Staffing for Safe and Effective Care:
RCN Member Campaigning in the UK
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1. Foreword

Patient care is too important to be subject to the changing whims of politicians. In setting spending levels and priorities, governments need to move away from short-termism towards robust, evidence-based workforce planning as a core component of service design. We are clear that this must apply across all publicly-funded care settings, no matter the provider.

The RCN isn’t going to wait any longer for governments to act. We are already rallying the public in our calls for governments across the UK to be explicitly and legally held to account for growing and developing the nursing workforce. The aim of this is simply so that the health and care needs of patients and the public are always met, wherever they are in the UK.

This isn’t just about nurses and patients: the World Bank is clear that investing in the health and care workforce protects the wider public health and supports economic growth. They are clear that spending on the nursing workforce should not be seen as a cost, but a basic investment that is guaranteed to reap dividends.

I know from experience the effect that understaffing has on the health and performance of nursing professionals, local services and the health and care system more widely. Our members now tell me that more than ever, the chronic shortage of nursing staff and the attendant pressure on morale is causing experienced nurses to leave our profession, with all that entails for patient safety. For all these reasons, I’ve made our safe staffing campaign the central tenet of my leadership of the College.

Governments across the UK rightly say that as we move into the future, care must be better integrated and delivered closer to home. As the largest and most flexible part of the health and care workforce, nurses are very well placed to understand just how patients and their families want and need to be treated and supported. But our profession won’t be able to deliver the required changes without a boost in the numbers of new recruits, and solid policies to support, educate and retain the existing workforce.

I want to warmly thank our members and supporters for backing the RCN’s campaigning on this priority issue. This publication is a record of the action we have taken already, and statement of intent for leading further campaigning, as we seek to overturn decades of neglect and move towards a brighter vision for nursing across all four countries of the United Kingdom.

Dame Donna Kinnair
Chief Executive & General Secretary
2. Executive Summary

It is time for governments and system leaders across the UK to be held fully to account on the workforce shortages across health and care settings.

The RCN in Wales successfully campaigned to secure nurse staffing legislation in 2016. The campaign is now focused on the effective implementation of this legislation and its expansion to protect patient care in all settings.

The RCN in Scotland campaign was instrumental in shaping legislation passed in May 2019 which enshrines staffing for safe and effective care in law in health and social care services. The campaign will now influence the development of guidance and secondary legislation before implementation begins.

Neither England nor Northern Ireland has legislative plans underway. RCN members in England are now mobilising to call for a legal framework to be introduced as part of the update of the health and care legislation. Northern Ireland is unable to make progress on this area due to the continued absence of government.

The RCN is actively campaigning for nursing workforce accountability to be clarified in law in every country within the UK.

In recent years, we have heard from our members on the frontline that staffing levels across the UK are compromising patient safety.

Almost a third of all nurses cited ‘too much pressure’ in their top three reasons for leaving the Nursing and Midwifery Council’s register, and 1 in 5 cited ‘staffing levels’. It is not acceptable for nursing staff to be held to account for system issues outside their control, including the extent to which government invest in growth and development of domestic nursing staff.

More than a third of registered UK nurses are due to retire in the next 10 to 15 years, and the pipeline of new nurses coming through the higher education route in the UK is not sufficient to generate the growth needed.

The workforce the UK had come to depend on from within the European EA dropped off almost entirely immediately after the EU Referendum in 2016. We are now seeing a surge in non-EEA international recruits, suggesting an over-reliance which will not be sustainable for services in the UK.

The World Health Organisation, along with the World Bank and the Organisation for Economic Co-operation and Development (OECD), have said clearly: The first step in building a high-quality workforce with the right skills mix should be a comprehensive national workforce strategy addressing gaps in numbers, distribution and retention, both in the short term and the longer term. Health professional workforce strategies must not deprive other health systems by attracting qualified staff away from their home countries’ health systems.1
3. Introduction

The RCN is campaigning for laws ensuring safe and effective staffing in England, Scotland and Northern Ireland, following a resolution passed by our members at RCN Congress 2016 after the successful introduction of the Nurse Staffing Levels (Wales) Act 2016. Campaigning by the RCN in Scotland has significantly shaped and influenced the Health and Care (Staffing) (Scotland) Bill which passed into law in May 2019.

