

Staffing for Safe and Effective Care

Nursing on the Brink

POLICY REPORT





Acknowledgements

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1. Introduction

At Congress 2017, the membership of the Royal College of Nursing (RCN) raised the alarm on the growing nursing workforce shortages across the UK, and their concern at the implications on patient safety.

We received a clear mandate from members to lobby for clear accountability for ensuring the provision of an adequate supply of registered nurses and nursing support staff, throughout the health and social care system to meet the needs of the population, in every country in the UK.

Having the right number of registered nurses and nursing support staff with the right knowledge, skills and experience in the right place at the right time is critical to the delivery of safe and effective care for patients and clients. The planning and delivery of nurse staffing for safe and effective care is necessarily complex due to the constantly changing circumstances and associated complexity and acuity of individual patients and clients.

In calling for clear accountability through legislation and guidance, language is incredibly important, and shared understanding is critical. The RCN has therefore undertaken extensive engagement with members, RCN Boards, and nursing workforce experts, which we set out in this report. The outcome of this engagement is a set of RCN principles which provide high-level objectives which most meaningfully represent what we need to achieve on staffing for safe and effective care, though legislation, statutory instruments and guidance, and sufficient funding, in every country in the UK.

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I've only been qualified seven months and I've never worked a shift where the staffing levels are adequate. ”

RCN principles for staffing for safe and effective care

Nurse staffing for safe and effective care is dependent upon the following, and legislating to secure nurse staffing for safe and effective care must address each of these areas:

1 A governance framework that details responsibility and accountability for ensuring an adequate supply of registered nurses and nursing support staff is available throughout the health and social care system to meet the needs of the population.

Responsibility and accountability throughout the health and social care system will be made explicit and transparent as they relate to Government Departments, commissioners of services, providers of services and regulators (those responsible for providing system assurance about quality and safety of patient care).

2 Ensuring that the right number of registered nurses and nursing support staff with the right knowledge, skills and experience are in the right place at the right time.

Any determination about nurse staffing must be informed by legislation, Nursing and Midwifery Council requirements, national regional and local policy, research evidence, professional guidance, patient numbers, complexity and acuity, the care environment and professional judgement.

Financial resources and expenditure must be in place to fully fund and support the delivery of workforce plans and the provision of nurse staffing for safe and effective care.

3 A workforce strategy addressing national, regional and local levels, detailing the overall aim, strategic objectives and required actions.

Clearly stated vision at Chief Nursing Officer level as to how nursing will contribute to population health and address the population health needs and objectives to be achieved to ensure that the vision is translated into action at all levels in the health and social care system will be specified.

4 Workforce plans developed at national, regional and local level to support strategic objectives as detailed in the workforce strategy.

Responsibility and accountability for the development, approval and implementation of workforce plans and monitoring of workforce against approved plans will be specified. There will be transparency through consistently recorded and publicly reported data across health and care settings on the actual numbers and skill mix of nursing staff.

5 Robust commissioning arrangements for pre- and post-registration education and development.

Any commissioning arrangement must be underpinned by credible assessment of supply and demand for the nursing workforce. Responsibility and accountability for determining the requirement for education and development programmes, at pre- and post-registration level, to meet the requirements detailed in workforce plans will be specified.

The UK nursing workforce remains in a critical state. There are fewer nurses on the UK-wide register this year than both previous years: there are now 2,278 fewer nurses than 2016. For a second year in a row there are more nurses and midwives leaving the profession than joining.

2. RCN campaigning across the UK

The numbers of nursing students are not growing quickly enough across the UK as a whole.

Legislation on staffing currently is in different stages of development in Wales and Scotland.

In Wales the Nurse Staffing Levels Act received Royal Assent in March 2016, but the RCN campaign in Wales hasn't stopped there. Statutory guidance explaining how to implement the Act was issued to NHS Wales in November 2017 and we have worked hard to make sure that protected time for educational mentors and the supernumerary status of the ward sister/charge nurse was protected. The Act has fully come into force in April 2018 and RCN activists in Wales are now busy scrutinising the Health Boards and challenging decisions locally. The RCN in Wales is also calling for scrutiny of the implementation in the National Assembly. At the same time the Welsh Government has promised to extend the Act to cover new areas of nursing including paediatrics, mental health and community nursing so this is a key policy influencing area for the RCN in Wales.

The First Minister for Scotland pledged to introduce safe staffing legislation at the RCN

Congress in Glasgow in 2016. Since then the RCN has campaigned hard to influence the shape of the Scottish Government's proposed Bill so that it will genuinely address the experiences and concerns which our members have shared around staffing for safe and effective care across settings. The RCN has yet to see the full text of the Bill, but from discussion with civil servants we understand that some, but not all, of our concerns have been addressed to date. The Scottish Bill is due to be published before the end of June 2018, with parliamentary debate starting in the autumn. The RCN in Scotland is now working to engage with members, partners and the public to ensure MSPs understand the positive impact robust staffing legislation could have on patient care and staff wellbeing, and to build alliances on possible amendments to the Bill.

In England and Northern Ireland, there are currently no plans to introduce legislation related to staffing levels and workforce to deliver safe and effective care for public safety and protection. Northern Ireland continues to be affected by an absence of government. This autumn, the RCN in England and Northern Ireland will be campaigning to drive public and political support for legislation.

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Newly qualified staff often cry during shifts due to stress and a fear of compromising patient care. I genuinely feel like I've been put in positions when my pin is at risk due to unsafe staffing levels.”

3. Engagement with our members

It is more important than ever to hear directly from the frontline, across health and care services in the UK, about the reality of current staffing levels and the impact that this has on people using health and care services, and on staff.

Since our annual Congress in 2017, we have carried out a range of engagement activity with RCN members, to develop our understanding of the issues related to staffing for safe and effective care which must be addressed by legislation and other relevant policies and action.

RCN representatives and stewards

In June 2017, we held a workshop with more than 100 RCN learning representatives, safety representatives and stewards who provide employment-related support to frontline staff in health and care workplaces across the UK. There was unanimous agreement that many individual employment relations cases are linked to the pressures on nursing staff to provide care and treatment within services that are experiencing workforce shortages. Participants expressed consistent views that registered nurses carry disproportionate risk for low staffing levels within services. This is exacerbated by the fact that Boards of providers of health and care services are not held to account.

UK nursing workforce experts

In July 2017, we convened an external expert reference group of academics and practitioners to support our work. This group meets regularly, providing expert guidance and inputs into our developing programme of activity. Their expertise and guidance is of significant value for the RCN in developing our understanding and positioning on complex issues.

In December 2017, we held a workshop to establish a set of principles to underpin legislation and other policy measures in every country in the UK. These were further refined and agreed by the RCN Professional Nursing Committee before returning to the Expert Reference Group in April 2018. These principles will be the basis of RCN lobbying in each country in the UK, which is already well underway in Wales and Scotland.

Registered nurse members

In November 2017, we held focus groups for registered nurses (Bands 5-7) in regions across the UK. We asked participants to tell us what staffing for safe and effective care means to them, what support employers should provide to ensure safe staffing levels, and what needs to be in place to address any concerns staff might have. Participants described staffing for safe and effective care as:

- Patient centred, focused on quality and outcomes, taking into account needs of patients and rising levels of demand, including supporting families and loved ones.
- Staff have access to training, including mandatory training, as well as continuing professional development.
- Staff are supported with the right level of registered nurse supervision to provide safe and effective care.
- Participants said that health and care employers need to ensure the following are in place to make this possible:
 - Right staffing to meet patients' needs, including the right 'skill mix', including proportion of registered nurses to nursing support staff and adequate specialist skills. Also no staff deployed outside the boundaries of their role or scope of practice, and ensuring that registered nurses don't have to spend excessive or disproportionate time on non-nursing duties so that sufficient times is available for people to provide patient care.
 - Accountability at Board level in any health and care employer, with supportive managers and leadership, responding to concerns, demonstrating efficient recruitment and retention systems, with clear accountability for admitting, transferring or discharging individual patients.

- Transparent decision making in workforce planning and management, including data/incident reporting and application of learning, open communication between leadership and staff, decisions focused on patients' needs and not driven by finance, service offer reviewed, decisions about nurses and nursing underpinned by the NMC's *Code of Practice*.
- Local protocols and guidance to support nurses to raise concerns by staff in all settings, and to support professional accountability, appropriate use of bank and agency staff with the right competencies, and appropriate movement of staff between specialist services to cover staffing gaps.
- Staff are valued by their employer, through measures such as flexible working, promotion of non-bullying culture, access to occupational health and subsidised health/wellbeing services including counselling, leadership highlighting success, encouragement and support for innovation, time allowed for debriefs at end of shift for learning and emotional support.

RCN Boards

In November 2017, we presented to RCN Boards across the UK and sought their views on priorities related to staffing for safe and effective care. The resounding consensus was that staffing levels and skills mix had reached crisis point, and that senior nurses and their employers (health and care provider organisations) were facing significant decision-making pressures regarding staffing of services for safe and effective care.

At that time the view from our Boards was that health and care providers must have shared corporate accountability within any organisation for ensuring first and foremost that services are safe, and that reviewing the services provided is necessary if this cannot be guaranteed due to workforce shortages. RCN Boards also agreed that it is imperative that governments across the UK hold formal accountability for growing the workforce supply to meet the health and care needs of our populations.

Directors of Nursing in the UK

In December 2017, we invited a number of senior nurses from across the UK to meet, and a position about the current workforce situation was developed in partnership with those who participated. This position reinforces and further develops the RCN's call for legislation to secure accountability for staffing for safe and effective care at national Government level in each country, as well as at corporate level locally. See Appendix 1.

