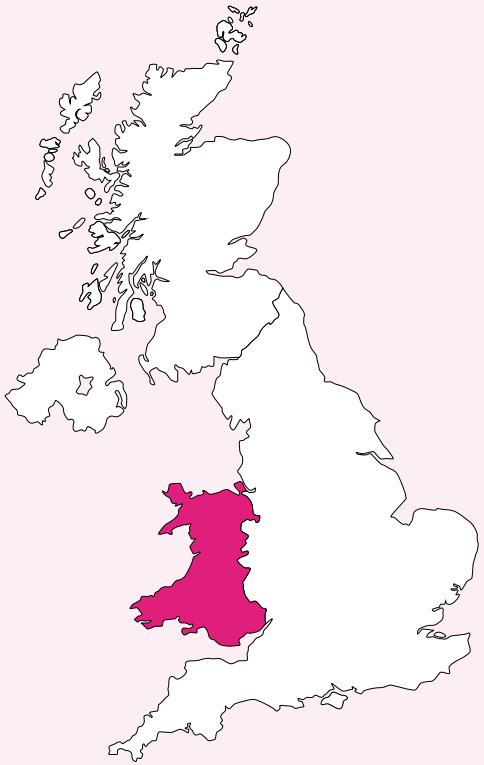
Wales

Wales was the first UK country to legislate on nurse staffing levels with the Nurse Staffing Levels (Wales) Act 2016. Duties in Section 25A (2017) applied to all commissioned and provided NHS services where nurses are required and Section 25B of the Act initially applied to adult acute medical and surgical wards and was extended to paediatric inpatient wards in 2021 and legally requires, through Section 25B, that health boards must calculate appropriate nurse staffing levels, take all reasonable steps to maintain those levels, and inform patients of the staffing level on the ward. Using a triangulated approach of professional judgement by senior nurses, and RNs and clinical leaders, evidence-based workforce planning tools and nurse sensitive indicators, the appropriate nurse staffing levels are determined. Final agreed nurse staffing levels, including the establishment and planned rotas must be agreed by the designated nurse with sufficient seniority such as the executive director of nursing. Section 25E requires health boards to submit reports to the Welsh Government every three years on compliance and any actions taken in response to shortfalls.



Evaluations and findings

Post-legislative scrutiny by the Senedd's Health and Social Care Committee (HSCC) and reports from the RCN Wales (2023) found mixed results on the Act's impact. These include positive outcomes including:

- increased transparency and accountability, making safe staffing a corporate responsibility for health board management, increased investment in nursing, resulting in improved staffing levels on wards covered by Section 25B
- the formal inclusion of nurses' professional judgment in staffing calculations has empowered nursing teams
- health boards are now using improved data capture and planning, with a national IT system implemented to track shift-by-shift staffing.

So far there is little evidence of improved patient outcomes and staff wellbeing. Compliance by health boards has been an issue with the Health and Social Care Committee (HSCC) highlighting concerns that the lack of statutory guidance for the overarching Section 25A made it difficult to ensure consistent compliance across all settings. The HSCC made several recommendations in 2024 to strengthen the Act, including:

- developing and clarifying guidance for Section 25A
- specifying clearer consequences for non-compliance with the Act
- providing a timeline for the extension of Section 25B to other settings, starting with mental health and community nursing
- ensuring independent inspectors like Health Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) report on compliance with the Act.

Kendal Andreason, RCN Professional Lead for Acute and Emergency Care and Defence Nursing

Northern Ireland

Northern Ireland does not yet have specific safe staffing legislation, however, the Delivering Care Policy Framework (2026) has been refreshed to ensure that nursing and midwifery workforce and workload planning in Northern Ireland remains robust, evidence-based, and responsive to the evolving needs of the population and the Health and Social Care system.

Key areas of focus within the scope of the refresh include:

- defining the responsibility and accountability for strategic workforce and workload planning across all fields of nursing and midwifery
- clarifying responsibility and lines of accountability for operational workforce and workload planning across all fields of nursing and midwifery
- making population health the centre of the workforce planning process

- using the six-step methodology in workforce planning and providing guidance on its implementation within workforce planning processes. The methodology emphasises the importance of engagement with service planning and design, working in partnership with service users and stakeholders and taking account of population and demographic needs

- a review of safe staffing legislation and processes within the UK nations where this is already in place (Scotland and Wales)

- agreeing safe staffing tools for use across the variety of health care settings and the frequency the Department of Health and Social Care is currently working in partnership with Scotland to secure access to the staffing level tools they utilise and the best available evidence will then be used to determine the most appropriate tool for each setting context in Northern Ireland

- securing regional agreement on monitoring arrangements to ensure effective workforce/workload planning, including the use of digital technologies, in line with any safe and effective staffing legislation should this arise

- maintaining the Delivering Care Policy Framework alignment with the strategic direction of the Department of Health including the Northern Ireland Health and Social Care Reset Plan (July 2025), with some flexibility to support the workforce in preparation for any potential safe staffing legislation.

The revised framework aims to strengthen reporting mechanisms, share accountability and reinforce the importance and use of evidence to inform decision making in workforce planning and management. Placing the responsibility of operational workforce planning with the health and social care trusts and independent employers the framework aims to support more responsive and context specific decisions which serve the local populations: Department of Health (2026) Refreshed Delivering Care Policy Framework.

An overview of registered nurse-to-patient ratios staffing guidelines by specialty areas in the UK

Acute hospital wards-adult

Guideline: NICE (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals: safe staffing guideline

Daytime shift: 1:8 RN-to-patients, excluding nurse in charge.

Critical care

Guideline: UK Critical Care Nursing Alliance (UKCCNA) (2024) Critical Care Nursing Workforce Optimisation Plan and Staffing Standards 2024-2027 Faculty of Intensive Care Medicine and Intensive Care Society (2022) Guidelines for the Provision of Intensive Care Services.

Level 3 patients: 1:1 minimum RN-to-patient to deliver direct care

Level 2 patients: 1:2 minimum RN-to-patients to deliver direct care.

Emergency care

Guideline: The Royal College of Emergency Medicine and Royal College of Nursing (2020) Nursing workforce standards for type 1 emergency departments

Resuscitation area: 1:1 minimum RN-to-patient

Initial assessment/triage 24/7: 1:1 minimum emergency charge nurse/ emergency nurse-to patient

Moderate/high dependency patients: 1:3 minimum RN to three cubicles.

District nursing

Guideline: The Queen's Nursing Institute (2022) Workforce Standards for the District Nursing Service

A caseload of over 150 is associated with work left undone and deferring visits.

A minimum of 30 minutes per RN visit – not including travel time.

One RN visit for initial assessment and then at least every fourth visit.

9-10 visits a day is associated with deferring work.

Mental health

There is some guidance related to safer staffing and calculating acuity however, none include ratios. Less robust research has been undertaken in mental health to demonstrate the relationship between staffing and care quality.

Learning and disability nursing

There is limited and fragmented evidence on staffing ratios within learning disability nursing settings across the UK and globally.

Care homes with nursing

UK evidence is very limited and there is no guidance, standards or ratios that set the nursing workforce.

Primary care

There are no ratios set within this setting across the UK and very little evidence internationally.

Children and young people

Guideline: Royal College of Nursing (2025) Defining staffing levels for children and young people's services RCN UK standards:

- Minimum of 70:30 registered to unregistered staff.
- Precise ratio will vary throughout clinical areas.
- Minimum of two registered children's nurses at all times in all inpatient and day care services.

Divided into nine specialty areas these include:

- Neonatal care.
- Designated children's intensive care and children's high dependency services.
- General children's wards and departments.
- Specialist children's wards and departments.
- Ambulatory care, operating theatres and recovery.
- Community children's nursing, health visiting and school nursing.
- Children and young people's mental health.
- Adolescent and young adult units.
- Independent and private sector provision.

