Running on empty
NHS staff stretched to the limit

UNISON’s staffing levels survey 2014
For the third year running UNISON has conducted a staffing levels survey. Front line nurses and midwives believe that national minimum nurse/midwife-to-patient ratios should be set. They believe it will improve patient care outcomes and that it will enable them to deliver the level of care which is needed. It has always been an employer’s responsibility to ensure that they have adequate numbers of staff in place to deliver the care that is required however so far many have failed to live up to this expectation and registrants have little, if any, confidence that they will, without it being enforceable.

We repeated the survey on a normal day the 4th March 2014; like last year there were no major adverse problems on that day and it was not a Monday where the service is still trying to manage the weekend’s emergency admissions. But despite this 51% of nurses working that day told us that they did not have sufficient numbers of staff to deliver dignified, compassionate care.

This wasn’t because staff didn’t care or try hard enough – they were simply understaffed and unable to provide the level of care needed. Nurses and midwives worked countless amounts of unpaid overtime on this day as well as working through their breaks, and it still wasn’t enough. 66% of respondents said that they didn’t have enough time with patients and of those 55% said that care was left undone.

We have included quotes from respondents to try to convey the depth of feeling and concern out there.

48% of respondents described their organisation as being at risk of a similar situation to Mid Staffs or that it was already happening in isolated parts or across their organisation.

Government, politicians and leaders need to listen to staff and act on staff concerns. The growing international evidence on minimum nurse-to-patient ratio numbers can no longer be ignored. The cuts which the NHS are currently being expected to make are detrimentally effecting patient care and service provision.

If UNISON members’ concerns were acted upon we would start to change the culture in the NHS from one in which blame is still derived, to one which welcomes and encourages concerns being raised; seeing all as an opportunity to learn, reflect and change.

Gail Adams  
*Head of Nursing UNISON*

Ann Moses  
*Chair of UNISON’s Nursing and Midwifery Committee*
Running on empty – NHS staff stretched to the limit
UNISON is the largest public sector union in health with 450,000 members employed across the service. We represent members in jobs throughout the nursing family.

UNISON has a long history of negotiating and campaigning on behalf of staff across the whole spectrum of health specialisms. As the voice of the whole healthcare family we are instrumental in influencing policy at regional, national and international levels.

UNISON is the union of choice for many nurses across the UK. Almost 60% of our members working in healthcare are in the nursing family. For many years we have been the leading force in negotiation on the issues of key importance to nurses and in the fight to improve their pay, terms and conditions. We do this by listening to their views, aspirations, concerns and working with them to develop key objectives.

We know that nurses feel very strongly about minimum staffing ratios, which they believe to be fundamental to patient safety and quality of care. A year on from the publication of his report into the care failings at Mid Staffordshire Foundation Trust¹, Sir Robert Francis identified the link between appropriate staffing levels and safe, compassionate care. UNISON wants to ensure that nurses are given the opportunity to perform their caring role to the best of their ability and that their contribution to care provision is recognised and valued.

In the four years since Francis published his first report many would argue that the impact of the economic cuts has had a further detrimental impact on NHS staffs ability to deliver safe, dignified and compassionate care.

This survey is now running in its third year and forms part of UNISON’s longstanding campaign for safe staffing levels in every healthcare workplace.

This type of survey is unlike any other. In 2012 it was the first of its kind to ‘spot test’ a single, ‘typical’ 24 hour period for staff across the country. This is the third year UNISON has run this survey and from across all four countries it asks what work was like on this day, Tuesday 4 March 2014, and what can we learn from the circumstances that nursing staff are facing. We received nearly 3,000 responses, a majority of which were UNISON members. Several alarming similarities between last year’s survey results have arisen from this research which we will discuss later in the analysis.

UNISON is proud to be a founding member of the Safe Staffing Alliance which campaigns for safe staffing levels. Evidence has shown that one registered nurse to eight patients (excluding the nurse in charge) is the level at which there is significant risk of harm occurring.