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Over the last 30 years in the NHS, I have seen a rapid decline in nursing numbers and this scares me. ”

4. Hearing more from frontline nursing staff

In May 2017, at our annual Congress, we launched a survey asking frontline nursing staff to report their experiences and perceptions in their last working shift or day working in health and care settings across the UK. In September 2017, we published *Safe and Effective Staffing: Nursing Against the Odds*, which published findings from 30,865 responses.

Our key findings included:

- 55% of respondents reported a shortfall in planned staffing of one or more registered nurses on their last shift (58% for NHS providers and 25% for independent providers).
- 41% of all shifts reported being short of one or more health care support workers.
- 20% of the registered nurses across the 30,000 shifts were temporary staff and 28% of health care support workers were temporary staff.
- 36% said that due to a lack of time they had to leave necessary patient care undone.
- Over half (53%) said care was compromised on their last shift.
- 53% felt “upset/sad” that they could not provide the level of care they wanted.
- 44% said no action was taken when they raised concerns about staffing levels or compromised care.
- 65% said they worked additional time, with on average almost one hour of extra work (53 minutes).
- 93% who worked extra unplanned time in NHS providers were not paid for this time. For non-NHS providers, the figure is 76%.

Based on survey findings, our conservative estimate was that the additional unpaid time worked by registered nurses in the NHS across the UK equates to £396million annually.

This survey provided valuable information on the realities of staffing levels and skill mix, directly from the frontline. It became undeniable that staffing levels have detrimental impact on patient care, and on staff. Responses to some of the questions revealed significant concern around

particular types of impact of insufficient staffing levels on the provision of safe and effective care for patients, and on staff (see Appendix 2).

We have since further investigated the additional information that 17,819 respondents provided about the impact of staffing levels on patients and staff, through additional free text responses to the survey (see Appendix 3). Most frequently used words were identified, as well as words associated with them. This was used as a basis to search for responses using these or similar words, and from these responses, themes appearing repeatedly and consistently were identified. For the first time, we present here the most commonly reported themes:

Care undone (missed care) due to lack of time

More than a third (36%) of respondents agreed or strongly agreed with the statement that due to lack of time related to shortages in the nursing workforce, necessary care had gone undone. This was highest at 45% in prison settings and 37% in hospitals.

Due to lack of time created by workforce shortages, staff described patients having to wait for treatment and care, including having access to toilet and washing, pain relief, and care such as action to prevent bed sores, ulcers and infections.

Due to inadequate staffing the observation of patients and their condition and recording of vital signs is not being carried out to the level required. Staff coming on shift are asked to deliver care that has been left undone. Some staff perceive that some managers view care left undone as a lack of competence on the part of staff.

Respondents reported a particular concern that care is becoming task-based, rather than being able to deliver the full range of care required by patients, and that they wish to provide, including treatment, emotional support, information and support for individual self-management. Some respondents were particularly concerned about being unable to spend enough time to listen to patients or their families, take time to give them information, including supporting patients to receive important news, or during end-of-life care. Some respondents even reported being

unable to ‘provide a good death’ due to staffing shortages and lack of time to be able to spend with individual patients.

In community settings, which include providing nursing care in people’s homes, and in primary care services, schools or hospices, caseloads and visiting schedules are described as unrealistic due to the lack of staff to carry out visits. Respondents described how this resulted in cancelled visits because there weren’t enough nursing staff to keep schedules, not allowing for travel time or adequate time with each patient. They reported having to prioritise only patients with urgent and complex needs, as opposed to the wider range of preventative and rehabilitative care that others are meant to be receiving. Some responses said that having to make these decisions because of lack of staff, and unrealistic caseloads and schedules, meant they are not providing the level of care they want to, and that they felt they are letting down people who are relying on them.

The impact nursing staff described is that patients and their families understandably become frustrated, and may complain about their care. Staff reported feeling unable to provide care to the quality they want, describing feeling guilty and apologetic, and reported a negative impact on morale. Staff also reported lack of time to take breaks whilst working, as well as regularly working extra time, typically unpaid.

Too much time spent on non-nursing duties

More than half of respondents (55%) agreed or strongly agreed specifically that they were spending too much time on non-nursing duties, given the impact of workforce shortages on meeting patient needs. This was highest at 58% in both care homes and in community-based services.

Respondents described having to make difficult choices when there are shortages of registered nurses, between completing paperwork and providing care and treatment, as well as an inadequate skill mix of nursing staff to provide required care and treatment. They also report further impact when the registered nurses on duty are bank or agency staff who do not know the client group and are not familiar with

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I am not sure if I want to stay in nursing. I feel the care I give is compromised by trying to complete specific tasks which are more concerned with audit and performance rather than care of the patient. The paperwork is onerous, repetitive and does not facilitate care planning. It is recognised that the staffing levels are inadequate and our senior charge nurse is trying to address this with management with some success. ”

treatment and care required. This included times when there were high levels of agency staff who were often unable to access IT systems to update files because the organisation’s system could not facilitate access by non-permanent staff.

Respondents described this approach as potentially unsafe, as well-kept records and notes are essential for safe and effective care. They said there was greater room for error due to having to rush, and that non-nursing duties might not be completed. Some respondents reported working extra unpaid time, specifically to finish paperwork. Respondents described feeling stressed by the volume of work, and the difficulties balancing clinical and management responsibilities because there aren’t enough nursing staff.

Time to support relatives and those of importance to patients

39% of all respondents disagreed or strongly disagreed that they had enough time to support patients’ relatives and loved ones.

Examples described often related to end-of-life care, as well care and treatment in community-based settings and in people’s homes, including self-care. There was a clear view that respondents wanted to spend time with relatives, and to provide information and support, but simply did not have the time to due to workforce shortages and the level of demand. Some respondents

reported being affected when relatives were frustrated that their needs were not being fully met, and dissatisfied with the service they were receiving. This experience was described as being particularly upsetting, leading to low morale in nursing staff, because this is an aspect of care many are very motivated to provide, but were unable to due to lack of nursing staff.

Concern about skill mix of nursing staff

Over a third (35%) of respondents said they were concerned about the combinations of people and skills, including registered and specialist nurses, and support staff, providing care and treatment (referred to as 'skill mix'). The highest level of concern about skill mix was reported in prisons and police settings at 49%, and second highest in emergency care at 48%.

Respondents consistently made reference to issues with the numbers of nursing staff at different levels of skill, particularly inadequate numbers of registered nurses to support staff, as a result of shortages. Respondents pointed out that staffing levels are as much about skill and specialism as they are about numbers of nursing staff, and that 'skill mix' was also affected when staff are moved between different clinical services to provide cover where there aren't enough people. They described how these decisions might be taken by managers who did not have expertise in the specialist skills required.

Respondents described too few registered nurses in proportion to nursing support staff, putting pressure on all involved. Registered nurses, for example, are responsible for aspects of assessment and treatment which support staff are unable to provide, meaning that they have a large volume of patients for whom only they can fulfil certain duties.

Poor skill mix was ultimately described as potentially unsafe due to difficulty providing the full range of treatment and care when there weren't the right numbers of people with the right skills in the right place at the right time. Respondents described feeling at risk as a result of this. The skill mix in terms of the right numbers of staff able to fulfil the right duties is also affected if a service is reliant on too great a proportion of agency staff, who may not be

familiar with the patient's care or have access to the IT system, meaning that regular staff are affected by needing to provide support to them in carrying out these duties.

Student respondents described being inappropriately counted within planned and reported staffing levels. They described being expected to fulfil the role of a health care support worker, when they should instead be protected and supported to gain nursing knowledge and develop nursing skills on their placement, and not be counted in the numbers of nursing staff providing care (supernumerary).

Just over one in four (27%) respondents also agreed or strongly agreed that they were concerned about support staff being expected to perform duties of registered staff without the appropriate supervision. This was highest in prisons and police settings at 37% agreeing or strongly agreeing.

All settings reported a high level of concern regarding employers expecting nursing support staff to carry out care and treatment at the level of responsibility of a registered nurse, which is not appropriate or safe.

Particularly in acute services, both registered nurses and support staff respondents reported concern that employers expect support staff to work outside of the boundaries of their role. Support staff described being given responsibility and allocated duties beyond their level of knowledge and skill. They also said they were unable to seek the support and supervision they require to provide care safely, as registered nurses did not have time to provide this, due to workforce shortages.

Prison and police services described support staff responsible for emergency care for entire prison wings on night shifts, and in some cases, emergency care staff also being required to cover non-emergency treatment, which they described as unmanageable.

Some senior nurse respondents with management duties said that their supervisory hours were not protected, and that they should not have been counted in the numbers of staff providing care and treatment, but were in fact counted and expected to fulfil unrealistic workload. They described being unable to take

a break during their shift, due to supervising a large number of support staff who, unlike registered nurses, are not able to carry out assessments of a patient's condition or their response to care and treatment. In this scenario, registered nurse respondents said it is not possible to provide thorough assessments of what patients in health and care services needed.

Are staffing level concerns addressed?

Only 37% of respondents said that action was taken to try to address concerns they had raised if there were not enough staff and patient care was compromised. This was particularly an issue in prison and police settings, with only 26% saying action was taken.

There was a consistent reported experience of the concerns of nursing staff not being acknowledged, listened to, or addressed by employers. Respondents consistently reported that their experience was that of employer organisations failing to take action to resolve staffing shortages, citing budget constraints or lack of available workforce to recruit into services. They also said that employers did not address the negative impact on patient care or on staff, holding nurse managers responsible for finding cover, and for providing good quality care with too few staff, or with an inadequate skill mix.

Respondents also reported attempts by managers to mask staff shortages by inappropriately including students on learning placements, and supernumerary senior nurses, in the staffing numbers counted and reported internally.