Acute hospital wards - adult summary

Guideline: NICE (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals: safe staffing guideline

1:8 registered nurse-to-patients on a daytime shift, excluding nurse in charge.

Where applicable:	England
Evidence reviewed:	Systematic review of evidence on nurse staffing and patient outcomes by University of Southampton; economic analysis by University of Surrey.
Quality of evidence base:	Large number of studies, reasonably strong, however this is now over 10 years since publication.
Professional expert opinion sought:	Yes
Public/patient involvement:	Yes
Beyond ratios:	• Nursing hours per patient day (NHPPD) recommended as means of expressing nursing staff requirements. • Endorsed the Safer Nursing Care Tool (SNCT) for determining staffing numbers locally per ward, based on patient dependency. • Red flag indicators of nurse staffing insufficiency identified.

Guideline detail

The NICE guideline was commissioned by the Department of Health and NHS England. Aimed at managers and commissioners, it provides recommendations on safe staffing for nursing, including registered nurses and health care assistants, in adult inpatient wards of acute hospitals, based on a review of best available evidence. It excludes intensive care, high dependency, maternity, mental health, acute admission or assessment units or wards, or inpatient wards in community hospitals. These areas were due to be covered by NICE in separate guidance, but work was suspended.

The NICE (2014) safe staffing guideline recommends that nursing hours per patient be used as a measurement to express nursing staff requirements, representing the number of hours of nursing time for direct patient care and other nursing activities provided by registered nurses and health care assistants per patient over a defined period. The guidelines recommend that while no single nursing staff-to-patient ratio can be applied across the whole range of wards to safely meet patients' nursing needs, evidence shows that **if registered nurses care for more than eight patients, there is an increased risk of serious harm** and should prompt urgent review.

The guidelines also recognise the need for:

- organisational strategy
- principles for determining nursing staff requirements
- setting the ward nursing staff establishment
- assessing nursing staff available on the day to meet patients' nursing needs
- monitoring and evaluating ward nursing staff establishments.

Safe staffing indicators recommended by the guidelines include:

- adequacy of meeting patients' nursing needs
- falls
- pressure ulcers
- medication administration errors
- missed breaks
- nursing overtime
- planned, required and available nurses for each shift
- high levels and/or ongoing reliance on temporary nursing
- compliance with any mandatory training.

How the guidance was developed

The NICE (2014) Safe staffing guideline was developed from two evidence reviews (Griffiths et al., 2014 and Simon et al., 2014), an economic analysis (Cookson and McGovern, 2014), three expert papers (Lawless, 2014; Kelly 2014; NICE 2014b) and a report of field testing of the draft guideline were also considered (NICE, 2014c). Whilst the evidence to support the NICE (2014) guidelines was extensive, there were notable limitations (Griffiths et al., 2014). The evidence available for review was of varying quality and validity, with the vast majority of research being conducted in the US and Australia, and very limited UK-based research available.

While informative, this guideline was developed based on evidence well over a decade ago. Given the continued changes across all aspects of health care including workforce, population characteristics, delivery, service demands and patient acuity, it is acknowledged a more current and ongoing review is required.

Related tools and guidance

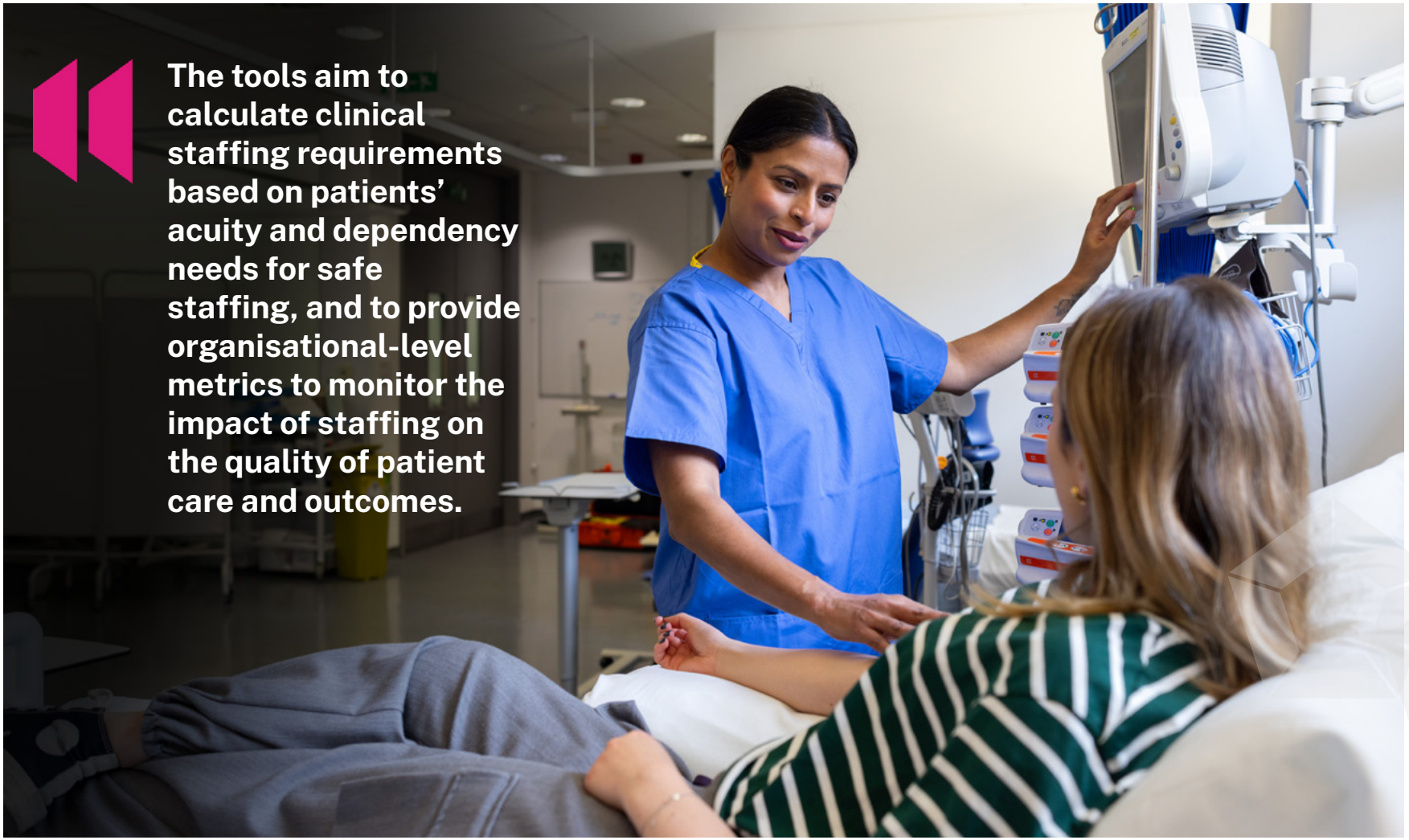
NICE-endorsed nurse staffing planning tools to be used to determine the number of nurses needed (as opposed to the minimum for safety).

Following publication of the NICE (2014) and National Quality Board (NQB) (2016) guidelines, Imperial College London and the Shelford Group developed a series of Safer Nursing Care Tools (SNCT) in specific nursing contexts, including:

- Adult Acute Assessment Units (AAU) SNCT
- Adult in-patient Ward (AIPW) SNCT
- Children and Young People's (C&YP) SNCT
- Emergency Department (ED) SNCT
- Mental Health Optimal Staffing Tool (MHOST).

The tools aim to calculate clinical staffing requirements based on patients' acuity and dependency needs for safe staffing, and to provide organisational level metrics to monitor the impact of staffing on the quality of patient care and outcomes. In Scotland the national Adult Inpatient Tool (Adult inpatient tool – Health care Improvement Scotland) provides guidance for wards greater than 17 occupied beds however, it does not include any ratios. Northern Ireland has Department of Health Policy regarding medical and surgical inpatient settings. Ward management is 100% supervisory and the skill mix is 70% registered nurse and 30% nursing support worker. Ratios are not specified, however, a staffing establishment model of three whole time equivalent (WTE) for each bed on a general ward and up to eight WTE on a specialist ward is applied. Wales has legislative guidance that exists for acute medical and surgical wards and paediatric in patient settings. There are no prescribed ratios within the legislation.