Staffing decisions continue to be based on finances and workforce availability, not safe and effective models of care and coherent workforce planning. We believe legislation can make a difference and help to deliver staffing for safe and effective care. This approach must tackle systemic problems and be implemented with sufficient funding.

In 2018, the RCN published a call for legal accountability for nurse staffing for safe and effective care in each country in the UK. Our methods for campaigning to secure this are different in each UK country, as they vary in current context and progress. However, five common principles, developed through member engagement, guide our approach, setting out what we want a legal framework to deliver in each country.2

- **Accountability** - We want it to be clear whose job it is to make sure there are enough nurses to meet patients’ needs.
- **Numbers** - We want the right number of nurses, with the right skills, to be in the right place, at the right time - so patients’ needs are met.
- **Strategy** - We want a vision for tackling nurse shortages and making sure nursing helps meet the whole country’s health needs.
- **Plans** - We want clear plans for getting the right numbers and skill mix of nursing staff and we want checks to make sure they really happen.
- **Education** - We want governments to educate enough nursing students, and develop existing staff, to meet patients’ needs.

Our campaigns ask for clear laws that ensure the right number of nurses with the right skills to provide safe and effective care, in all publicly funded health and care settings – regardless of provider.

We also want governments across the UK to have a clear workforce strategy that tackles nursing shortages and ensures a sufficient number of future nurses are being educated so that health and care services can meet the needs of each country’s population, and the UK as a whole.

We are clear that at every level of decision-making about the health and social care workforce, from Government level to local provider, any determination about nurse staffing must be informed by: legislation; Nursing and Midwifery Council (NMC) 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. These decisions should be considered individually in relation to the workforce, and then embedded into broader decision-making on service planning at national, regional and local levels.

In a 2017 survey, 55% of RCN members said one or more registered nurses were missing on their last shift. 53% said they were upset that they couldn’t provide the level of care they wanted to.3

We know that nurses are passionate about their work and dedicated to providing the best possible care. In our latest employment survey of over 8,000 nurses across the UK4, nearly ¾ (73%) believed nursing is a rewarding career, and over a third (35%) would not want to work outside of nursing. Despite this, nearly 30% would not recommend it as a career.

There are currently tens of thousands of vacant nursing posts across the UK, and this is set to increase. Staff are having to plug these gaps by working longer hours, missing breaks and leaving care undone. In the same survey, 38% of respondents told us they work in excess of their contracted hours several times a week.
and 17% work over their contracted hours every shift. Although some nurses choose to pick up additional paid shifts above their contracted hours or can accrue TOIL, 53% said the additional hours they worked were unpaid. Furthermore, 48% of people who said they were looking for another job want to leave because of staffing levels.

Those on the frontline know only too well the impact of the vacant posts but now the public is also becoming aware that services are struggling to staff their services adequately. Three out of four people in the UK think there aren’t enough nurses to care safely for patients in the NHS, according to an RCN survey of public opinion.5
4. The UK Nursing Workforce

There is no comparable data across the UK countries providing workforce numbers across the full range of health and care settings, or for nursing vacancy rates. We have therefore taken the few UK-wide workforce data sets available to understand the current picture for the workforce across the whole of the UK. These are the nursing register data from the NMC, and the statutory data from the higher education system providing information about applications and acceptances onto nursing courses across the UK.

There are 6,384 more nurses/dual registrants in the UK compared to last year which is a growth of less than 1%. However, we know that there is a shortage of approximately 40,000 nurses in the NHS in England alone. Analysis of the NMC data shows that only 1,491 more nurses, midwives and nursing associates joined the nursing and midwifery register than left it this year.

This follows two years where there were many more nurses leaving than joining – nearly 6,500 in both 2016/17 and 2017/2018. The NMC surveys people leaving the register and this year, 19% gave staffing levels as one of their top three reasons for leaving the profession. This can be broken down further to show where leavers and joiners from the register initially registered – the UK, EEA and outside the EEA.