Respondents reported that employers expected staff to work extra time past scheduled shifts, as well as go without breaks or annual leave. This experience was reported as the norm, leading to people being absent from work due to work related stress and exhaustion, and colleagues starting to leave their jobs. Some respondents also felt that raising concerns put them under scrutiny themselves, with potential risk of repercussions for having done so.

Morale of nursing staff

44% of respondents agreed or agreed strongly that they have been demoralised by the impact of short staffing. Agreement with this statement was highest in urgent and emergency care at 50%, and then prison and police settings, at 49%.

Respondents described being affected by being unable to provide the quality of care they wish to, due to staffing levels, and by feeling undervalued as they and their colleagues struggled to cope with ever more difficult working conditions as result of shortages. The experiences described were that of being under constant pressure to maintain standards of quality and safety, and feeling at risk professionally.

Recently graduated nurses reported feeling overwhelmed, with some respondents considering leaving their job, and descriptions of colleagues leaving due to the pressures caused by staffing shortages. Respondents consistently described feeling regularly stressed, exhausted and upset by these experiences, and not well supported by their employer.

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I now find myself regularly feeling that I've not been able to provide safe - let alone quality - care to my patients. This is completely inappropriate and unacceptable, and to be put in a position where I feel as though I am harming patients due to a systemic lack of concern for safe staffing levels is pushing me towards seriously considering a new career. This must stop. This is scandalous, cruel to both patients and staff and quite frankly dangerous! ”

Appendix 1 - RCN Statement: nurse staffing for safe and effective care

The Royal College of Nursing and senior nurse members from across the UK have worked together to act on the concerns raised by of frontline staff about nurse staffing for the provision of for safe and effective care in all health and care settings. The following points within this statement clearly identify actions required to address the professions' concerns.

The RCN will lobby for legislation and supporting statutory instruments to be in place for each country of the UK that clearly demonstrates specific accountability within each health and care system to ensure that nurse staffing is appropriate to provide safe and effective care.

1. Nurse staffing that provides for safe and effective care enshrined in law is appropriate and required within each country of the UK.
2. Legislation should be devised to specify accountability for staffing across health and social care systems, in a manner that addresses supply and demand in the nursing workforce.
3. Government, national and local system accountability for staffing must be specified in law, including the requirement for health and social care systems to have credible and robust workforce strategy, and data-driven workforce planning.
4. Funding should be established, developed and follow models of safe and effective care.
5. There must be corporate accountability for staffing at Board level (national, regional and local) of public and independent organisations, in all health and care settings. Executive Directors of Nursing are responsible and accountable for the advice that they give to Boards, and Boards are responsible and accountable for the actions they do or do not take as a result of that advice.
6. When determining "safe," legislation must address ensuring "the right numbers of registered nurses with the right knowledge, skills and experience in the right place at the right time."
7. Legislation and statutory instruments for staffing should provide for any setting in which nursing care is commissioned or delivered, to ensure the right numbers of registered nurses with the right knowledge, skills and experience, supported by appropriate nursing support staff, are in the right place at the right time.
8. Clear guidance should be incorporated into statutory instruments which ensures that professional judgement, and patient acuity are provided for in each health and care system, alongside the quality, experience and outcomes of patient care.
9. Sustained investment in education, training and professional development are essential for the provision of the right numbers of registered nurses with the right knowledge, skills, competencies and experience to provide safe and effective care.

Appendix 2 - UK perceptions and wellbeing questions by setting

I had enough time to provide the level of care I would like (n. 27,584)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	7%	7%	12%	7%	9%	10%	8%
Agree	24%	23%	29%	23%	25%	29%	23%
Neither agree nor disagree	18%	16%	18%	13%	15%	18%	16%
Disagree	37%	40%	30%	38%	37%	35%	39%
Strongly disagree	13%	14%	9%	19%	13%	8%	14%

I had the time to support relatives and those of importance to the patient (n. 27,448)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	8%	6%	8%	3%	9%	8%	6%
Agree	28%	24%	20%	6%	30%	26%	25%
Neither agree nor disagree	30%	28%	45%	58%	28%	35%	29%
Disagree	27%	33%	20%	18%	28%	23%	31%
Strongly disagree	7%	9%	7%	16%	7%	8%	8%

I felt satisfied with the quality of care I was able to provide (n. 27,513)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	10%	10%	18%	11%	14%	14%	11%
Agree	33%	32%	37%	27%	40%	40%	33%
Neither agree nor disagree	20%	21%	18%	17%	18%	21%	20%
Disagree	28%	30%	22%	35%	22%	20%	28%
Strongly disagree	9%	8%	5%	11%	6%	5%	8%

I was concerned about the skill mix (n. 27,481)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	15%	16%	12%	23%	10%	20%	15%
Agree	31%	31%	24%	26%	26%	28%	30%
Neither agree nor disagree	24%	22%	23%	22%	26%	23%	23%
Disagree	23%	24%	27%	23%	28%	22%	25%
Strongly disagree	7%	7%	14%	6%	10%	8%	7%

I was able to provide the quality of care that I would want to receive as a patient (n. 27,491)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	9%	9%	17%	10%	15%	15%	10%
Agree	26%	28%	32%	24%	37%	37%	29%
Neither agree nor disagree	20%	19%	22%	18%	17%	19%	19%
Disagree	33%	34%	21%	34%	24%	22%	32%
Strongly disagree	12%	10%	8%	14%	7%	7%	10%

Due to the lack of time, I had to leave necessary care undone (n. 27,502)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	35%	34%	33%	24%	37%	39%	7%
Agree	7%	7%	7%	14%	7%	6%	28%
Neither agree nor disagree	21%	19%	21%	21%	18%	24%	19%
Disagree	26%	30%	21%	31%	24%	18%	35%
Strongly disagree	11%	9%	18%	9%	13%	13%	10%

I was too busy to provide the care I would like (n. 27,452)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	17%	185	15%	20%	13%	13%	17%
Agree	39%	41%	29%	43%	34%	29%	40%
Neither agree nor disagree	15%	14%	17%	14%	16%	22%	15%
Disagree	21%	20%	26%	18%	27%	27%	21%
Strongly disagree	8%	7%	14%	5%	10%	9%	7%

Too much of my time was spent on non-nursing duties (n. 27,500)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	20%	16%	21%	18%	22%	12%	18%
Agree	38%	37%	34%	33%	36%	29%	37%
Neither agree nor disagree	20%	23%	23%	27%	20%	25%	22%
Disagree	18%	19%	14%	19%	18%	26%	19%
Strongly disagree	4%	4%	8%	3%	5%	8%	4%

I was concerned that support staff were being expected to perform the duties of registered staff without appropriate supervision (n. 27,390)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	7%	7%	9%	14%	7%	8%	7%
Agree	21%	20%	13%	23%	18%	18%	20%
Neither agree nor disagree	17%	21%	28%	29%	26%	25%	21%
Disagree	41%	39%	32%	22%	35%	29%	38%
Strongly disagree	14%	14%	18%	12%	14%	20%	14%

I was provided with the appropriate supervision and support (n. 27,424)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	7%	7%	10%	6%	8%	8%	7%
Agree	23%	28%	21%	18%	28%	22%	27%
Neither agree nor disagree	30%	30%	33%	20%	30%	30%	30%
Disagree	27%	26%	26%	30%	23%	26%	25%
Strongly disagree	13%	10%	10%	25%	10%	14%	10%

I felt fulfilled (n. 26,786)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	6%	4%	7%	6%	6%	6%	5%
Agree	21%	20%	25%	15%	24%	20%	21%
Neither agree nor disagree	27%	25%	27%	26%	25%	24%	25%
Disagree	32%	37%	28%	33%	33%	35%	36%
Strongly disagree	14%	13%	13%	21%	11%	15%	13%

I felt demoralised (n. 26,699)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	14%	15%	16%	24%	15%	18%	15%
Agree	29%	30%	28%	25%	29%	32%	29%
Neither agree nor disagree	23%	22%	21%	23%	22%	20%	22%
Disagree	25%	25%	25%	19%	26%	22%	25%
Strongly disagree	10%	7%	10%	9%	9%	9%	8%

I felt upset/sad that I could not provide the level of care I had wanted (n. 26,786)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Strongly agree	19%	22%	15%	22%	17%	16%	21%
Agree	33%	34%	24%	38%	27%	30%	32%
Neither agree nor disagree	18%	18%	25%	20%	21%	20%	18%
Disagree	20%	20%	23%	14%	25%	23%	21%
Strongly disagree	9%	7%	13%	6%	9%	11%	8%

Thinking more generally, if there are not enough staff, or if patient care is compromised, have you been able to raise a concern? (n. 26,871)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
No	19%	21%	17%	22%	18%	17%	20%
Not applicable	9%	7%	12%	8%	9%	6%	7%
Yes	72%	72%	71%	70%	73%	77%	72%

When you raised a concern, was any action taken to try to address the issue? (n. 19,184)	A care home	A hospital	Other	Prison/police custody	The community	Urgent and emergency care (non-hospital)	Total
Don't know	18%	19%	19%	24%	18%	20%	19%
No	40%	45%	43%	50%	43%	42%	44%
Yes	42%	36%	36%	26%	39%	38%	37%

Appendix 3 - Free text responses to perception and wellbeing questions

Safe and effective care survey – free text responses on perceptions and wellbeing

The themes presented in this report are based on exploration of free text information entered by 17, 819 respondents. These entries provide examples and further detail related to the closed ended questions about perceptions and wellbeing. Respondents indicated whether or not they gave permission for their entries to be published.

In our September 2017 report, we published a selection of illustrative quotes. To further bring to life the experiences described within this large data set, we now present here entries referring specifically to examples of impact of 'staffing' on patient and staff, for which permission was given to publish. These represent responses from across the UK and are presented by main setting indicated by the respondent.