Kendal Andreason, Professional Lead for Acute and Emergency Care and Defence Nursing


The tools aim to calculate clinical staffing requirements based on patients' acuity and dependency needs for safe staffing, and to provide organisational-level metrics to monitor the impact of staffing on the quality of patient care and outcomes.

Critical care summary

Guideline: UK Critical Care Nursing Alliance (UKCCNA) (2024) Critical Care Nursing Workforce Optimisation Plan and Staffing Standards 2024-2027.

Faculty of Intensive Care Medicine and Intensive Care Society (2022) Guidelines for the Provision of Intensive Care Services.

Level 3 patients must have a minimum registered nurse-to-patient ratio of 1:1 to deliver direct care.

Level 2 patients must have a minimum registered nurse-to-patient ratio of 1:2 to deliver direct care.

Where applicable:	UK-wide
Evidence reviewed:	Yes
Quality of evidence base:	UK evidence is limited (in terms of size and scope) informed by a combination of available evidence and professional consensus, due to limited empirical evidence in some areas.
Professional expert opinion sought:	Yes, though limited information on processes.
Public/Patient involvement:	No
Beyond ratios:	A minimum of 50% of registered critical care nurses must be in possession of a post-registration critical care award. No more than 20% of registered nurses from bank/agency who are NOT substantively employed by the unit should be on any one shift.
Endorsed by RCN	The Guidelines for the Provision of Intensive Care Services Version 3 was published in January 2026 and endorsed by the RCN.

Guideline detail

Two publications outline minimum standards for safe staffing in critical care settings:

a) Critical Care Nursing Workforce Optimisation Plan and Staffing Standards 2024-2027

The UKCCNA (2024) outline 14 minimum staffing standards with recommendations that all 14 standards are adhered to together to optimise staffing. Of these 14 standards, four relate specifically to staffing ratios, as highlighted in bold.

1. **Level 3 patients must have a minimum registered nurse/patient ratio of 1:1 to deliver direct care.**

2. **Level 2 patients must have a minimum registered nurse-to-patient ratio of 1:2 to deliver direct care.**

3. Each critical care unit must have an identified supernumerary critical care matron/lead nurse, dedicated solely to managing critical care, who has overall responsibility for the nursing elements of the critical care service.

4. A supernumerary clinical shift leader on duty 24/7 in all critical care units.

5. Units with more than 10 beds and/or units with large numbers of single rooms, additional infection prevention control requirements or a wide geographical unit footprint, must have an additional supernumerary enhanced critical care nurse (band 6 with the critical care course and step 3 competency).

6. A minimum of 50% of registered critical care nurses must be in possession of a post-registration critical care award.

7. Each critical care unit must have a dedicated supernumerary clinical educator responsible for co-ordinating the education and training of critical care staff.

8. Clinical educators must be in possession of a post-registration Adult Critical Care Award, National Competencies for Adult Critical Care Nurses Step 4 and an appropriate postgraduate certificate in education or equivalent.

9. Assistive and supportive staff must not be used to replace RN roles. The role of a registered nursing associate (NAR, England only) is assistive in care delivery and should not be used as a substitution for registered nurses.

10. Registered nursing associates will be provided with a supernumerary period of supported induction and training required to undertake the assistive role.

11. All novice critical care nursing staff (staff new to critical care, including internationally educated nurses) must be allocated a period of 12 weeks supernumerary practice to enable achievement of basic specialist competence. This can be split over more than one period if required. Following assessment, where staff have transferrable skills, this overall period may be reduced.

12. **No more than 20% of registered nurses from bank/agency who are NOT substantively employed by the unit should be on any one shift.**

13. Each critical care unit should have dedicated professional nurse advocates within the establishment, who are given designated time to deliver the role. The national aspiration is 1:20 registered nurses to deliver restorative clinical supervision.

14. Each critical care unit should support and encourage the continuous professional development of nursing staff.

The standards were informed by the World Federation of Critical Care Nurses (WFCCN) (2019) position statement on the provision of a critical care nursing workforce. This position statement was produced by a review group comprising 13 international members, including critical care clinicians,

leaders and researchers from Australia, Canada, Croatia, Peru, Sweden, United Arab Emirates, United Kingdom and the United States of America, with the aim to inform the development and provision of an appropriate critical care nursing workforce (WFCCN, 2019).

b) Faculty of Intensive Care Medicine and Intensive Care Society (2026) Guidelines for the Provision of Intensive Care Services V3.

The Faculty of Intensive Care Medicine is a UK-based professional and statutory body for the specialty of Intensive Care Medicine, the doctors who lead Critical Care services and Advanced Critical Care Practitioners and has Critical Care Pharmacists as members.

The Intensive Care Society is a multi-professional intensive care membership organisation, including doctors, nurses, psychologists, physiotherapists, speech and language therapists, dieticians, pharmacists, occupational therapists and other allied health care professionals working in critical care.

The Faculty of Intensive Care Medicine and Intensive Care Society (2026) Guidelines for the Provision of Intensive Care Services (GPICS v3) is set out in five sections relating to critical care: structure, workforce, clinical care, service development, and preparedness.

Within this guideline, specific registered nurse-to-patient ratios and skills mix are outlined, including:

- level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care
- level 2 patients must have a registered nurse-to-patient ratio of a minimum of 1:2 to deliver direct care
- a minimum of 50% of registered nurse-to-patient ratio must be in possession of a post-registration academic programme in critical care nursing
- units must not utilise greater than 20% of registered nurses from bank/agency on any one shift when they are **not** their own staff
- ICUs with more than 10 beds, and every additional 10 beds thereafter, and/or ICUs with large numbers of single rooms, additional infection prevention control requirements or a wide geographical unit footprint, must have at least one additional enhanced critical care nurse who is not allocated a patient
- the ratio of clinical educator must equate to a minimum of one WTE per 75 registered nurses and non-registered health care support workers (headcount).

How was the guidance developed?

The UKCCNA (2024) staffing standards builds on the Guidelines for Provision of Intensive Care Services (GPICS) (2022), NHS England, NHS Wales and the Health and Care (Staffing) legal mandate in Scotland from 1 April 2024. The standards were informed by GPICS (2022), evidence, where available, and professional consensus. The UKCCNA is made up of:

- British Association of Critical Care Nurses
- CC3N (Critical Care National Network Nurse Leads)
- Intensive Care Society Nursing & AHP (Allied Health Professional) Forum
- RCN Critical Care Forum
- NOFF (National Outreach Forum)
- PCCS (Paediatric Critical Care Society).

The Faculty of Intensive Care Medicine and the Intensive Care Society Guidelines version 3 builds on previous editions encompassing learning from the pandemic emerging literature, and changing practice and opinion. The guidelines have been developed through expert clinical opinion by health care professionals, and input from patient and public representatives, an equality and diversity lead and UK-wide representation.

Suman Shrestha, RCN Professional Lead for Critical Care

Emergency care summary

Guideline: The Royal College of Emergency Medicine and Royal College of Nursing (2020) Nursing workforce standards for Type 1 Emergency Departments

There will be a **minimum of 1:1** in the resuscitation area.

There will be a **minimum of 1:1 to undertake initial assessment/triage 24/7**.

There will be a **minimum of one registered nurse to three cubicles** where moderate and high dependency patients are nursed.