There are more nurses, midwives and nursing associates from the UK leaving the register than joining it, although the gap is beginning to narrow. 54% of those leaving who had trained in the UK gave retirement as one of their top three reasons for leaving the register. More than a third of registered nurses are aged over 50 years, so it is likely we will see a large number of nurses retiring in the next 10 to 15 years.

The current UK pipeline of students is not enough to replace these nurses as they retire. Although the number of acceptances onto nursing degree courses in the UK has increased by 7% between 2010 and 2018, this has only amounted to an additional 1,985 students over this period.

There has also been a 13% drop in the total number of nurses and midwives on the register from the EEA over the past two years. Following the EU referendum, the previous trend of there being an increasing number of individuals joining from the EEA began to fall and the numbers of leavers increased. Last year only 968 nurses and midwives joined the register from the EEA compared to 3,333 leaving it. With continued uncertainty over Brexit, it is unlikely that we will see a significant reverse in current downward trends.

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1 Much of the NMC data groups together midwives, nurses and from 2019, 489 nursing associates. The total number of people on the register at 31/03/19 is 698,237. The number of registered nurses/dual registrants comprise 94.64% of the register. The number of nurses/dual registrants is 660,832.
There has been a 126% increase in the number of nurses and midwives from outside of the EU registering to work in the UK for the first time, rising from 2,720 in 2017/18 to 6,157 in 2018/19. The RCN values the contributions of nursing colleagues from around the world. However, it is not sustainable to rely disproportionately on an international workforce to address the current and future nursing workforce shortage. This not only applies to what is sustainable for services across the UK, but also for those countries around the world from which the UK is attracting nurses.

We must consider this data in the context of already high vacancy rates across the UK, as well as the growing demand on health and care services due to an ageing population, and more complex needs. It is clear that governments will need to take radical action to address the UK wide shortage. This must be done by growing a sustainable, domestic UK workforce to meet the assessed needs of each country’s populations. UK countries should not rely too heavily on attracting high numbers of international nursing staff, since there is no guarantee that they will come. This approach is unsustainable going into the future, in part due to the growing global shortage of nurses.
5. The Current Evidence Base: Impact of Staffing Levels on Safe and Effective Patient Care

The nursing workforce is usually the largest in any health care system and they have great potential to avoid or reduce adverse patient outcomes such as mortality and morbidity (prevalence of health condition), and also to contribute to the wider productivity of an overall health system. Nursing provides high risk clinical care, 24/7, without waiting lists to manage.

A growing evidence base shows the impact of registered nurse staffing levels on the quality of patient care and outcomes. Most research is conducted in acute inpatient hospital settings. The majority of studies have taken place in the USA, though some from the UK (mostly England), Canada and other countries across the world. It is important for the UK to learn from countries where the research findings can be transferable.

We have been monitoring some of the recent studies examining the impact of staffing levels. The National Institute for Health Research (NIHR) has also recently reviewed the range of evidence about staffing acute wards. In addition, the first outputs from the RCN’s Strategic Research Alliance with the University of Sheffield provide a scoping review of the wider research on the impact of staffing levels on patient care, and a systematic review of research pertaining particularly to primary and community settings (including care homes). The latter warranted a particular focus for a systematic review since the wider scoping review found a focus on acute settings in much of the research.

Overall, the evidence shows us that the patient outcomes most significantly affected by registered nurse staffing numbers are mortality, care quality, missed care and adverse events (for example, infection, pressure ulcers, medication errors). There is also evidence within study findings of a positive association between an appropriately planned nursing skills mix and patient safety outcomes.

The RCN recognises and values the contribution of health practitioners, and our view is that this evidence highlights the importance of understanding the skill mix requirements to deliver a service, within a nursing team.

**Acute settings**

Research suggests a correlation between nursing workforce staffing levels and clinical patient outcomes. A study on staffing for safe and effective care in an acute NHS Trust in England found 40 correlations between safety factors, physiological data and staffing factors. For example, wards with a higher ratio of registered nurses to health care support workers (HCSW) had lower rates of slips, trips and falls (STF). Whereas wards with a higher number of HCSW had a higher rate of STF.