UNISON is supportive of international campaigns which seek to secure a ratio of one in four (one registered nurse to four patients) and good care outcomes have been linked to a ratio of one in six. We also recognise that in some areas the ratio level would need to be even lower eg specialist environments.

Summary of main points

“Every day we struggle with beds. Constant harassment from managers to free beds and discharge patients, sit patients out of bed, etc. There is no time for anything meaningful. Managers are obsessed with targets. Targets don’t measure quality of care.”

Three quarters of respondents reported that 4 March 2014 was a ‘typical’ day at work. The survey response rate was one of the highest in the three years that the survey has run, with nearly 3,000 responses from staff performing different roles from across the nursing family. The survey had responses from every UNISON region and across all shift and workplace types.

There is no support for organisations to simply set their own staffing levels and very strong support for legally enforced standards. UNISON does support the use of workplace tools, however in the absence of them a default position should be a legally enforced minimum.

Worryingly, the survey results from respondents working a ‘typical shift’ on 4 March 2014 mirrored many of the same results from the survey conducted exactly 12 months ago, highlighting no significant changes in the areas around patient care. Six in 10 respondents (65%) reported not having an adequate amount of time with each patient and over half (54%) reported that there was care left undone due to understaffing.

One of the most worrying results, especially in a post Francis era was that 59% of all respondents felt there were not adequate staff numbers to deliver safe, dignified, compassionate care.

When looking at nurse to patient ratios on those working within a ward setting on 4 March 2014, nearly half of all staff (45%) were caring for eight or more patients. This percentage went up significantly (51%) when staff were working on night shifts. This is deeply worrying as the Keogh Review of the 14 hospitals in special measures also found issues around safe staffing on night duties.

Research tells us that if you are looking after eight or more patients that harm is occurring. UNISON is a founding member of the safe staffing alliance and supports the principle of never looking after more than eight patients.

A year on from the publication of Robert Francis’s recommendations, nearly a third of respondents (31.1%) reported their organisations were at risk of a situation similar of those at Mid Staffordshire Trust developing and 17% of respondents indicated that care failings similar to Mid Staffs were happening in isolated parts across the organisation.

Many organisations are using bank and agency staff to fill long term vacancies and established posts, 88% of respondents said that they have bank or agency staff on their shift. Respondents reporting frequent use of bank and agency staff in their team or ward were more likely to report a lower quality of patient care, working overtime and missing their breaks. Over use of bank or agency staff also demonstrate poor workforce planning, as they are often used where substantive posts would have existed. This
leads to a false economy of sacrificing full
time jobs and people for the sake of meeting
financial targets.

Over half of respondents worked over their
contracted hours, 45% of respondents
working up to 60 minutes of additional time
(unpaid). 10% worked up to 2 hours over
their scheduled finish time. Only 40% of
respondents were able to take all of their
breaks that day.

Over half of respondents (58%) reported
working overtime and through their breaks.
Although UNISON recognises that flexibility is
necessary at times in a healthcare
environment, we strongly disagree with what
appears to be an institutional practice that
takes advantage of workers who put their
patients’ needs before their own.

51% of respondents felt unconfident in
raising concerns locally, which in a post
Francis era is deeply worrying.

Despite the National Quality Boards\(^2\)
guidance only 24% of workplaces displayed
intended numbers of staff on duty. While
they have until June to undertake this
UNISON found it surprising that not more
areas met this requirement already as it
takes little effort – unless your numbers are
routinely below those which are needed to
meet care requirements.

---

### Recommendations

- UNISON will work with all UK organisations
  including NICE to develop staffing levels
  standards which can be applied locally.
  However these standards must be legally
  enforceable and in the absence of this a
  nationally set mandatory minimum level of
  nurse to patient ratio should be identified – with
  the minimum in a number of areas being one
  nurse to four patients or one to six patients.

- UNISON believes that the standard set by NICE
  must never breach or place a registrant in a
  position of caring for more than eight patients –
  as research tells us that in these circumstances
  harm is occurring.

- Organisations including boards should review
  this information along with bank and agency
  use as part of its workforce planning reviews.