Where applicable:	UK-wide
Evidence reviewed:	Based on existing guidance and competency frameworks rather than research. Collaboration between the Royal College of Nursing (RCN) Emergency Care Association (ECA) and the Royal College of Emergency Medicine (RCEM).
Quality of evidence base:	Professional consensus.
Professional expert opinion sought:	Yes
Public/Patient involvement:	Yes
Beyond ratios:	The nursing workforce will comprise a minimum of 80% registered nurses. A minimum of 50% of registered nurses will be in possession of an academic post registration award in emergency nursing. No greater than 20% of individuals on any given shift will be from bank or agency with the substantive emergency department (ED) nursing workforce.

Guideline detail

The Royal College of Emergency Medicine and RCN (2020) Nursing workforce standards for Type 1 Emergency Departments

1. The ED nursing workforce will be reviewed on at least an annual basis.
2. The ED nursing workforce will be determined by triangulating:
   - professional judgement - Telford Model
   - benchmarked with appropriately selected and comparable peers.
3. Each ED will have a lead nurse manager (band 7/8a).
4. Each ED will have a matron / senior lead nurse (band 8a).
5. Each ED will have at least one emergency nurse consultant (band 8b/8c).
6. Each ED will have a WTE dedicated practice development lead (band 7/8a).

7. In EDs with > 75 individuals in the nursing workforce, practice educators (band 6/7) will be required to support the practice development lead.

8. When calculating the nursing workforce WTE a minimum uplift of 27% will be applied to cover planned leave, unplanned leave, mandatory training and specialty specific training, without compromising patient safety.

9. **The nursing workforce will comprise a minimum of 80% registered nurses.**

10. **A minimum of 50% of registered nurses will be in possession of an academic post registration award in emergency nursing.**

11. All nursing associates and clinical support workers will have training for their role to include competency assessment and a personal development plan according to local policy.

12. Individuals appointed to the nursing workforce will be allocated a supernumerary period.

13. The shift patterns for the nursing workforce will be determined by the predicted variation in clinical demand according to time of day and day of week.

14. Rostering patterns for the nursing workforce will take into account best practice on safe shift working, minimising the use of long shifts where appropriate and in consultation with staff.

15. **No greater than 20% of individuals on any given shift will be from bank or agency outwith the substantive ED nursing workforce. When using registered nurses from bank or agency, the ED must be assured that they are competent to work in the role or clinical area to which they are allocated. All staff from bank/agency will be provided with ED orientation.**

16. There will be a nominated emergency charge nurse/emergency nurse lead for each of the cross-cutting themes and clinical domains in the RCN Competency Framework for Registered Nurses in Emergency Care: Level 1 and 2.

17. There will be a nominated lead for nursing research. Research demonstrates that active EDs have better clinical outcomes.

18. There will be a clinical co-ordinator (emergency charge nurse band 6/7) on duty 24/7 in addition to the nursing workforce required to deliver direct patient care.

19. An emergency charge nurse or an emergency nurse with level 2 competencies will be the nominated shift lead for the resuscitation area.

20. **There will be a minimum of one registered nurse to each patient in the resuscitation area.**

21. **There will be a minimum of one emergency charge nurse/emergency nurse to undertake initial assessment/triage 24/7.**

22. **There will be a minimum of one registered nurse to three cubicles where moderate and high-dependency patients are nursed.**

23. **Where EDs receive children there will be at least two registered children's emergency nurses on shift.**

24. The nursing workforce on shift will be sufficient to accommodate staff breaks without compromising patient safety and quality of care.

25. Audio-visually separate areas of the ED will have a minimum of two members of staff present at all times, unless a reliable and effective method for summoning immediate support is in use.

26. Where other registered health care professionals, such as paramedics, are used to complement the nursing workforce, they must be able to demonstrate the relevant competencies from the RCN ECA National Curriculum and Competency Framework for Emergency Nursing for the role/clinical area to which they are allocated.

27. The nursing workforce will be complemented by other staff such as receptionists, ward clerks, porters and housekeepers.

How was the guidance developed?

The Royal College of Emergency Medicine and the Royal College of Nursing (2020) produced a joint publication on the Nursing Workforce Standards for Type 1 Emergency Departments. This involved consultation with the RCN Emergency Care Association Forum, The Royal College of Emergency Medicine Service Design and Configuration Committee and the Royal College of Emergency Medicine Council.

Related tools and guidance

Competency Framework for registered nurses in Emergency Care: Level 1 and 2 | Publications | Royal College of Nursing

RCPCH (2018) Facing the future: standards for children in emergency settings

Whilst none of the guidance and tools below include reference to nurse-to-patient ratios specifically, they are relevant.

In Northern Ireland, the Department of Health, Social Services and Public Safety document Delivering Care: Nurse Staffing in Northern Ireland (phase 2) concerns emergency departments. The second phase of the Delivering Care project builds on the methodologies and learning of the first phase which was related to general and specialist medical and surgical adult in-hospital care settings and was completed January 2014. This government policy sets out a strategic direction for services in Northern Ireland, including principles for urgent and emergency care models for the future. It was stated that a staffing model presented to provide a flexible, considered approach to determining nursing staffing establishments for services within a changing model of provision. A population type ratio is described in this document in a range format: 1:700 -1:850 nurse: annual emergency department attendances, per year. Skill mix recommendation is 80% registered nurses and 20% nursing support workforce.

In Scotland, Healthcare Improvement Scotland have published staffing workload toolkits which now support the legislation enacted in 2024 related to safe staffing.

One of the toolkits is related to emergency care and provides information, and a recommend whole time equivalent (WTE) for staffing based on the workload data entered, however, there are no ratios provided. (see Emergency care provision staffing tool – Health care Improvement Scotland)

In England, the National Quality Board (NQB) 2016 document set out 10 expectations and a framework within which organisations and staff should make decisions about staffing that put patients first and central to the delivery of high-quality care that is safe, effective, caring and responsive. NQB work was not nursing specific; it focused on whole team and set out principles for ensuring right staff, with the right skills, in the right place at the right time. Work is currently underway to update the guidance. NHS Improvement's published guidance *Developing workforce safeguards - Supporting providers to deliver high quality care through safe and effective staffing.*

NQB and NHSE guidance related to emergency care has been used to inform the Emergency Department Safer Nursing Care Tool (ED SNCT), which has been developed to help NHS hospitals in England measure patient acuity and/or dependency to inform evidence-based decision making on staffing in the emergency department, including paediatrics. The tool does not include reference to ratios.

Kendal Andreason, RCN Professional Lead for Acute and Emergency Care and Defence Nursing

District nursing service summary

Guideline: The Queen's Nursing Institute (2022) Workforce Standards for the District Nursing Service

Caseload and time-maxims

A caseload of **over 150** is associated with work left undone and deferring visits.

Registered nurse visit should be a **minimum of 30 minutes** to allow for the entire nursing process to be enacted (assess, plan, implement and evaluate) - not including travel time.

The minimum visit ratio should be one registered nurse visit for initial assessment and **then at least every fourth** visit to apply the nursing process in full and initiate any changes, assess new needs, or evaluate care.

Nine to 10 visits a day is associated with the tipping point for people deferring work.

Where applicable:	UK-wide
Evidence reviewed:	Yes. Data modelling (mixed methods) and tested with a range of community services staff.
Quality of evidence base:	Professional consensus.
Professional expert opinion sought:	Comprehensive, multiple sources.
Public/Patient involvement:	No
Beyond ratios:	Workload should be the driving factor for defining caseloads and factors such as patient acuity and social issues such as isolation should be considered. Skill mix of team: 60% experienced RNs; 20% newly registered nurses; and 20% nursing support workers.

Guideline detail

The Queen's Nursing Institute (2022) Workforce standards for the district nursing service outlines standards relating to caseloads, capping caseloads, visits, skill mix and red flags, for the district nursing workforce in the UK.

In summary:

Caseloads

Maximum caseloads are not defined here as there is no one definition of caseload in the community, which makes modelling this challenging. In addition, there is no strong correlation between caseload and workload due to differing levels of complexity of patients, demographics and the need for that particular population. This also relates to the availability of services in that area. Workload should therefore be the driving factor and factors such as patient acuity and social issues such as isolation and service availability should be considered. However, caution is urged on caseloads per whole time equivalent (WTE) of over 150 – this is identified as a likely tipping point into more work being left undone and deferral.