The NIHR is centred on England, working closely with the devolved administrations in Scotland, Wales and Northern Ireland which co-fund many of their programmes.
A further study found that nurse to patient ratios and registered nurse burnout (a key component of which is emotional exhaustion that can lead to emotional and cognitive detachment from work) were associated with urinary tract and surgical site infections in patients. Further, when registered nurse burnout was reduced, there were fewer infections.

The NIHR recently conducted a themed review focused on staffing on inpatient wards. This suggested a relationship between the number of registered nurses in hospital wards and patient safety.

A number of studies have demonstrated a link between low staffing levels and poor patient outcomes, such as for each day that registered nurse staffing fell below the ward average, the relative risk of a patient dying increased by 3%.

Research across nine countries (including England) reported that an increase in a registered nurse workload by one patient increased the likelihood of an inpatient (undergoing common general surgery) dying within 30 days of admission by 7%. Further, every 10% increase in the number of degree-educated nurses was associated with a 7% decrease in the likelihood of patient death.

The NIHR review also identified a lack of clarity around role boundaries (between registered nurses and nursing support staff) as an issue that needs consideration in determining staff requirements.

Research across six European countries identified that increasing concentration of registered nurses among the nursing skill mix was associated with lower chances of mortality, lower probability of poor hospital ratings from patients and fewer reports of poor quality and safety. The study concluded that dilution of the nursing skill mix might contribute to preventable deaths, reducing quality and safety of hospital care.
In the UK, research found that increased numbers of ward-based registered nurse staff was significantly associated with reduced mortality rates for patients in hospitals. Higher mortality links to more occupied beds per registered nurse/doctor, and trusts with an average of six or less patients per registered nurse had a 20% lower mortality rate than those with more than ten patients per nurse.  

Numerous studies advocate modelling staffing levels to assess the impact on nursing workload and quality of care. One such study modelled different the effects of differing nurse-patient ratios on care quality and nurse workload. The model demonstrated that as the ratio increases; care-quality deteriorated (for example both missed care and number of tasks increased by 120% when the ratio increased from medium to high).  

Research into staffing levels and patient-reported care found that a greater percentage of registered nurses in the staffing mix resulted in patient reports of more rapid responses to their needs (and fewer delays to their care).  

Alongside sufficient numbers, the evidence highlights the necessity of a positive working environment. Recent studies show that this has positive effects on both patient experience and staff wellbeing. Patient experience is generally better and more positive when staff felt part of a good team with support from colleagues, were satisfied with their jobs, experienced a positive organisational climate and had low emotional exhaustion.  

Research of medical-surgical units in US hospitals found that patients being cared for in hospitals with better work environments for registered nurses (for example, having greater autonomy and control over their resources and practice, having excellent working relationships with colleagues), were 16% more likely to survive after an in-hospital cardiac arrest (IHCA) than those cared for in hospitals with poor work environments. Further, each additional patient per nurse was associated with a 5% lower likelihood of surviving IHCA to discharge.  

A study across hospitals in 12 European countries examined links between shift length and overtime with care quality, safety and care left undone. They found that nurses working shifts of 12 or more hours (and those working overtime) were more likely to report poor or failing patient safety, poor/fair quality of care and increased care activities left undone. The report highlights that having staff work overtime to fill staffing shortages risks care quality.  

The most commonly missed nursing care activities in US acute care hospitals were talking to and comforting patients, developing/updating care plans and educating patients and their families.
A Canadian study found that building a personal connection between patient and staff was a precursor to ensure patient involvement in care and safety, however the potential for this connection reduced when nursing staff were under stress or had a high workload. The study reasoned that high workloads and stress for nursing staff does not provide a basis for building relationships, thus making patients less involved in their care and safety.27

Primary care and community settings

Whilst the quality of the existing evidence in these care settings is robust, the breadth is limited. One study looked at district nursing teams in Scotland and found that direct involvement of registered nurses in patient visits enhanced patient safety.28 Following their scoping review, a systematic review examined evidence specifically on missed care in primary and community care settings (including nursing homes).29 The evidence identified does indicate that missed care has an impact on patient safety in primary and community care settings – and that this impact may differ from that in acute care.