- A hospital, such as adult acute, children's acute, mental health inpatient etc.
- Community-based services, such general practice, district nursing team, hospice, school nursing etc.
- Urgent and emergency services (non-hospital, for example call centre, walk-in centre, home visits)
- Prison and police custody settings
- Other services, including specialist clinics, forensic mental health services, ambulance services, assessment centres, occupational health, children and adolescents mental health services (CAMHs), respite services, pharmacy, supported living etc.

1 Hospital

I've only been qualified seven months and I've never worked a shift where the staffing levels are adequate. Someone has usually always phoned in sick, or there's been a family issue. Quite often the shortage has just been down to poor planning. I don't feel safe or supported. The patients can tell we're short staffed, they've mentioned it to management in person and they've mentioned it on the friends and family questionnaire at the end of their admission. A lot of patients, both young and old feel they are troubling us, as they've witnessed us buzzing around at a 100 miles an hour and won't ask for a drink or the toilet until we approach them. Sometimes this can be hours. One newly qualified nurse and two HCAs is not safe or practical for 15 patients!!

The whole team on my ward feel demoralised — particularly the nursing staff that shoulder all the responsibility as there is so much pressure on the system at the moment. It is breeding an atmosphere of discontent and is driving staff to leave which in turn creates strain on existing staff to cover all the antisocial shifts which impact on their family and quality of life. Nurses feel undervalued and under paid for the complexity and pressure of the job.

I now find myself regularly feeling that I've not been able to provide safe — let alone quality — care to my patients. This is completely inappropriate and unacceptable, and to be put in a position where I feel as though I am harming patients due to a systemic lack of concern for safe staffing levels is pushing me towards seriously considering a new career. This must stop. This is scandalous, cruel to both patients and staff and quite frankly dangerous!

We are significantly bottom heavy in terms of skill mix which means these junior colleagues are getting pushed into progressing before they are ready, which is destroying them as people, leaving patients in unsafe settings because these nurses simply lack experience to be able to adequately perform the roles expected of them. These nurses then leave and our staffing becomes worse and worse.

At times, patient care has been compromised and my concerns for my registration and mental health have been higher than at any

other time in my career. I was frequently completing paperwork after handover as there was not enough time in the shift to stop attending to direct patient care and complete it.

As a student in my final year, I am concerned with the time spent getting up to scratch ready to qualify due to staffing levels are so low. I am regularly left doing tasks such as medications without proper supervision. I am constantly finding someone to double check and countersign my meds as I will not do it without.

In theatre the difficulty of poor staffing levels mean that patients could be cancelled. Though not compromising care it is awful when this happens. We also have great difficulty in teaching junior staff, putting extra pressure on the more experienced and I feel a sense of failure towards the junior staff with regard to their training needs.

As Matron I am aware of all staffing issues which are taken to the bed meeting twice a day. No ward is left unsafe because we adjust and move staff where necessary. However, working in a very specialised hospital it is difficult to ensure speciality skilled staff stay in their own areas. Some nurses find this very stressful and get fed up with being moved. Over the last 30 years in the NHS, I have seen a rapid decline in nursing numbers and this scares me.

I fill in regular incident reports for unsafe staffing levels, none of which I've ever been spoken to about. Vital medication was missed during this shift as I had too much on my mind, I missed breaks and I went home feeling hungry, tired and like a failure. I am looking for a new job leaving nursing.

I work on a busy respiratory ward, often we get very unwell patients on the ward who really should be in ICU. I am a sister and am always in charge, coordinating and I have nine patients to look after. I am expected to look after those patients, attend a ward round, and support junior staff and discharges. I cannot remember the last time I left on time, I always stay at least 30 minutes late to finish work/writing. Lack of medical staff is also an issue, we often only have an FY1 on the ward who often lack the experience to deal with such unwell patients. Weekend medical staffing is awful, doctors are so busy with unwell patients in A&E that ward patient care is

compromised, e.g. today I had a patient who was end of life and needed a syringe driver, we were unable to start it for several hours as no doctors were free to prescribe it. Newly qualified staff often cry during shifts due to stress and a fear of compromising patient care. I genuinely feel like I've been put in positions where my pin is at risk due to unsafe staffing levels.

Not enough time to talk to patients. Repetitive answers in paperwork because it has to be done, and not enough time to do it properly. Drugs nearly always late, and an increased risk of errors because you have to do other things such as give out commodes at the same time as doing drug rounds. Reduced staffing puts you at risk of losing your pin, because management will not back you up if you make a mistake due to poor staffing.

Working in a busy oncology clinic is demanding when we are fully staffed. When there is poor staffing levels, morale drops and patients don't get the care and attention they deserve. Nurses are expected to carry out the same work load and tasks as they do when they are fully staffed. I leave work feeling drained and stressed.

Due to staff mix, the staffing during my last shift was all junior nurses, In order to ensure that my patients were provided with the best care I could give them, I cut my break short.

As a mental health Nurse one of my last shifts had four patients on continuous observations due to their mental state and there was six members staff of on duty, staff did not receive their correct breaks and patients were left frustrated as their needs could not be met in a timely manner! I personally feel that patients are not receiving the care they should be due to staffing levels and I feel that staff are stressed, over-worked and under appreciated by the trust!

I am perennially impressed by the resilience I see in the nurse population. As a nurse with 38 years' experience, I generally enjoy what I do. I work bank for the unit I used to manage out of a sense of loyalty to the service that needs help. I work from a position as a bank nurse where I know that I will be in a short staffing scenario as the unit will not call me if they have their full compliment. I also work a small amount of agency in other hospitals and again this is always because they are short staffed.

Nurses do not generally express their concerns to management as they feel the managers are hamstrung by policy devised by an intransigent, indifferent government that will hold us professionally to account but fail to treat us professionally.

Recently our staffing levels have improved. This is the first time in the last two to three years we've had our staffing compliment. This improves the care we can safely deliver efficiency and effectiveness. Students and new staff have more learning opportunities with their mentor. Staff can get their breaks and get off duty on time which all which improves staff morale.

When staffing levels are low it impacts on the staff who are trying their best to give patients the best possible care. In my workplace we do lots of dressings and sometimes it seems like a conveyor belt to get the next patient seen and to treat the patient holistically rather than just changing a dressing. Our patients need our time also to convey their thoughts and feelings but sometimes the pressure to get patients in and out is overwhelming and at the end of a busy shift we are left with feeling "we should have done more".

As part of the management structure but at the bottom tier you feel very vulnerable. You know staffing levels are not good, you try to move staff, to cover a shift from another area to minimise the risk but you are in turn leaving two areas short. There are no staff in the recruitment pool but you are not permitted to close ward beds regardless of the number of suitably skilled staff. In fact you are being told by senior management that you have to put extra patients into the ward in corridors or squeeze them into a bay as extra.

We have had staffing levels at crisis for months, vacancies for nursing posts have not been advertised quickly, delays up to a year... There are shifts where patient care is compromised, the phrase "accident waiting to happen" is used daily. Management have only begun discussing how to support our units staffing, nothing has been done yet. Morale is at an all-time low. We are losing staff quicker than we are gaining.

The impact that staffing levels has had on myself is, feeling more pressurised when being left in charge of a ward when you regard yourself as being a junior member of staff, crying when leaving

a shift because you feel that you haven't been able to provide the best possible care to patients, exhausted from not being able to take a break.

When there are staffing level issues I feel I question if I am good enough to be a nurse, sometimes I feel I'm not "cut out for this" — and there are also occasions where relatives/families may complain due to me not being able to complete some necessary tasks or care due to not having time. This makes me feel I have failed my duty to that patient despite sometimes staying over one hour late (unpaid) to finish some tasks.

I am not sure if I want to stay in nursing. I feel the care I give is compromised by trying to complete specific tasks which are more concerned with audit and performance rather than care of the patient. The paperwork is onerous, repetitive and does not facilitate care planning. It is recognised that the staffing levels are inadequate and our senior charge nurse is trying to address this with management with some success.

Increased staffing absence, increasing turn over in staff, vacancies, increased stress and pressure on existing staff. Increased expectations from management to achieve standards and increased expectations of service users, unrealistic towards the reality of the situation. "Pressure. Cooker"

Certain shifts I have worked, I have not had time for breaks and have felt demoralised and exhausted. I have had occasions when my feet have been blistered and bleeding after work. Due to poor staffing there has been incidents where personal care has been delayed and relatives have been aggressive and abusive towards staff due to this.

Short staffing levels effect the patients, they can tell we're stressed and running around so therefore they feel afraid to ask for help. It also creates a stressed atmosphere and when they're isn't enough staff even for basic personal care of two people to a patient then the patient isn't cared for in the manner in which you wish you were doing it, which is awful.

I now work in a day surgery unit which is staffed well with a good mix of skills. However senior management often pull staff from our unit to cover the ward areas that are short. This then

leaves us short with a high turnover of up to 60 patients a day. When I worked in the wards the staffing was terrible and I felt I could not give the care I wanted to. Patients deserve better care.

As senior charge nurse I feel I have to be the strong person for everyone and can go above and beyond the call of duty when staffing is below safety levels to ensure staff on duty are supported and patient care is maintained. This often means you are firefighting with your other managerial duties. Sometimes my brain is like a messy filing cabinet, which in itself is exhausting. Somehow you pick yourself up and start again the following shift.

Staffing levels have a very negative impact on everyone. We are unable to spend quality time with patients, get to know them and ease their concerns. Patient have to wait longer to be attended to, including basic care such as washing and toileting. Staff become stressed and are often off sick due to the situation. You feel alone and abandoned by management.