Capping Caseloads

Although there was no consensus on the size of caseloads, in the modelling a caseload of over 150 (per WTE) was associated with more work left undone and deferring visits. Whilst there was no consensus on number, there was agreement that caseloads should be capped and therefore an agreed caseload size/case-mix should be determined and escalated if exceeded as a risk. Currently there is no limit to district nursing caseloads in any part of the UK.

Visits

Based on data from district nurses and community staff nurses nine to 10 visits a day is associated with the tipping point for people deferring work. It is recommended that for scheduling, district nurses and RNs visits should be at least 30 minutes in duration, not including travel time, to allow for the entire nursing process to be enacted (assess, plan, implement and evaluate). The average travel time varied – with a mean of 2-3 hours per day. There is an assumption that rural settings increase travel time. Although more miles are covered in rural settings, urban travel times are also high and ebb/rise during the day, for example travel during commuter or school run times.

Travel time should be factored into scheduling visits, as well as time for documentation. The minimum visit ratio should be one registered nurse visit for initial assessment and then at least every fourth visit to apply the nursing process in full and initiate any changes, assess new needs, or evaluate care.

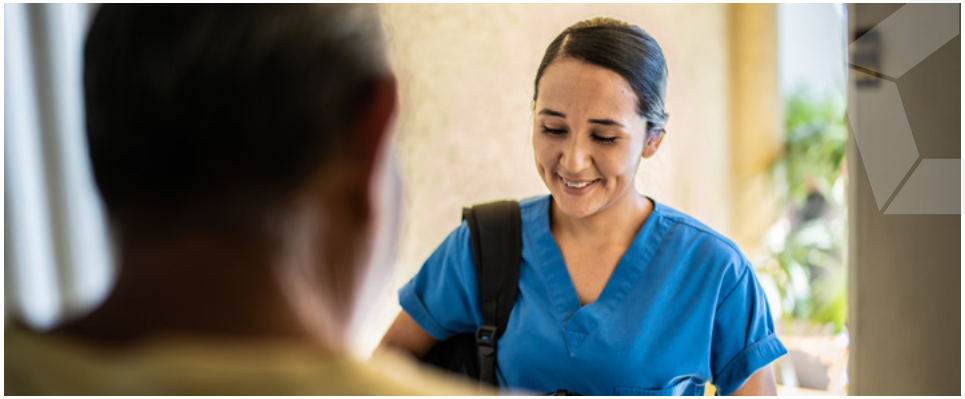
Skill mix

Skill mix of teams should reflect the demand placed upon them by populations/needs. There are currently high rates of deferral and teams felt that too much complex work was delegated. Nursing support workers also occasionally reported the discomfort they felt around the work they were being asked to undertake.

Work should be allocated with a focus on risk, unpredictability, complexity and acuity of the situation and not simply task competency. Situational awareness is crucial for safe care. For example, the administration of insulin to a person with diabetes could be uncomplicated or it could be more complex depending on the situation (family support, cognitive issues etc). The consensus based on the data was that a registered nurse should attend every fourth visit as a minimum to carry out the nursing process. Whilst nursing support workers including nursing associates can be involved in the nursing process and play a vital role in the delivery/ implementation of care, the assessment, nursing diagnosis, planning and evaluation of care is the responsibility of the registered nurse. Based on the data, there was a consensus too on the ratio of skill mix, considering the experience, knowledge and skills of the team members: 60% experienced RNs; 20% newly registered nurses; and 20% nursing support workers. Support workers include many different groups such health care assistants and nursing associates.

Red flags

- District nursing services unable to close a caseload, leading to unremitting and unsustainable demand.
- Deferring or rescheduling work every day or most days should be a red flag and escalated.
- Deferring any high priority and time critical work at all (for end-of-life care, people with blocked catheters and insulin administration) should be escalated as a safety concern.
- High turnover and high sickness absence should also be considered a red flag for both patient safety and system resilience (QNI, 2022; pages 7-8).



How was the guidance developed?

These UK-wide standards, led by Professor Alison Leary, were determined from modelling, using data from multiple sources, including:

- the ONS (Office for National Statistics) for population-based data
- activity analysis (Cassandra) Activity/incident data (local 2015-2021)
- pulse surveys
- cross sectional whole population survey (DN Today 2019) n~3000
- stratified cross sectional surveys (three months 2021 n=922) NHS benchmarking data
- qualitative data on perceptions of workloads
- literature (grey and peer reviewed).

The findings were contextualised using data from an analysis of *Prevention of Future Deaths reports in England and Wales* (2016-2019 inclusive) which focused on recurrent concerns from coroners, the most common of which was missed, delayed or unco-ordinated care, lack of care planning and elements of the nursing process. The resulting findings were tested with a range of community services staff supporting the district nursing service (approximately 600) working in different roles (team leaders, executive positions, and frontline staff).

Related tools and guidance

The Queen's Nursing Institute (2022) Workforce Standards for the District Nursing Service should be read alongside the RCN *Nursing Workforce Standards* and the NHS Staff Council document *Welfare Facilities for Healthcare Staff.*

Cathryn Smith, RCN Professional Lead in Adult Community Nursing and End-of-Life-Care

Mental health summary

There is some guidance related to safer staffing particularly regarding calculating acuity and dependency however, none include ratios. Some evidence exists related to nurse staffing and relationship with care quality and safety, but it is methodologically limited. A mental health services evidence review by Lawes et al., (2018) of safe staffing structures agreed with the findings of Rutter et al., (2015) that there is limited evidence on optimum staff ratios and a general lack of research. Other frameworks and guidance include:

- **Mental Health Optimal Staffing Tool (MHOST):** This evidence-based, multidisciplinary tool helps ward staff assess patient needs and convert that data into a required number of full-time equivalent staff
- **NHS England's Mental Health Staffing Framework:** This framework was developed based on the NQB's principles to support quality assurance in safe staffing

- **improvement resources:** The NQB and NHS Improvement have published resources to help mental health services implement these expectations for safe and sustainable staffing.

- Scotland's framework focuses on workforce planning and support through its **Vision for the Mental Health and Wellbeing Workforce** and a common methodology for determining staffing levels based on tools and professional judgment. Northern Ireland uses the **Service Framework for Mental Health and Wellbeing 2018-2021** to define standards and improve consistency, and is also developing a new regional framework, while Wales has the **Strategic Mental Health Workforce Plan** for high-level implementation.

- Northern Ireland has a range of regional frameworks like the **Regional Mental Health Service (RMHS)** and the **Delivering Care** project, focusing on safe, effective, community-based care, workforce planning for nursing, and addressing inequalities. Services range from GP referrals for common issues to specialist support, aiming for integration, personalised care plans, and supporting recovery within communities. Phase 5A of Delivering Care (2019) for inpatients has a proposed range of ratios.

- UK legislation Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times

Although the Mental Health Act Code of Practice (2015) does not explicitly mention safer staffing, it repeatedly ties patient safety and quality of care to having appropriately trained and sufficient staff across inpatient settings. References to adequate staffing are dispersed throughout the document and are contextual - for example, references to adequate staffing levels appear in relation to enhanced observation, safety, and children and young people.

In the absence of a published, evidence-based mental health workforce tool, Health Education England commissioned the development of Mental Health Optimal Staffing Tool (MHOST).

This multidisciplinary tool is intended for local use to determine clinical staffing requirements in mental health wards. It is based on an assessment of acuity-dependency levels and forms part of the SNCT suite developed by the Shelford group. The five acuity and dependency levels have associated descriptors developed by expert reference groups.