The most common type of missed care identified in the systematic review related to optimizing health outcomes, ongoing health monitoring and relational care, with evidence suggesting that these were caused by patient acuity, complexity of cases, volume of work and organizational factors. There were also findings that suggest that particular groups (older people, people with complex conditions, and people with mental health challenges) experience the most severe impacts from missed care (such as care follow up activity, availability of resources).

Some of the causes of missed care may be unique to primary and community care settings, for example caseload complexity. The review highlighted the less well-evidenced issues including relationships between nursing staff (appropriate skills, staffing levels) and patient safety in primary and community care settings. The review also found particular gaps in the evidence in primary care settings, and that theoretical models have not been developed or tailored to primary and community care settings in empirical studies.

Overall, missed care is underexplored in primary and community care settings and existing empirical studies have focused on a few specific initiatives. More research (both quantitative and qualitative) is required to conceptualise and evaluate missed care and more specifically, the impact of numbers of registered nurses on patient safety outcomes in primary and community care settings.

Conclusions

These experiences of missed care directly mirror the experiences our members described in our 2018 report, Nursing on the Brink.30

The concept of patient safety has broadened in the evidence base from a definition of error and neglect, to that of missed care and care left undone. However, there is a lack of evidence using intervention studies in relation to skill mix interventions and safety being the principal outcome.31 This is an important finding for the research community to note. We have a growing understanding of the impact of nursing staff shortages, but little evidence on how this can most effectively be managed.

Whilst the evidence base in acute care settings provides a clear indication of the impact of
registered nurse staffing on patient outcomes and experience of care. Most of this research is from the US, and that from the UK is mostly from English acute care settings. Further research is needed both in community and primary care settings, and from other countries in the UK.

Whilst the relationships between staffing and patient outcomes could be non-linear, mathematical models for acute staffing could be built from routinely collected data. The Qureshi research demonstrated the capability of computerised modelling to understand, quantify and predict the impact of changing nurse to patient ratios on nurse workload and care-quality, and provides a more cost-effective and safe alternative to trial and error methodologies.

There is a lack of research on the impact of nursing-led interventions specifically on patient outcomes. However, one study focused on registered nurses on an inpatient surgical unit who assessed patient risk and used this as a guide for staffing decisions and nurse-patient assignments. They found that this example of nurse-led practice led to a decrease in adverse events for patient safety indicators including falls, catheter-acquired urinary tract infections and pressure ulcer prevalence. Additionally, this delivery model reduced both overtime and patient cost.

The RCN’s Strategic Alliance with the University of Sheffield provides an opportunity to build on some of the evidence gaps, including strengthening our understanding of the particular role of nurse led care in improving patient safety and outcomes. We also call on the wider research community to consider some of the challenges set out by the current evidence – particularly in relation to understanding interventions which can be used by senior nurses now.
6. The RCN Campaigns: Update

Wales:

After campaigning for almost 10 years, members in Wales helped secure the first law in Europe for safe and effective nurse staffing in 2016. The Nurse Staffing Levels (Wales) Act 2016 means that health boards and trusts have a legal duty with regard to ensuring appropriate levels of nurse staffing to enable nurses to care sensitively for patients in all settings.

Furthermore in adult acute medical and surgical care settings, the nurse staffing level must be calculated and maintained using an evidence based methodology. The Act, the statutory guidance and the operational guidance sets out how decisions should be made, taking into account professional judgement, workforce planning tools and the needs of the patients. Providers are required to report on this. The RCN is working with the Welsh Government to make sure the law is implemented, and to extend it to ensure the duties of Part Two (the statutory methodology) can be applied to more areas including children’s nursing, mental health, community and care homes.

In 2018, the Welsh Government produced a future vision for the health and care system. In this, the Government commits to a ‘quadruple aim’ comprising: improved population health and wellbeing; better quality and more accessible health and social care services; higher value health and social care; and a motivated and sustainable health and social care workforce. This vision also made the commitment to develop a new health and care workforce strategy, in partnership with the NHS, local authorities as well as the independent and voluntary sectors.