- UNISON believes that NHS organisations are
  being placed in an impossible position of
  making cuts which detrimentally effect patient
  care. This is unacceptable, given time
  managers would be able to make changes
  which use improvement in care outcomes to
demonstrate efficiency.

- UNISON believes that staff should be
  encouraged to raise concerns and that
  employers should see these as golden nuggets
  of information which enable them to reflect,
  review and improve patient care.

- UNISON members should automatically
  report situations when they are caring for
  eight or more patients, when they cannot
deliver the standard of care required and or
  care is left undone.

- A member of the board should be accountable
  for staff engagement and staff complaints
  about care or service and these should receive
  the same level of commitment and action as
  patient complaints.

---

\(^2\) National Quality Board, November 13,
How to ensure the right people, with the
right skills, are in the right place at the
right time.
Minimum staffing levels around the world

Safe staffing and ratios has remained a debate, which has been taking place across the globe. In our report last year we highlighted the impact which campaigns, had achieved in Australia and the United States of America.

Victoria was the first state to achieve nurse to patient ratios in Australia. The New South Wales Nursing Association as it was known then built on this by campaigning to achieve ratios as part of an industrial campaign across the state of NSW. The Australian Nurses Association is working with them to seek to extend this to other states.

Both sought to build on the success of the Californian Nurses Association (CAL) campaign, which built up public and staff confidence in the argument for ratios. In all states where set ratios exist, patient care has received a positive boost.

National Nurses United (NNU) a new body in the United States, which incorporates the former CAL, is seeking to extend the ratios campaign across the country. The model they use sets mandatory staffing levels, which differ based on the type of environment. For example in medical and surgical wards their ratio is one nurse to four patients. However in other areas where dependency is greater for example emergency or respiratory care their ratio is one nurse to one patient.

Their campaign is one which we believe many could learn from. It has always been an employer’s responsibility to ensure that they have adequate staff numbers in place with the necessary skill mix, to ensure patients receive high quality care. However, in the US with an insurance-based healthcare system they argued that so far the employers had failed to live up to that expectation. They successfully made a strong case that nurses needed to be their own game keeper and couldn’t afford to wait for someone else to do it for them.

Current active campaigns led by NNU nurses are seeking to achieve state legislation in the District of Columbia and the states of Florida, Missouri, Massachusetts, Illinois and Pennsylvania.
Workforce tools or mandated minimum – the UK debate

In the UK, research has been undertaken linking nurse-to-patient ratios to patient mortality. A study by Professor Rafferty in 2006 reported 26% higher mortality rates for patients in hospitals that had the highest number of patients per nurse. In other words, more patients die where there are fewer nurses to care for them. Nurses in these hospitals were also more likely to report low or deteriorating quality of care on their ward or in their hospital. A further study in 2013 confirmed these findings when it was found that the 14 trusts in England with the highest levels of patient mortality rates had, on average, six fewer nurses per 100 beds than other trusts.4

Studies including the 2009 Boorman Review into NHS Health and Wellbeing5, establish solid links between understaffing, stress, job satisfaction and patient care. Workplaces that report understaffing are likely to have high levels of stress and low levels of job satisfaction. In turn, workplaces with high stress and low job satisfaction are likely to have more patient safety incidents and higher rates of patient mortality.

What also is clear from the majority of research in this field is that there is not a “one size fits all” ratio that is appropriate for any and every area of healthcare, for example higher rates are clearly needed in intensive care units. It is important therefore to take into account the various specialities and to also allow for flexibility in terms of nurse deployment and changing circumstances.

UNISON is supportive of the use of workforce tools, however, many to date have proved ineffective. The idea of basing your nursing workforce establishment on the number of bed is ludicrous. As Roy Lilly once put it “nurses care for patients not furniture”.

The historical midnight census of beds occupancy is ineffective, some would argue you should manage hospital beds in the same manner to which hotels measure availability, but this fails to take into account the patient journey6. Research highlighted the inaccurate interpretation by organisations of reduced length of hospital stay for patients, to mean that you require less nursing staff. In fact the reverse is true, a reduction in length of patient stay demonstrates efficiencies but it must also recognise the increase of patient dependency.