The National Association of Psychiatric Intensive care and Low Secure Units (NAPICU) Minimum Standards for Psychiatric Intensive Care published jointly including the RCN and Royal College of Psychiatrists in 2014 recommended: 'The nursing staff establishment on PICUs should be at least one third higher than on general acute psychiatric wards (weighted per bed). On each shift, a third of the nursing staff should be qualified, and no less than two per shift. As an example, minimum shift staff numbers for ten patients in a male PICU should not fall below six for the early and late shift, and four for the night shift. These numbers should not include management and other specific therapy staff.' Subsequently the Royal College of Psychiatrists report on standards for inpatient mental health services includes a section related

to staffing levels however, there are no ratios or numbers included. Twenty years earlier, a 1998 Royal College of Psychiatrists report stated: 'It is unlikely that a ward of 15 acute patients could be safely managed with less than three registered nurses per shift during the day and two at night, irrespective of other staff available.' (NAPICU, 2014).

The *The NQB (2018) An improvemnt resource for mental health* gives a high level overview on staffing, from a multidisciplinary perspective, focusing on general principles; no specific guidance is given on nurse staffing and levels of RMNs. Further guidance is currently being reviewed with no confirmed date for publication.

A rapid review of evidence published in a series of resources (report commissioned by NHSE, Lawes, Marcus and Pilling) includes ratios as one strategy that was associated with the reduced use of seclusion and the number of patients secluded. In terms of numbers, the evidence for the use of nurse-to-patient ratios was mixed. The stronger argument is for an increase in registered nurse numbers, and a richer skill mix overall.

NHS England's England (2023) The mental health nurse's handbook has been endorsed by the RCN. Whilst it covers factors that impact on staffing needed – staffing is not considered specifically.

Amber O'Brien, RCN Professional Lead for Mental Health

Learning disability nursing summary

There is limited and fragmented evidence or mention of ratios within learning disability nursing settings across the UK and globally.

In 2020, the Care Quality Commission in England published a report entitled: Out of sight – who cares?: Restraint, segregation and seclusion review. This report looks at the use of restraint, seclusion and segregation in care services for people with a mental health condition, a learning disability or autistic people.

NHS England have resources including an evidence review on their website related to safe staffing. There are no current ratios.

The Mental Health and Learning Disability Inpatient Nurse Staffing Level Tool staffing level tool is part of the suite of tools provided by NHS Scotland which can help plan the number of staff needed. There are no ratios included.

Jonathan Beebee, RCN Professional Lead for Learning Disability Nursing

Care homes with nursing summary

The care sector is complex, and language used is important as the context is different across the UK. Therefore, 'care homes with nursing' is used to mean any residential setting that always has a registered nurse present.

As with all settings, any ratio would need to be in addition to acuity or resident-specific nurse staffing considerations. Also, most providers and employers are from the independent health and social care sector.

Currently the evidence regarding the nursing workforce required within this setting is very limited within the UK. There are no universally applied UK-wide standards specifying nursing workforce levels or ratios. There is some international evidence related to care homes and worth noting in Australia, where the Aged Care Bill (which covers all states) was introduced in 2024, following a report from the Royal Commission into Aged Care Quality and Safety in 2021. Whilst the new law does not specifically set the ratio for registered nurse-to-resident it is encompassed as part of wider legislation that includes a formula for setting nurse staffing levels.

Primary care summary

The RCN's 2023 review showed there is very little evidence related to nurse staffing in primary care. Nonetheless, the overall relationship between practice nurse input and outcomes has been explored; using data from 7,456 general practices in England, one study found practices that employ more nurses performed better in a number of clinical domains, as measured by the Quality Outcomes Framework (Griffiths, 2010).

There are no ratios set within this setting across the UK and very little known internationally.

The types of ratios that would likely be needed are population focused and also case load.

For context its worth looking at activity and policies related to GPs. The European Union of General Practitioners and BMA have recommended a safe level of patient contacts per day in order for a GP to deliver safe care at not more than 25 contacts per day.

In Scotland, there is a toolkit for safe working in general practice. This gives a population ratio for general practitioners (GP): 72 appointments per 1,000 patients each week and an average list size of 1,600 patients (per GP).

Kim Ball, RCN Professional Lead for Primary Care

Contents - Children and young people

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Guideline: RCN (2025) Defining staffing levels for children and young people's services RCN UK standards

Where applicable:	UK-wide Underpinned by various guidelines eg, Department of Health England (2009) Toolkit for high quality neonatal services and Paediatric Critical Care Society (PCCS) which published its latest version of the standards in 2021 (PCCS, 2021) and RCPCH Facing the Future audit on standards in acute paediatric and care outside hospital (2017).
Evidence reviewed:	Varied
Quality of evidence base:	Based on other published guidelines.
Professional expert opinion sought:	Yes
Public/Patient involvement:	No

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Beyond ratios:	There will be a minimum of 70:30 registered to unregistered staff (although the precise ratio will vary throughout clinical areas. For example, it is expected that there will be a higher proportion of registered nurses in areas such as children's intensive care, specialist, and in many cases general children's units). There should be a minimum of two registered children's nurses at all times in all inpatient and day care services.
Endorsed by RCN	The RCN has endorsed the PCCS (2021) standards, the RCPCH (2017) Facing the Future document, the RCPCH (2025) Standards for Children and Young People in Emergency Care Settings, alongside the RCN Safeguarding Children and Young People: roles and competencies for health care staff (2025).

Guideline detail

Royal College of Nursing (2025) Defining Staffing Levels for Children and Young People's Services

The guidance outlines 16 core standards, mapped against the RCN *Nursing Workforce Standards* (RCN, 2025) as the minimum essential requirements for providers of services for babies, children, and young people. The standards specifically relating to staffing skills mix and registered nurse-to-patient ratios are highlighted in bold below and overleaf.

- The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff. See the RCN's resources on supervisory ward sisters or team leaders at: rcn.org.uk/publications
- Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff.

- At least one nurse per shift in each clinical area (ward/department) will be trained in advanced paediatric life support (APLS) and European paediatric advanced life support (EPALS) depending on the service need.
- **There will be a minimum of 70:30 registered to unregistered staff (although the precise ratio will vary throughout clinical areas. For example, it is expected that there will be a higher proportion of registered nurses in areas such as children's intensive care, specialist, and in many cases general children's units).**
- A 27% increase to the minimum establishment is required to cover annual leave, sickness and study leave.
- **There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas.**
- Nurses working with children and young people (CYP) should be trained in children's nursing with additional training for specialist services or roles.
- **70% of nurses should have the specific training required for the specialty for example, children's intensive care, children's oncology, children's neurosurgery.**
- Support roles should be used to ensure that registered nurses are used effectively.
- Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks.
- The number of students on a shift should not exceed that agreed with the university for individual clinical areas.
- Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels.
- Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.
- Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24-hour period. A senior qualified children's nurse is a registered nurse who holds a children's nursing qualification, master's degree in an appropriate health/social care-related subject, with a minimum of five years' full time experience in uninterrupted clinical practice.

The expectation is that this post would be at a minimum of band 8a, dependent on the full scope and remit of the position, in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification.

- All staff working with babies, children and young people must comply with the Competencies for Health Care Staff (2025).
- All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day.
- Children, young people and young adults must receive age-appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs.

The standards are further divided into:

1. neonatal services
2. designated children's intensive care and children's high dependency services
3. general children's wards and departments
4. specialist children's wards and departments
5. ambulatory care, operating theatres and recovery
6. community children's nursing, health visiting and school nursing
7. children and young people's mental health
8. adolescent and young adult units
9. independent and private sector provision.

Specific registered nurse-to-patient ratios were cited for neonatal services, designated children's intensive care and children's high dependency service, general children's wards and departments and specialist children's wards and departments. Ratios and skills mix are also suggested for ambulatory care, operating theatres and recovery, community children's nursing, health visiting and school nursing, children and young people's mental health, adolescent and young adult units, or independent and private sector provision.