Because of low staffing levels there is not enough time for quality patient care, although the majority of the time essential care is always given, there is not enough time to spend with patients. On my last shift one of my patients wounds dehiscd and she was worried and scared that she might have to return to theatre and although I tried my best I would have liked to have spent more time with her. Staff morale is at an all-time low.

I've noticed on many wards now, that a lot of one-to-one nursing from either a HCA or nurse has to be provided to patients with e.g. delirium or safety risk, this reduces staff numbers on the floor, and often we have more the one patient requiring this care which leaves us short. This isn't factored into staffing levels as there are eight staff on shift but not always eight staff working on the ward floor.

I work within acute mental health admission ward poor staffing levels out patients and staff at risk, no time to do proper therapeutic interventions end up reacting to situations rather than proactively working with patients.

1:1 care is a big issue, patients are falling and being left in vulnerable positions as staff are unable to supervise due to staffing levels. Stress is high due to lack of staff, support from

management and amount of increased work load with no extra staff. Palliative care patients are not getting the quality of care they should be receiving some being left alone for hours as staff are too busy to check them. Patients who are needing help to feed are being denied due to staffing levels!

When staffing levels are too low, in my outpatient clinic we try to provide the very best care for our patients. Patient care is the last thing to suffer. However, the stress, working extra hours, lack of breaks and pressure put on us makes us nurses ill and demoralised. Nobody can work like this.

There have been times where as a student nurse or as an auxiliary I have had shifts were we as a whole struggled due to staffing levels but nevertheless pushed on to provide the best care we can for patients. We are there for our patients because they matter.

We are a neurosurgical ward and our patients require a lot of care due to their challenging and diverse needs. We are staffed to take this into account. Unfortunately higher management see this as having too many staff as they only look at staffing levels and not the time that it takes to care for these type of patients. Consequently nearly every shift one of our nurses are taken to staff another ward!

My area of work is regularly used as a 'bank' for the level 3 NICU sister unit, we are regularly left short staffed in order to cover staffing issues in the NICU. Morale is extremely low with staff stating that they feel completely demoralised and only come to work as they feel they need to support colleagues

We received four post-operative patients within an hour of each other. Due to staffing levels I was unable to perform observations in a timely manner. A patient in my team needed a nasogastric intubation tube, I didn't get time to do this during my shift so stayed on an extra 20 minutes to complete this to ensure the patient would be fed that night.

We have had an increase in patient falls recently, we often work understaffed and are therefore unable to observe the patients as much as I would like. We get berated if we submit Datix forms about dangerous staffing levels and we often work with no managers on shift and just one qualified nurse.

I strongly suspect that many patients do not ask for as much input as they need because they know we are busy and under pressure, although we try to hide that...We cannot follow all policies and standards expected from management especially the paperwork side of the job which is legally required. Feel very vulnerable then. Staffing levels affect our training and development as we can't be released from the ward to attend training sessions.

I was a ward manager and had 10 patients a day on an acute respiratory ward, plus I had to meet audit deadlines, attend all meetings, manage staffing with eight full-time band 5 vacancies and I always worked alongside agency and overseas nurses which I was mentoring. I had under ten breaks in a year and worked up to 54 hours a week, all unpaid over my full-time hours.

I feel like I'm spinning plates, except the plates are patients. That to me is the worst feeling. A feeling of having no control. Going from crisis to crisis continuously is so incredibly stressful. Front line staff feel like they are working on a battlefield, we don't know who to go to first...There is no support or acknowledgement from management of the level of stress front line staff are under and the impact this has on our mental health. We are told their hands are tied as there is no staff. Therefore staffing levels are distributed for the greater good across the hospital.

The impact on staffing levels do not only have repercussions on staff but also on patients. whilst attempts have been made to increase staffing levels, agency nurses are not able to read pumps, draw up iv medications or perform certain duties, therefore whilst it looks good on staffing levels, it means regular qualifieds often look after their own patients and those of agency staff.

2 Community-based services

Families losing allocated continuing care hours due to staffing, leaving families at risk of things going wrong when they have been up all night and all day looking after children with complex health needs.

In the community, communication is vital and when staffing levels are low patient visits get missed and staff go without any breaks. At the end of the day you are exhausted and then have to come home and write up patient notes in your own time. Driving under pressure to carry out all visits is dangerous and so is eating and drinking

in the car. Lone working policies not adhered to and nurses' safety compromised daily.

We are unable to provide a service at weekends due to poor staffing levels. Service Users in crisis are left without any support.

We have staffing shortage, the trust do try to recruit but just not enough qualified staff locally/ nationally. Emphasis put in to defining referral criteria, but this does risk excluding some patient groups.

Associate Directors and senior management they are only concerned about bed management and timeframes when patients can be discharged. A lot of avoidance, not willing to validate the anxieties and stress staffing constrains put on those who turn up for work.

All staff generally doing more than two hours extra work a day than they should. As a team leader with the specialist practitioner qualification in District Nursing, I spend most days completing clinical work — with no time for management — therefore all management and admin is completed in my own time at home.

Better care outcome for patients if staffing levels adequate. Time to deliver holistic care is not possible, conflicts with what we as nurses espouse to do daily but cannot. Frustrating and demoralising need to dig deep to keep going. Only motivator is patient and families and knowing you make a difference keeps intrinsic motivating factors alive. How long can I keep going on this?

Currently have been in district nursing 25 plus years. I'm currently looking for an opportunity of employment outside nursing in order to put my health and family life first. Live on coffee and chocolate bars at work and too exhausted to exercise when I come home. No longer want to work in nursing as don't want to be part of an organisation which doesn't value staff. Also don't want to be forced to work in a way that patient care is compromised. In district we cannot do with current staffing levels all that management expects of us.

I am trying to do complicated dressings in 10 to 15 mins and then get the wound care chart completed. This past week I have worked about two hours unpaid to catch up. I also went to a diabetic foot update for another two hours in my own time.

My health was affected and I went off sick — I had not been off sick at all for 15yrs but I felt completely stressed and overburdened. GP practice's rarely use agency staff as it is too expensive and they would rather cancel clinics than pay the rate of agency staff. Increasingly health care assistants are taking on roles normally performed by registered nurses and I'm not convinced that they are fully competent to do some of the duties but they are cheaper to employ. Many GP practices do not abide by Agenda for change rates and my pay rate is less than those employed by health trusts with no pay rises, bonus or incremental increases.

Had to leave my centre as a District Nurse sister and help in a very under-staffed centre, leaving my patient but having to reassess patients who have not had holistic assessments. My partner is fed up with me bringing work home. Both my stresses and my experiences. Work can take over as nurses we just can't leave our patients once we leave their house.

As the team manager I am meant to be 20% clinical, 80% managerial. I often have to spend 60-70% of my time in a clinical role and so my management tasks fall behind. This causes problems for more senior managers as often managerial targets are not met. I feel strongly that the clinical role takes a more important place in my job and this can lead to conflict at times.

While patients are grateful for the visit they always comment that we too busy to talk, we're 'just in and out'. We have more verbal complaints than written ones so this info not really captured. Patients visited but quantity rather than quality is what is captured via IT system.

Longer waiting lists for clients, early discharge when ideally people would have benefitted from more care. Exhausted and demoralized staff. Team work has been good as we have had to support each other.

Paperwork takes priority on most shifts according to management. The infamous quote 'if it's not documented it's not done' is the favourite saying of the management and the care inspectorate. I agree that it is important, but the care and wellbeing of our frail residents should be the priority. It's easy to document care that hasn't been done! Staff morale is low, leading to increased levels of staff absences and low staffing levels. As they too are usually short staffed.

Staffing levels mean I am often the only nurse on a drop in, this can be after 5pm or on a Saturday. Managers state they are available by phone and very rarely are. When issues occur and you require advice or to get permission this is then impossible, so you have to make decisions, which are then never correct when the next day comes. I have requested various training and been denied it. The whole situation is awful. Nurses are treated like secondary citizens, it's like 'nurse' is a dirty word. I love my profession but after 10 years I'm looking for other employment opportunities.

Low morale increased sickness, difficult getting staff and keeping them. Concerns raised but no response from management. Staffing levels dramatically less than 18 months ago.

Staffing has been low. Due to this I've been physically and mentally exhausted due to extra patient caseload that I had to pick up. Patients have all been seen and assessed and treated but I do question, to what level they were treated and assessed.

We have a lot of palliative patients with complex care needs and it has been difficult to meet their needs with the time we have and staffing levels i.e. complete referrals, order equipment etc. It has required us working through our lunch break most days and sometimes finishing late and worn out to ensure their needs are met.

Work demands vary from day to day and the staffing numbers are pushed when demand increases.

As nursing staff you have an ethical duty of care so I do not normally go home until I have completed all duties. The level of care I provide is good but I am unable to effectively provide the emotional and comfort support due to time constraints.

We cannot fulfil all elements of our duties relating to care; record keeping, care plans, reviews, etc. We are very much hands on having on average 42 contacts a day. The last time I spoke to a Manager was prior to the Easter holidays; lack of support. A risk document has been completed by Manager for Heads of Directorate to no avail. We do not get breaks and no extra cover at easily foreseeable times when there is extra pressure on the service. Morale is very low. My colleague is suffering anxiety symptoms with chest pain and is becoming increasingly paranoid and negative.

Stressed. Exhausted. Never take breaks. Put upon by service. Don't feel listened to by management. Threatened with disciplinary when things go wrong, no consideration of work pressure. Love my job love the patients but feel bogged down with documentation and volume of calls.

A lot of our time is spent with palliative patients in their own home, it is very frustrating for staff and very upsetting for relatives when we have to rush these visits due to workload.

So community services are expected to provide the care needed for these people who are often very isolated from family and services. Social services are unable to assess and provide care due to their lack of resources and inevitably it is the community nursing team that intervenes as social problems develop into health issues. At times things have felt unsafe. I also feel there is an unrealistic expectation from patients as to what we can provide under the stretched and limited resources we have.