The RCN in Wales campaign will continue to robustly scrutinise the effectiveness of education commissioning and of the new body responsible for its implementation, Health Education and Improvement Wales. The RCN will monitor the implementation of the Act and constructively offer challenge and support to the NHS and Welsh Government on progress. There will be a focus on supporting members to participate in the campaign, including scrutinising health and social care workforce planning in the context of the Act being implemented and extended.

Recent key activity from RCN Wales includes the successful call for a National Assembly for Wales Committee Inquiry into Community Nursing, in which the RCN presented strong evidence on the need to extend the Act. RCN Wales also held a successful event in the National Assembly with RCN members working in care homes, drawing attention to staffing issues in this sector preparatory to calls for extension to the Act. This also made the argument for extending duties to the mental health setting through participation in the NHS Wales nurse staffing programme symposium on this topic.

The early experience of the legislation in Wales has demonstrated change is possible when the law requires that evidence be used to set staffing levels.
Scotland:

At the RCN Congress in Glasgow 2016, Scotland’s First Minister Nicola Sturgeon MSP, announced her plan to introduce safe staffing legislation in Scotland. Since then, the RCN in Scotland has worked hard to influence the shape of legislation, both in its original drafting and by seeking extensive amendments as it passed through the Scottish Parliament. Working with members, with the public, with partner organisations, government officials and politicians from all parties, we lobbied to get the legislation to ensure staffing levels that provide safe, high quality health and care services for the people of Scotland.

Through our #askformore campaign, the RCN successfully lobbied for:

**Positive Outcomes** for people and staff at the heart of decision making.

**A strong professional voice** ensuring nursing leaders, whether at ward, team or governance level are able to exercise their professional judgement in staffing decisions.

**Informed decision making** where all staffing decisions are based on robust, up-to-date data and evidence.

**Responsibility, accountability, real-time action and long-term planning** with processes for risk management and reporting.

**Scrutiny and sanction** with duties to report compliance in the NHS and care homes, right up to the Scottish Parliament.
The staff to care for people across Scotland with duties on the Scottish Government to do everything they can to ensure the supply of nurses and the time and resources for clinical professional development for nursing staff.

On 2 May 2019 the Scottish Parliament passed the Health and Care (Staffing) (Scotland) Bill. This ground-breaking law is the first legislation of this kind in the UK to apply to both health and social care services and it now reflects the vast majority of the RCN’s key asks.

Members support for the #askformore campaign played a key part in the RCN’s ability to influence the legislation. Over 5,000 members and members of the public signed up to the campaign and more than 3,300 emails were sent to MSPs ahead of the final parliamentary debate.

The Act is only a starting point. Legislation alone won’t address the nursing staff challenges that Scotland’s NHS and care sector are facing.

A lot of work is still needed to develop guidance and secondary legislation before implementation begins. There is also significant work underway to review existing nursing workforce and workload methodologies and develop new NHS and care home methodologies to set establishments. And the RCN is also working with Scotland’s Chief Nursing Officer and others to shape Scotland’s care assurance framework, which will sit alongside this legislation.

None of this will be a quick process and while this work is taking place, the RCN will be supporting members to look at the existing safety culture, continuing to engage with members to shape the next steps, and preparing nursing staff for implementation of the legislation in workplaces across the country.

England:

In England, there is currently no clear mechanism to hold Government and the range of national, regional and local bodies to account for nursing workforce supply or planning. We have called for Government to spend at least £1bn per year on nursing higher education in England, but there is no recourse to hold Government accountable for taking action. We have been actively lobbying on these asks of Government and the health and care system in England for two years, strengthening the case for change and gaining recognition that the workforce gap requires significant action.

We are calling now for a complete legal framework setting out specific duties and responsibilities for Government, national bodies, commissioners and providers to make sure there are enough health and care staff to meet patients’ needs, and a mechanism by which to hold bodies responsible for the decisions they make. This should support the use of policy and funding levers to ensure sufficient workforce
supply, recruitment, retention and remuneration required to deliver safe and effective care.

The Secretary of State for Health and Social Care should therefore be explicitly accountable for the provision of workforce. Each player throughout the health and care system then needs a clearly defined role commensurate to the level and complexity of their responsibilities, so that they can be clear about their functional role in delivering sufficient health and care staff to meet population need. They would have specific responsibilities for ensuring those staff are available in the right place and the right time to deliver safe and effective care.