Neonatal care summaries of clinical areas

Standards cited from Department of Health England (2009) Toolkit for high quality neonatal services (p40), updated by the British Association of Perinatal Medicine Service Quality Standards in 2022 (BAPM, 2022)

Special care: 1:4 registered nurse-to-infant (this group will include babies requiring treatment for jaundice and extremely premature infants requiring tube feeding)

High dependency care: 1:2 registered nurse-to-infant (this includes babies requiring nasal continuous positive airway pressure (CPAP) or intravenous nutrition or observation and treatment for convulsions)

Intensive care: 1:1 registered nurse-to-infant (this group includes babies born with congenital anomalies requiring surgery, or babies requiring respiratory and other system support due to extreme prematurity); there are times when this ratio will be increased to 2:1 registered nurse-to-infant, such as in neonatal extracorporeal membrane oxygenation (ECMO)

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Neonatal services

The standards relating to neonatal services are cited from the Department of Health England (2009) Toolkit for high quality neonatal services (page 40), updated by the British Association of Perinatal Medicine Service Quality Standards in 2022 (BAPM, 2022) and have since been reinforced during the recent reviews of maternity and neonatal services in England (NHS England, 2022; EFCNI, 2018) and Scotland (Scottish Government, 2017).

When planning neonatal unit establishments, skill mix and education programmes (such as post-registration neonatal courses, foundation degrees, neonatal life support) must be considered.

Guidance includes:

- NICU and HDU: 80% of nursing capacity should be registered nurses
- Special care: 70% should be registered nurses
- of these, 70% should hold a post-registration neonatal qualification
- nursing support workers (eg, nursing associates, nursery nurses) should have NVQ3 or foundation degree training and work under direct supervision of a registered nurse
- infant dependency must be reviewed at least once per shift to ensure effective staffing
- workforce plans should be reviewed annually to meet projected birth rates. Scotland mandates a neonatal workload planning tool.

Designated children's intensive care (Level 3) and children's high dependency (Level 1&2) services

Defined and refined by both RCN and the UK's Paediatric Critical Care Society (PCCS) which published its latest version of the standards in 2021 (PCCS, 2021)

Level 1 basic critical care: 1:2 registered nurse-to-patient (children requiring close supervision and monitoring following surgery or with single system problems, mental health issues requiring supervision, stable long-term ventilated patient).

Level 2 intermediate critical care: 1:2 registered nurse-to-patient children requiring close supervision and monitoring following surgery or with single system problems, non-invasive ventilation).

Level 3 advanced critical care: 1:1 registered nurse-to-patient (this includes children requiring intubation and ventilation).

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3:2 registered nurse-to-patient (this may include ventilated children on vasoactive drugs or with multiple system problems, or a stable intubated patient in a cubicle).

2:1 registered nurse-to-patient (this includes children requiring ECMO or advanced renal replacement therapies).

The ratio of registered nurse to nursing support workers should not fall below 85:15 (PCCS, 2021).

In all categories, the ratio will increase by one level if the child is nursed in a cubicle or has mental health needs requiring close supervision.

There needs to be a minimum of one nurse per shift who has APLS or equivalent training.

Designated children's intensive care and children's high dependency services

The optimal nurse staffing levels for level 3 paediatric critical care units/paediatric/children's intensive care units (PICU/CICUs) and level 1 and 2 high dependency units have been defined and refined over the last 25 years by both the RCN and the UK's Paediatric Critical Care Society (PCCS) which published its latest version of the standards in 2021 (PCCS, 2021). These have defined levels of care and related registered nursing requirements which are now widely used during workforce planning.

Staffing ratios

- Minimum ratio: registered nurse to nursing support workers should not fall below 85:15 (PCCS, 2021).
- Cubicle care, mental health needs, or deterioration: Requires 1:1 registered nurse-to-patient ratio until stabilised.
- APLS-trained nurse: At least one per shift (RCS, 2013; PICS, 2021; RCN, 2020a).

Establishment calculation

- Minimum 7.01 registered nurses per bed, including 27% allowance for sickness and annual leave (PCCS, 2021).
- Does not include specialist education or additional roles (eg, matrons, professional nurse advocates, educators).

Leadership and supernumerary roles

- Each unit must have:
  - critical care matron/lead nurse responsible for nursing aspects
  - supernumerary clinical shift leader (advanced level) with no allocated patients
  - supernumerary enhanced-level nurse for every eight beds (or more if side rooms/ infection control precautions apply)
  - nurses involved in transfer services must not be counted in bedside staffing (PCCS, 2021).

Qualifications

- Minimum 70% of registered nurses must hold a post-registration paediatric critical care award (QIS).
- All nurses must have PCCS-specific training and competencies (RCPCH, 2014a; PCCS, 2021).

Education and training

- Each unit requires a supernumerary clinical educator at advanced level.
- Local educator numbers depend on:
  - student and newly qualified staff numbers
  - range of specialties and complexity
  - delivery and assessment of mandatory and specialist training (NMC, 2018).

General children's wards and departments

Bedside, deliverable hands-on care:

Children < 2 years of age 1:3 registered nurse-to-child, day and night.

Children > 2 years of age 1:4 registered nurse-to-child, day and night.

The patient population should be assessed to consider whether mental health, learning disability and/or nurses with expertise in managing transition to adult services are needed as part of the workforce.

General children's wards and departments

Whilst guidance remains based on RCN's *Defining staffing levels for children and young people's services* (RCN, 2003), it is acknowledged that increased patient acuity and complexity, shorter length of stay, and the introduction of paediatric assessment decision units, coupled with the current challenges associated with rising admissions of children with emotional distress and self-harm, requiring additional nursing support (RCPCH, 2017) means an annual review of staffing levels, or more frequently during service pressures (eg, seasonal surges, high acuity) is needed.

In addition:

- staffing ratios should reflect the average patient age: higher ratios of registered nurses required for wards with many children under two years of age, for example
- hospitals must use validated acuity assessment tools tailored for children
- extra nursing support workers and nursing associates (England only) may be needed during the day for:
  - theatre runs
  - ward rounds
  - elective admissions
  - family support.
- one ward manager (supervisory, advanced level, not counted in bedside ratios)
- in addition to ward sister/charge nurse, a competent, experienced registered nurse must be available 24/7 to advise on clinical issues across the organisation (National Quality Board, 2018a)
- one ward receptionist (+/-admin support)
- one health play specialist
- at minimum, one nursing support worker (NAR/CSW/HCA), increasing with capacity and acuity
- One housekeeper or equivalent +/-one hostess or equivalent.

The nursing support workforce (including nursing associates in England) is **additional to registered nurse ratios**.

Specialist children's wards and departments

The standards for specialist wards must be supported by a suitable acuity tool as a number of children in specialist units will meet the criteria for Level 1 and 2 high dependency care.

The relevant standards above must be followed (for example, 1:2 registered nurse-to-child).

The minimum standard for other children being 1:3 registered nurse-to-child.

In all the above units, a supernumerary registered nurse in charge (band 6 or above is also expected).

Specialist children's wards and departments

It is recognised that children on specialist units are increasingly complex and have high acuity (RCPCH, 2017). In many specialist units a number of children will meet the criteria for level 1 and 2 high dependency care (HDU). The standards for specialist wards must therefore be supported by a suitable acuity tool so that relevant standards are followed (for example, 1:2 registered nurse-to-child). The minimum standard for other children being 1:3 registered nurse-to-child. (RCN, 2018: page 13).

Many of the same principles for general wards apply, such as supervisory ward sister/charge nurse and support roles.

In addition:

- 70% of nursing staff should be trained in the specialty
- at least one nurse with specialist training on duty 24/7
- a practice educator is required to maintain high standards
- Local educator numbers depend on:
  - student and newly qualified staff numbers
  - range of specialties and complexity
  - delivery and assessment of mandatory and specialist training (NMC, 2018).