Care is never compromised however documentation not always completed as should be. Incidents are delayed in reporting utilizing online system. Non-nursing jobs not always completed. Feel stressed. Never take breaks. No opportunity to take time owing. No offer to be paid for overtime worked. NHS would fall apart and patient safety comprised if nurses worked to rule and did job thoroughly!!

My stress levels are high on a regular basis and I often feel anxious. I always complete the work given to me but I work on average seven hrs unpaid overtime a week. When I come home from work I do not want to engage with my family straight away as I feel I want some quiet time which is not easy as I have three children and look after my elderly parents. I often do paperwork in the evenings as there is no available time within my working day. To be honest I am not enjoying a job that I used to love.

I felt inadequate as a team leader and unsupported in trying to manage a large caseload and quarter of staff. Management then decide to quote negatives which demoralised staff who work extra for patient care not to be compromised often detrimental to their own wellbeing.

As a school nurse working a caseload jointly on 15 hours a week I currently am responsible for over 5,000 children. Together we simply

achieve the basic safeguarding first but when the flu immunisation programme starts in October I'm not sure how we will continue to deliver a safe service. This also impacts on us being able to contribute to the Public Health of our school aged children with many elements of our role disappearing.

Several patients walked out of clinic as we were unable to satisfy their needs at the time.

Staff are looking for new jobs. Morale is rock bottom with no signs of any chance of it improving. Staff are crying and feeling depressed. Staff feel unappreciated and concerned about potential complaints and or incidents which may arise. Paperwork and documentation is a heavy time consuming burden which is taking qualified nurses away from patient contact.

I was unable to address multiple health problems that majority of patients present with. 15 mins isn't enough to examine, assess, prescribe and explain treatment for one problem never mind for four issues.

I have had to recently write to the Local Health Board and commissioners to say that there is a real danger that our team will fail to meet the continuing care cover required for a few families in a certain area. As a new manager of the service I find myself awake at night contemplating how I can manage a service that is so understaffed.

Large amounts of time completing paperwork or rushing to complete paperwork due to a patient being admitted to hospital or being assessed under the MHA and subsequently sectioned takes its toll, as quite often you forego lunch/drinks or even simple things like going to the toilet. Having to start work earlier and still finishing your shift late, unpaid, with paperwork still outstanding, is demoralising and frustrating! This results in feeling exhausted and losing the will to return to work.

3 Care homes

Home has trained carers for 12 weeks calling them care practitioners to save on nurses but all it does is increase your level of responsibility leaving you frustrated and doubling your work. My last shift was my first shift of the week where I had the correct staffing numbers. I regularly work 70+ hours a week due to lack of

qualified staff. I can't go home after a 12-hour night shift if the day shift nurse calls in sick and have had to stay another 12 hours to do the night shift. Am physically and mentally worn out. Management are not interested. I came to care because I care. I cannot leave my residents to suffer getting late medications just because somebody has called in sick.

Staffing levels in care settings have negative effects on basic care. In a care home the daily routine is full on with medications, including time specific, dressings, care planning. It leaves little time for extra duties i.e. if a patient is poorly or requiring palliative care. District nurses have an increased workload therefore more workload on the nurse on duty. Senior managers are focused on paperwork and care plans being correct (not just daily notes) and extra care plans written for example if short-term treatment required, if paperwork is not completed you are disciplined and therefore impacts on patient care. Nursing has gone away from the basics and patient care meaning nurses often have little patient interactions during working day but are expected to know the patient inside out.

The staffing levels at my workplace is of a concern and it has been an ongoing issue that the Managers are turning "deaf ears" to, and as a result the patients are not getting the appropriate care needed. The permanent staff are being used to the extent that they don't want to do any overtime, because they've been stretched to their limit and this has had impacts on most of them, health wise.

When caring for someone who lives in a nursing home you will need to rush and that means that you will not be able to provide care at high standards. My last shift was an easy one. Previously I had a shift where due to lack of trained staff and a high number of residents plus a poor medication management I was in a situation where an emergency would've put residents at risk. On overall most care homes will need one more carer on night shifts to have normal staffing level. Worst staffing level that I come across was 53 residents and just three carers and one nurse.

This staffing level had an impact on me as I couldn't have my break as I'm suppose to but at the same time couldn't provide the care I wanted to my residents. HCA on the floor are struggling

to provide a high standard of care due to their number. At the end we managed to do our best and handed over to the next team what was left.

Staffing levels have impacted my shifts negatively. It has led to be taking a back step on my nursing role and having to focus on a carer's role. As a nurse, I adapt myself to both roles however with staff shortages my role as a nurse is put on hold to ensure the individuals are provided care for are safe, clean and have their dignity and respect maintained, with compassionate care. This delays my tasks as a nurse, during my shift, effecting my breaks and can often affect the individual's routine.

I recently take care for highly dependent residents and under staffing makes my duty really challenging. It is very difficult get even one more staff on shift. Lot of carers are leaving our nursing home as they are paid minimal salary in highly demanding environment. Teach all the time new carers who never worked in care sector or teach agency people is so demanding. I think for my residents are the best to have permanent staff, as they get used to them and trust them.

The nurse's role has become one of administrator, book keeper, font of all knowledge, financial juggler, diplomat, counsellor, etc. and generally to be adept at everything and knowledgeable about everything attempting to process enormous quantities of information. So much so I packed the last job in after six weeks and am considering strongly looking at a totally different career.

After a busy night shift that was a good shift there was then no staff nurse to take over from me for the early shift, I had to arrange staffing, call the manager in and give some early medication with day staff. I felt exhausted and ready for my bed. I stayed one hour and forty five minutes and have put the overtime on my time sheet and in the overtime book but doubt I will be paid for it; but I have a duty of care which I up hold.

Negative: low staffing levels lead to nurse being able only to provide basic care (alongside HCAs), no opportunities to provide "additional duties" e.g. spending time to talk to patients/residents, non-clinical contact. Mistakes happen as well; drug errors. Reduced supervision might lead to increased number of falls in care homes. Delays

in providing treatment e.g. wound care, end-of-life care assessments and subsequent actions.

I constantly raise concerns each morning about staffing levels, risks to the clients. It falls on deaf ears. The manager does not listen or care, the deputy manager is only concerned with losing her job if she says anything. I had to call an ambulance last week and the paramedics were appalled at the staffing levels. I am so stressed. I care about the elderly very much but this situation is unsafe. What can I do about it?

The home is divided into two sides. Often there are only three nurses instead of four. When this happens the third nurse has to spend half her time in each of the sides, running from one to the other. When there are less care staff than needed, as happened on my last shift I also had to take on the role of a care assistant to help meet the basic care needs of the residents. I go home totally stressed and feeling 'used'.

When I have to take care of 30 residents and something extra must be done I am worried that some of them are not taking e.g. antibiotics or Parkinson's medicines on time.

I have witnessed co-workers getting frustrated with being constantly understaffed and exhausted. This reflects in the care they give. I feel I am very patient and I have cut down my hours as I cannot cope with the dependency of high demands by nurses who are not hands on. Nurses only constrict to paper work and tablets. I feel it a shame and disgrace they are counted as a number on the floor as this does not reflect the care given.

Falls, dealing with an acutely unwell patient on my own, not being able to support relatives, care staff feeling frustrated, all impacting on team morale.

Only having one staff member in the afternoon, does not give you the chance to spend quality time with the residents that you are looking after. You are always having to be toileting, doing mobility supervision and not spending one to one time.

Trying to do too much with inexperienced care staff having to muddle through without being given support and training, being thrown in at the deep end is common.

Staff are altered from shift to shift without prior request/notification, this impacts on child care and family life in general. Majority of managers care more about the money than the quality of care delivery to the residents. Staff from overseas given jobs with virtually no understanding of the English language. Staff being allowed to work a full day then carry on to night shift. Managers knowing full well that their staff have other jobs, however continue to give them 30+ hours per week in the home.

Having new staff who don't know environment/clients and not completed full induction are expected to be included in staffing levels thus causing staff conflict. Short staffed but expectations to have workload completed as if fully staffed. Agency nurse not receiving full handover of clients thus compromising care needs. Having to spend less time with clients. Having inadequate staffing levels compromise planned care which gets neglected and planned care not adequate to individual needs thus not being person centred. Inadequate staffing levels equate to task orientated care rather than person-centred.

I feel one nurse for 30 residents is far too much. You put your residents first so you have no breaks on a 12-hour shift. You have three drugs rounds, paperwork, updating care plans etc. It's so hard to spend quality time with residents.

I have stayed after my shift as staff nurse regularly to take on health care position unpaid to make sure that my staff are supported and not under stressed and help them with their duties.

We are apparently fully staffed but despite the best efforts of support staff, we are only achieving basic care without the time or encouragement to provide a satisfactory quality of life for residents.

As students, we rely on all members of staff to assist in our learning. If the team is short we are expected to fill this gap. This comprises our overall learning and is not acceptable as there is no supervision.

For me — doubting my career choice, anxiety, low mood. For residents — lack of time to support emotional needs, care plans not truly reflecting current needs.

Worked through my break to ensure patient care was not compromised, stayed 45 mins after shift to ensure writing was up to date.

Too much time spent trying to cover shifts from staff phoning in sick. This time should have been spent on the service users and ensuring their safety and wellbeing.

Staffing levels are usually adequate, but if staff go off sick there is no-one to cover. The care home refuses to use agency staff because it is expensive. All the staff get very tired and are not physically able to work extra hours to help to cover sickness.