The NHS has proposed a series of updates to key legislation, with the stated intention of delivering the Long Term Plan and removing barriers to integration. These proposals did not include amendments needed to provide clarity about roles, responsibilities and accountability for the workforce. The public engagement process closed on 25 April, and the RCN supported more than 10,000 RCN members, and members of the public, to submit a response to the engagement process, calling for accountability for workforce to be included in the legislation update.

The RCN in England has also launched a new collaborative approach to mobilising members across the nine regions to plan campaign activity to engage the public and stakeholders within the regions, to secure support for accountability in legislation.

**Northern Ireland:**

In Northern Ireland progress has been challenging due to a lack of government. However, the *Delivering Care* framework sets out guidance in relation to nurse staffing.

The approach taken in *Delivering Care* incorporates the role of professional judgement. It avoids ratios and, instead, identifies staffing ranges, recognising that there are variations in acuity and demand, and advocates an evidence-based approach in response to local need. There are, currently, limited opportunities to address the structural barriers related to supply, or to increase funding, due to the lack of government.

In May 2018, a regional workforce strategy entitled ‘Health and Social Care Workforce
Strategy 2026: Delivering for Our People’ was published. This sets out goals for a workforce to meet the requirements of a transformed health and social care system. It also seeks to address the need to tackle serious challenges with the supply, recruitment and retention of staff.

In Northern Ireland a lack of workforce planning has led to high agency spending bills.

Under the governance of the RCN Northern Ireland Board Safe and Effective Care Campaign Sub-Committee, the RCN in Northern Ireland is now campaigning in relation to safe staffing and the link to pay inequality in Northern Ireland.

The first phase of this campaign has recently been completed, involving a series of public engagement events across Northern Ireland to engage members of the public, as well as RCN members, on the causes and impact of nursing shortages. In the continuing absence of the devolved institutions in Northern Ireland, the opportunity to lobby for legislative measures around safe nurse staffing is currently denied but the RCN will continue to campaign around safe staffing within these political constraints, linking the issues to the continuing RCN pay campaign in Northern Ireland.

How to get involved:

You can sign up to get involved with campaigning in your country via the RCN website:

rcn.org.uk/safe-staffing
7. Appendix 1: Workforce data methodology

**NMC data**


**Number of nurses on the register**

The figure of 660,832 is calculated by combining the number of nurses and dual registrants on the register from the NMC data tables showing the breakdown of the register on 31 March 2019. The total number of registrants was 698,237 so nurses made up 94.75% of the register.

**Age of nurses on the register**

The breakdown of nurses by age is reported in the diversity reports published by the NMC. [https://www.nmc.org.uk/about-us/reports-and-accounts/equality-and-diversity-reports/](https://www.nmc.org.uk/about-us/reports-and-accounts/equality-and-diversity-reports/)

The latest data available is from 2017-18.

**Age of individuals on the register**

The proportion of registrants in each age group has been calculated from the figures published showing the breakdown of the register on 31 March each year. Some age bands have been combined.

**Country of initial registration**

The proportion of nurses and midwives on the register by country of initial registration has been calculated from the annual data collected on 31 March.

**Joiners and leavers from the register from different countries**

This is taken from annual data collected on 31 March showing the number of nurses and midwives that have left the register by country/area of initial registration.

**Reasons for leaving the register**

The NMC surveyed nurses and midwives who left the register between 1 May 2018 and 31 October 2018 to ask why they left. There were 3,504 respondents.

**Higher education data**

**Applications**


This data is from the UCAS 15 January deadline analysis and insights, published 7 February 2019 (Table DB.2). The comparison has been drawn with 2016 as that is when the bursary was withdrawn for nursing students in England.

**Acceptances**


This data is taken from the UCAS 2018 End of Cycle Data published in February 2019. The figures come from the provision-based statistics data, specifically DR3 015-01 using the detailed subject group ‘B7 – Nursing’.
8. References


4. Forthcoming RCN Employment Survey 2018


30 RCN (2018) Staffing for Safe and Effective Care: Nursing on the Brink