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Emergency departments

- Dedicated children's emergency departments: all registered nurses must be children's nurses or have comprehensive demonstrable experience in working with children and young people.
- Two nurses per shift must demonstrate skill in trauma management and one must have APLS or equivalent training.
- Mixed adult and children's emergency departments: a minimum of two registered children's nurses with trauma experience per shift, or nurse with demonstrable and comprehensive education and experience in caring for children and young people including at least: level 3 safeguarding, effective communication with children and families, pain assessment and recognition of the sick child.
- One nurse per shift must have APLS or equivalent training.

Assessment units

- One registered children's nurse lead at senior level to manage and co-ordinate the service.
- Two registered children's nurses available throughout opening hours; one of these must have valid APLS or equivalent training including: level 3 safeguarding, effective communication with children and families and recognition of the sick child.
- One advanced practitioner children's nurse available throughout opening hours in nurse-led services.

Minor injury units

- All children and young people must be assessed by a nurse with demonstrable knowledge and experience and competencies in care of the child or young person including: level 3 safeguarding, effective communication with children and families and recognition of the sick child.

Outpatient departments

- One children's nurse must be available at all times to assist, support and chaperone children.

Day surgery

- A minimum of two registered children's nurses must be available at all times.
- One nurse must hold valid APLS or equivalent training.

Operating theatres and recovery

- All nursing staff must possess paediatric assessment skills, airway and circulatory management skills, safeguarding knowledge at an appropriate level to role and knowledge of communication and play which is developmentally appropriate.
- In recovery: a minimum of one registered children's nurse, unless epidural or spinal anaesthesia is used, then two registered children's nurses are required to ensure 1:1 in the immediate post-operative period.

Emergency departments, outpatient departments, assessment units. Minor injury units, day care and day surgery, operating theatres and recovery

- Ratios outlined for the above units are linked to the Royal College of Emergency Medicine/RCN guidance on Type 1 Emergency Departments (2020) and the RCPCH Facing the Future-standards for children and young people in emergency care settings (2025).
- For day surgery units, 2011 guidance from the Association of Anaesthetists Great Britain and Ireland (AAGBI) on staffing is incorporated. Minimum training requirements for all nurses working in the above areas are outlined in chapter nine of the document.
- For operating theatres and recovery, consultation on the ratios and expected skills was sought from the British Anaesthetic and Recovery Nurses Association.

Children's community teams

At a minimum 20 WTE community children's nurses are needed to cover an average-sized district with a child population of 50,000.

Core community children's nursing teams: must be led by a registered children's nurse who has a demonstrable portfolio of clinical expertise and academic accreditation.

At a minimum, 25% of the registered workforce must completed a recognisable community education and development programme.

The minimum ratio of registered nurses to nursing support workers should not fall below 70:30.

Continuing care teams: predominantly working in homes, schools and/or respite care may have a lower minimum ratio of nursing support workers to registered nurses due to the complexity and acuity of care needed.

Palliative and end-of-life care: 24-hour access to a children's nurse, with ratios dependant on level of need. Community and specialist ward ratios can provide a benchmark for ratios needed.

Health visitors

One health visitor per 400 children at a minimum. To deliver comprehensive health improvement, one health visitor per 250 children in a population is needed.

School nursing

A minimum of one school nurse with registration as a specialist community public health practitioner per secondary school and its cluster of primary schools and supported by a skill-mixed team.

The size, complexity, geographical and social demographics of the school population must be taken into account.

Special needs school nursing

One special needs school nurse based in every school during school hours.

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Safeguarding

Acute health care: a minimum of one WTE named nurse for safeguarding children and young people for each organisation. There must also be dedicated clinical nurses safeguarding specialists for each site.

Community health care: a minimum of one WTE named nurse for a child population of 70,000, recognising a number of factors may require a higher number of named nurses.

Maternity services: a minimum of 0.4 WTE named midwife for safeguarding should be available.

Looked after child services: a minimum of one WTE for each provider service. Caseloads should not exceed 50 children in addition to the operational, training and education aspects of the role.

A minimum of one WTE designated nurse for looked after children for a population of 70,000; again population demographics, geography and number of organisations the individual must engage with in the role may increase nursing ratios.

The independent health and social care sector

It is recommended to follow the same ratios as outlined above, making reference to the publication on page 49 for specific guidance.

Community children's nursing, health visiting, school nursing and special needs school nursing

Consultation around ratios was undertaken across the following specialist organisations: The Queen's Institute of Community Nursing, the Institute of Health Visiting and the School and Public Health Nursing Association. In addition, charitable organisations who support children in the community also contributed to the rationale for nursing ratios: WellChild; Roald Dahl Children's Charity and Together for Short Lives.

Independent and private sector

The principles of safer nursing staffing in the main body of this document are relevant to all independent providers, including aspects of training in resuscitation and safeguarding.

In addition, specific aspects that independent providers should consider as a minimum requirement for safer nurse staffing include:

Leadership

- Providers performing invasive procedures must have leadership from a registered children's nurse responsible for quality, safety, and staffing.
- For consultation-only or non-invasive procedures, a designated lead must ensure staff have mandatory CYP care skills.

Inpatient/day case ward standards

- Children under 16 must be cared for by registered children's nurses.
- 16–17-year-olds on adult pathways may be cared for by registered adult nurses, but providers must ensure they have appropriate CYP skills.

- Minimum requirements:
  - at least one nurse per shift with APLS/EPALS
  - RN (child): patient ratios:
    - 1:4 for children over two years of age
    - 1:3 for children under two years of age (day and night)
  - contingency plan for day case admissions exceeding expected numbers
  - at least two children's nurses on duty at all times
  - a registered children's nurse must remain on the ward with post-op children once the first child returns from theatre.

Post-operative recovery areas

- Must be child-friendly, equipped with paediatric equipment, and staffed by trained personnel.
- Minimum standards:
  - staff (ODPs, RN child or adult) must have CYP skills for safe recovery care
  - child managed in a designated CYP recovery bay on a 1:1 basis until airway is self-maintained
  - staff must have paediatric immediate life support (PILS) and paediatric emergency response skills
  - at least one staff member with advanced life support skills (APLS/EPALS) available at all times.

Outpatient areas

- For **non-invasive consultations**, RN adults with CYP skills may provide care.
- For **invasive procedures**, at least **one RN (child)** must be present for CYP under 16 years.

Hospices

Hospices in the UK are independent, or third-sector organisations and staffing ratios are difficult to standardise due to varied care models (in-hospice, home, community). The chapter on specialist wards and community children's nursing provides a useful model for in hospice care and hospice care at home respectively.

The recommended approach would be to analyse:

- model and level of care delivered
- patient profile (age, diagnosis, stage of disease)
- family involvement in care
- environmental factors (eg, distance from emergency facilities)
- availability of medical support.

For end-of-life care, NICE (2019) recommends:

- families of children with life-limiting conditions at home must have 24/7 access to:
  - advice from a children's palliative care consultant (eg, telephone)
  - registered children's nurses.

Safeguarding and looked after children nurse specialists, named and designated nurses

Each UK nation sets legislation and policy in this area; all health care providers must safeguard and promote welfare and co-operate with other agencies. The intercollegiate document: *Safeguarding Children and Young People: roles and competencies for health care staff* (2025) outlines the minimum staffing requirements set out in the summary section.

How was the guidance developed?

The Royal College of Nursing (2025) guidance was first produced in 2003 as a result of a Delphi study and revised in 2018. The intercollegiate document (2025) Safeguarding children and young people and children and young people in care: Competencies for health care staff is a result of a UK-wide revision, amalgamation and replacement of the previous *Intercollegiate knowledge, skills and competencies for safeguarding children and young people : Roles and competencies for health care staff (2019) and Looked after children: Roles and competencies for health care staff* (2020).

Related tools and guidance

- Toolkit for high-quality neonatal services, Department of Health (2009)
- A background report on nurse staffing in children's and young people's health care (2012)

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