Morale is very low due to pressure of work. We are always rushing to give even basic care. The stress levels are high. Sickness rates are high. I myself have just returned to work after being ill for the past three weeks due to a viral chest infection. My GP did ask if I had been suffering from stress recently. I have returned to work and the stress levels have not altered. I am considering whether I will continue in nursing. It is a very sad situation.

Whilst generally the care provided remains good. The work is carried out in a hurried way. Stress comes from fearing something might be missed and worry in case mistakes could be made by not having adequate time to think things through. Work is multitasking to an extreme. Medication administration is not protected time. Interruptions from visiting inspectors, auditors, general practitioners and incessant phone calls are the main source of concern when ratio of one Nurse per 20 residents. On the positive side good opportunities for training and updating. In the area I work we have reliable experienced carers who do a good job however the strain is often evident in a physical and emotional ways.

4 Urgent and emergency (non-hospital)

Due to low staffing levels at other areas within my locality staff have been moved leaving teams short which is having an impact on the remaining staff being moved within teams which impacts on continuity.

We are short of staff due to sickness, vacancies and management of change issues. Services keep changing the goalposts of what they expect from us which has a further impact on staffing. Also as a new service we need to form as a team and develop ourselves. Not everyone works the same in rate or ability.

Poor staffing and skill mix is affecting staff development as experienced practitioners are leaving the service due to enforced change and standards of care becoming unsafe, extra pressure is placed upon staff still in post to meet complex patient care need and develop over half the workforce in Advance Nurse Practice roles.

If we do not have enough nurses/social workers within our team on a daily basis we literally cannot cope with the amount of referrals we receive. People wait longer to be seen and GPs become quite hostile. Due to deliberately reduced staffing levels within general community mental health services we are turning away patients who would previously have got a service and it feels wrong.

Staffing levels at all levels of the organisation have an effects on nursing. For example a shortage of competent admin staff means that nursing staff are responsible for reporting and chasing up all IT issues, and ensuring that replacements for broken hardware are obtained which takes ages. We are responsible for allocating staff lockers, filling up the printers with paper, photocopying patient education leaflets, finding wheelchairs I could go on. My point is we need admin/clerical and support staff in post as well as nurses because any deficit in other areas the nursing staff pick up their duties.

Minor injury and illness unit swing complex and chronic cases. Demand increased due to patients stating they cannot access GP surgeries it also a convenience culture by the public who often come late in the evening with children who have been ill for more than 24 hours, individuals not attempting any self-care at all such as simple analgesia. Non realistic expectations when presenting with chronic and complex conditions inappropriately leading to complaints and aggressive behaviour. Staffing numbers not increased despite 100% increase in attendances alone not including the increased complexity resulting in staff being forced to work beyond their limitations and the unit working beyond its capabilities. Staff nearly always off late.

High volume of patients combined with low staffing levels are very stressful and makes you go home worried sick that you may have missed something at triage etc. Happens a lot.

Varies but when adequate staffing is achieved service works well, poor staffing levels cause stress anxiety, demoralising and then things get missed and problems arise. We need better money and better staffing levels, but unless we appreciate our nurses we will continue in this downward spiral of care.

I work as an Advance Nurse Practitioner in general practice and GP Out of Hours (OOH). I cover OOH in place of GPs and get requests daily asking to provide cover. I am employed full time in practice 25% of my hours increased capacity not permanent unsure when finances will be confirmed to continue full time even though practice under pressure with one GP for 2,600 patients over two sites.

Short of telephony nurses, constant serious and urgent calls relentless, pressure on call back to patients deemed less acute.

Weekend shifts very short. Queues of very ill, vulnerable patients waiting up to six hours to be called back to arrange assistance , advice and care. I report this weekly, never get feedback on my concerns and nothing gets done. In fact it gets worse! I am ashamed and feel we are not providing a safe service.

Manager in the centre assisted with hands on care.

Poor staffing levels. Expectation to do more with less and made to feel that you are the problem if you.

Due to the unknown number of patients that may present to ED on any given day our staffing levels can be perceived either as good or bad. On busy shifts I feel we often feel overwhelmed by patient to staff ratios if numbers and acuity is high, I frequently feel I give substandard care due to pressures of staffing levels however on a shift like today I had enough staff to maintain standards and give excellent care to all my patients.

Working in a small rural A&E the staffing is a bare minimum. With two staff on a day shift one on nights when there is an emergency or the department gets busy, staff have to leave the ward to assist us. But they only have two qualified and two HCA on day shift, this leaves their ward area short staffed. The reverse is true if the ward has a cardiac arrest, A&E staff attend, leaving our department short staffed. There are no hospital Doctors. Medical cover is by GP who

may or may not be in the building so staff feel very vulnerable during these times.

Not enough staff qualified and unqualified taking calls. Queues not being managed appropriately. Inappropriate calls being queued.

Nurses being used as call handlers. Patients waiting too long for call backs.

Calls that should have been waiting a maximum of 2hrs were waiting over 4hrs. Nurses doing the work of call handlers and not nurses, while calls are waiting more than double the safe call back time.

They are expanding a service and doubling the work load but nowhere near enough staff to deal with the volume of calls coming in. Patient care is being compromised daily.

Too much emphasis on triage and not the patients we physically see.

I work for a mental health crisis team, our staffing levels have been denuded over the years from five or six staff per shift to often three or even less. We are regularly breaching assessments (clients not seen within four hours) and failing to fulfil our commitments to other services – e.g. police and paramedics.

I feel that within my team we are adequately staffed as long as we have no sickness, which is not realistic. Also annual leave, study leave is not catered for and then remaining staff have to regularly cover extra clinics and the hospital wards which is exhausting and impossible to safely manage in-depth specialist patient management.

Normally there is only one trained member of staff on duty in my department. If I need advice I have to phone the A&E department. This is not ideal. When we are really busy it is really hard to provide a safe service. It could be that I have several seriously injured patients turn up at the same time and somehow I just have to manage.

5 Prison and police custody

Not enough patients are able to be assessed with mental health issues.

Only have one member of staff on the shift. Had there been any emergencies including arterial self-harms, overdoses and other serious

incidences, I would have had to attend and manage them on my own, and left the rest of the prison without any health care. Had there have been two incidences there would have been a death in custody.

My last NHS shift was atrocious, I was left to care for 18 people pre- and post-op traumas. I was unsupported and despite raising issues and concerns, nothing happened. I was given little to no training and felt undervalued and under paid. This was not an unusual shift this was every day. I left the NHS 10 months ago and now work for a private company and have the complete opposite experiences. Well staffed well supported and well trained.

The level of my documentation was poor due to time constraints and poor staffing which leaves me anxious working in a highly litigious environment.

People leaving the job and whilst working deliberately avoiding jobs and patient contact situations.

Being made to choose between how best to use staff when you have more things that have to be done there and then due to prison regime than you have staff for - emergency call, new receptions and medications with two nurses only on duty.

Unable to thoroughly attend to emergency calls, to carry out reviews after emergency calls, the emergency response nurse had 12 emergency calls over 10 hours as well as medicating a wing of 360 men, and a diary containing dressings, observations and jobs picked up on the day, working alongside pharmacy technicians who can do no patient care we also take on their wings, and diary jobs and patient care.

I have been left in charge of the unit with just a support worker to 19 patients two discharges and two new admissions. Commence duty at 13:00 hrs and did not stop or sit down till 19:10 hrs and then write up all notes awaiting for night staff therefore no breaks and no time to eat until leaving at 20:45hrs-21:00hrs.

Constantly short staffing levels lead to lack of care to patients, also staff feel very demoralised no motivation when we get no support from management. It's the nurses who work short staffed not the management.

Poor levels of staffing leads to long delays in people accessing health care. With some waiting over seven hours for an assessment.

Nervous that an emergency will occur and not enough staff to cope with this and everyday duties.

Not enough nurses using health care assistants in the numbers too. Much pressure and workload leaves me emotionally drained.

Burnt out and managers are burnt out.

I like to work hard and I don't mind doing it for very little money. I have gone from a high salary in the private sector to come back to the NHS for approx. £20,000 less per year. Again this was my choice but I do not expect to complete the work for two people due to insufficient staffing levels for such poor money. Sometimes I am working 60-70 hr weeks for little in fact zero appreciation from senior management which leaves moral at an all-time low.

Low staffing levels cause anxiety to staff as there is not enough time to complete one task before having to move onto something else.

You're constantly "firefighting" and don't have enough time to triage patients. Sometimes prisoners just want to have a chat, but while the weekend should be quiet to allow this, often it isn't. We often have to double up our work areas if there aren't enough staff. We don't get to take coffee breaks and are often late getting to lunch and leaving work.

Regardless of numbers and reporting issues Trust staffing levels remain poor and Agency get paid much more than everyone else who are Band 5. Very bad morale.

Staff sickness means we have to cover more stations and patients often have a delay in their care.

We are very short staffed at this time, but have bank staff recruited to help, unfortunately these staff members are not sufficiently trained. New members of staff get five weeks to learn the job where's bank staff get two days. This can lead to major problems on a shift, and bank staff not returning due to the stress levels they are put under.

We are taken off our roles to do the work of general nurses constantly, despite the prison being full of drugs and mental health issues.

We are not supported and although specialized, we are paid as band 5.

I have worked in the prison setting for a number of years and find changes implemented by NHS are causing many difficulties. The most frustrating and upsetting for me being the lack of support and training provided to new staff coming into the setting. NHS provide little insight for new staff into the population in prison and their behaviours. New staff are frequently put under pressure by time constraints of prison regimes and make frequent drug errors and are distracted by behaviour of the patient group.

Fear that an emergency situation would occur when not enough staff on shift to provide the basic cover, for basic duties.

Registered nurses are carrying out duties more suited to HCA and administration staff. We cannot always complete our own tasks due to this and patient care is then compromised.

At times it feels there is not enough hours in the day. Time constraints within a prison setting can restrict service provision.

It affects my concentration as stress levels are high due to trying to cover others work duties which effects quality of my patients care.

All staff are expected to step up and fill void by working bank shifts. As a band 6 nurse I refuse as I will not work bank as band 5 money. It is hard to recruit and retain staff in prison health care however this is cultural and down to poor management issues. As a nurse my hands are tied due to attitudes of other nurses and managers. Not good working environment. Sick rate is through roof. Do not have anything positive to say about prison health care. Plan to leave as soon as I can get another post.

Our service is very supportive of each other out lead nurse is approachable and I feel listened to. We provide an excellent level of care and clinically support each other in all aspects of our job.

As nurse in charge, when someone is off sick – I have to cover their clinical work AND do my Senior Charge Nurse work also. This means changing my shifts many times per week and I am becoming behind in my administration work for the service and tired that I am at work or on call at least five days per week.

Every day, we prison nurses struggle, and I mean struggle, to cope with the lack of staff and clear direction. We also continually deal with above normal aggression and at a level of pay that is a disgrace for the work we do. Hence why we continually lose staff.

I don't have days off as I am always trying to backfill shifts. If we work over our time it's considered tough luck and we are told to remember that sometimes we have quiet shifts! Lunch breaks are not an option. We have been told to eat a sandwich in the car.

Poor management seems to be mostly responsible for poor staffing and skills mix. Some managers unwilling to work the floor to support.

6 Other services

You always have to be on your toes because you need to check hourly on your patients. You have to do the extras by serving teas and coffees and to keep the kitchen neat and tidy. To help patients in and off from bed to toilet/commode etc. End up with up to 10 patients to one nurse. The main thing is always the risks you're taking. Wish these can be on paper, written in black and white to state the limit, as a standing rule how many patients per nurse. To have on all shifts a health care nurse to help with answering buzzers, to serve tea and hot drinks etc, so that the nurse mostly can concentrate on medicine and patient care...10pm medication to be given promptly and not at 11pm or sometimes still just before midnight.

High sickness rates, on call cancelled regularly, regularly work in excess of 20 hours including call out. Management cherry pick unworkable solutions, age profile not consideration. >60% of work force could walk out now with semi-retired staff, skill mix appalling, no incentives to stay working many staff looking for alternative jobs!

Correct staffing levels allow us to provide appropriate and unrushed care to patients and allow time to support relatives/carers. Staffing at present in the NHS does not allow this and makes us work to targets, budget and doing the work of at least three members of staff on daily basis due to shortage and very poor skill mix. The patient is no longer the centre of care. It is becoming more of a production line which makes me very sad after 42 years in nursing. I loved my job but do not feel I could highly recommend it to the younger generation, sadly.

Not listened to despite raising concerns, promised I could have an assistant a year ago and I am still waiting while working alone (education).

The management are aware of concerns. They are unable to meet current government targets and are unable to recruit. Targets are connected to money — the drive is to meet targets to the detriment of clients.

*Difficult to determine staffing levels, software not always making things plain. I know I'm the only nurse *here* tonight — in fact the only person, but I'm not sure how many others there are across the service. I do know I get lots of text messages asking me to work extra hours. Not unique to us I know, but a good picture. I know some days are a lot busier than others, again, not unique.*

Working overtime on regular basis demoralises the team and difficult to set up expectations. However, customer care has not been compromised.

We are unable to take new patients onto our service because of staffing, but not nursing. Early supported discharge service for stroke patients. Cannot take on new patients because of few physios and OT.

The team wrote a letter of concern to managers and it has not been acted on. Staff morale is low with people leaving or looking to leave the service.

Despite being busy and rushing around we were able to get things done and I would not have had time to spend caring for my patients if we were not fully staffed.

Had to work extra hr to complete paper work as I felt that my patient was more important. Breaks are something you rarely get.

I go home and worry that I have missed or not provided the care that is expected of me. I feel my manager is not listening to the staff and soon staff will start to leave as they are totally unhappy.

When there is not the amount of staff that are needed to complete care then patients have to have their appointments cancelled and rearranged and this is poor service for them. It means that there is a build-up of people to see so that when staff are available they are rushing around and although they all try to give the best care possible it means they are worn out and feel frustrated.

Work in very small specialised team. Have to ensure only one member of staff on A/L at any one time. No cover for sickness except for current staff. May have to cover even if on annual leave (and have previously done so) in which case had to cancel annual leave and move it to another time. Also minimal resources may it very difficult to do job effectively, also workspace not an ideal environment to do workload efficiently.

We are a dementia assessment unit and my role is a life skills recovery worker but all I do all day is cope from one hour to next without an incident happening, as there are not enough staff to cope with the demands of our unit. The bank and agency are not interested in patients, some are so tired as they work day after day without giving there all. I love my job and get deflated when all around me are just there for the pay packet. The set out of the building also means the staff that are there are not worked big together as one team.

Delay discharge of patients. Lack of effective mental health follow up because of poor staffing levels. We positively manage referrals so are as effective as possible. We have good effective relationships with our general hospital colleagues. We have some consultant psychiatric cover and this makes the team feel more supported and effective. Previously I have worked without medical cover and minimal management support in another liaison situation and frequently flag up the risks which nobody appeared able to resolve.

Lack of time to support frontline staff on the ground at times. Delayed response to urgent requests. Frontline staff not getting timely support with complex patients requiring complex clinical skills or specialist deteriorating patient input.

Poor skill mix, band 6s having to complete more assessments more frequently with less time, under unrealistic and punitive targets.

I am in an outpatient service which despite dire lack of funding relative to demand provides an excellent service with limited resources. The service is managed well to ensure staff leave is planned and there is low sickness rates overall. There is never enough time to do everything needed and I very often work at home in evenings and weekends on paper work that can be done safely on my NHS remote device. There is an expectation to be have patients booked

into clinic continually and if your diary is not full you are therefore not busy enough hence there is no protected admin time to ensure your paperwork completed in a timely manner. Everything feels rushed. However patients in sessions are completely unaware of this and will always receive thoughtful, sensitive care from my service. We just wish we had the resources to be able to actually deliver this care to more patients who need it.

There has been a cut in staffing levels from total of six to five. This began in Feb/March 2017. I was told that the Nurse in Charge would need to be working with patients and assist where necessary. This is doable. On my shift, I was the Nurse in Charge and we had a confused patient who required 1:1 enhanced supervision. I ensured that all four staff had their full breaks in a timely fashion. I supervised the 1:1 enhanced patient during breaks, and assisted other patients' during breaks as well as completed audits and opened the front door to allow relatives in. There were continuous stream of relatives coming and going, however, I sat in the Multidisciplinary Team room at 1500 to 1530 and had my lunch with door open so that I could let relatives in and out. So although I did not miss a break, I did not complete my break undisturbed. In principle, we need to be three on the floor, and we were two nurses and one nursing assistant always. I overlapped the lunch breaks. I was exhausted at the end of the shift as I was unwell and this came to light this week. I am positive as a person.

Waiting times for Community Mental teams and psychological services are very long, sometimes over a year and teams are quick to discharge if there is a 'Did Not Attend' or difficulty in engaging. That with people whose insight may be at best limited.

Working within the Crisis Team for Mental Health services, day to day changes, so you can start a 12.5hr shift one day fully staffed and the level of demand can decreased or short staffed and high demands from services or service users.

I work for a trust that does not employ agency staff. During this survey, I answered based on my last night of four night shifts. Generally, in the hospital I work there are periods (especially day shifts) where staffing levels are not satisfactory and patient care is compromised, also putting

staff wellbeing at risk. Unfortunately, it is recognised that money is a factor of play... the type of service I work in there used to be an additional 'forensic' pay which was stopped and in turn must influence amount of bank pay/ regular staff pay and staff recruitment.

Difficult to give full picture of the shifts. But example, I put in time owing of 113.5 hours OVER TIME without pay in three months. Serious understaffing in past shifts leaving the service and the patient care compromised.

Service was unable to respond to some callers and next shift had to spend first few hours calling patients back responding to voicemails.

Paperwork/documentation excessive. Unable to have rest breaks and use facilities. Lack of support and recognition of workload from senior staff and lack of support.

On this shift staffing levels were good and the shift went well, we also had two new students which impacted on staff time. Some days this is not the case we use agency staff who are less motivated and we end up doing the minimum necessary as there isn't time to do anything else.

Basic care given. Social supports cancelled.

Increased waiting times for clients waiting to be seen (pre-booked appointments) because involved in managerial issues during clinic due to lack of manpower. Multi-tasking not appropriate. Easy to make errors in paperwork. Rushed appointments.

Unable to complete duties required, tired and frustrated both with myself and others! Too much watching to see what others doing — difficult to manage staff sometimes.

People are being brought into a service and seen to stop clock! However, this creates internal waiting lists, parents are waiting over a year for any diagnosis. A ridiculous time to wait. Other staff are working later in the evenings for ADHD clinics so as to get people seen! Interventions have been ceased and it's about signposting to other agencies e.g. which are mostly voluntary and hearing now that an agency such as action for children are unable to accept any new referrals at this time! Crisis after crisis!

I have worked five out of six days at 12hr shifts and have two more to go. I am nearing burnout. We are grossly understaffed which will impact on the quality of patient care, paperwork is going undone to give enough time to patients.

Work-life balance and relationships are being affected in a negative way. Patients often see how demoralised and exhausted we are despite putting on a brave face.

I should have been on night duty but eight hours before commencing duty I was changed to day duty due to staff shortage. Changing your shifts last minute is now becoming a regular thing. This does not help with tiredness and is not compatible with a family life.

Management do not acknowledge that staffing is a problem.

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