“Graf, Millar, Feiteau, Coakley and Erickson (2003) at Massachusetts General Hospital showed that as length of stay (LOS) decreased, nursing acuity increased. Decreased LOS concentrates the need for nursing intervention but also allows increases in the throughput, thus shorter lengths produce a double burden on nurses to manage the concentrated care needs

4 Nursing Times. Study suggests link between fewer nurses and higher death rates. 12 March, 2013. http://www.nursingtimes.net/5055934. article?referrer=e1
6 Nursing Economics, May-June 2009/vol27/No.3 Churn: Patient Turnover and Case Mix, Duffield, Diers, Aisbett and Roche
in a shorter time frame and to manage the movement on and off of the ward.”

If you took a six bedded bay and it was fully occupied at 7am, and remains so at 3pm then the average occupancy would be 100%. However, if three patients were discharged and a further three admitted then the average utilisation is 150%.⁷

Workforce tools can play a very important role. However, in the absence of them being a mandatory requirement UNISON would argue that a national minimum nurse to patient ratio should be the default position. By this we mean that if organisations choose not to work cooperatively using the workforce tools and set nurse to patient ratios, then they have to meet the mandatory minimum nurse to patient ratio. Our members and many other nurses would argue strongly that a mandated minimum is better in many instances than their current workforce numbers.

The argument described by the most senior nurses in the UK in opposition to a set minimum level is an empty one. Establishing a minimum ratio sets a standard below which we should not fall. No one making the case for a minimum has said it should be the same across the board, we recognise dependency differs from patient to patient. However, research has helped us to better understand the benefits of such a system – if care and patient outcomes improve with a ratio of one registered nurse to four patients and evidence demonstrates harm is being caused where a ratio of one nurse to eight patients exists – we have an evidence base level above which nurses should not practise.

In November 2013 the National Quality Board⁸ published guidance on staffing levels; while it highlights a number of organisations with examples of good practice and sets some standards for board’s assurance on the nursing workforce, it simply doesn’t go far enough.

Research evidence

The registered nurse forecast⁹ (RN4Cast) published in the Lancet in February 2014 was the most comprehensive study in some time looking and considering nurse numbers and education coupled with their impact on patient mortality. It looked at almost one million patients, in 300 hospitals analysing data across Norway, Ireland, Netherlands, Finland, Sweden, Switzerland, England, Belgium, and Spain. The research carried out over a number of years found that an increase in a nurse’s workload by one patient was associated with a 7% increase in patient mortality.

⁷ Safe Staffing Alliance, March 2014, Jane Lawless

⁸ National Quality Board, November 2013, How to ensure the right people, with the right skills, are in place at the right time

⁹ Lancet, 26th February 2014, Nurse Staffing and education and hospital mortality in nine European countries; a retrospective observational study, Aikens, Sloane, Bruneel, Van den Heede, Rafferty, Griffiths, Busse & others
The number of patients to an individual nurse cared for varied across the countries:

<table>
<thead>
<tr>
<th>Country</th>
<th>Patient number</th>
<th>Registered nurse number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>5.2</td>
<td>1</td>
</tr>
<tr>
<td>Ireland</td>
<td>6.9</td>
<td>1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Finland</td>
<td>7.6</td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td>7.6</td>
<td>1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>7.8</td>
<td>1</td>
</tr>
<tr>
<td>England</td>
<td>8.8</td>
<td>1</td>
</tr>
<tr>
<td>Belgium</td>
<td>10.8</td>
<td>1</td>
</tr>
<tr>
<td>Spain</td>
<td>12.7</td>
<td>1</td>
</tr>
</tbody>
</table>

UNISON’s staffing levels survey has repeatedly found nurses reporting regularly looking after eight or more patients. Nurses looking after eight or more patients should be considered an automatic breach and be reported.

We are not confident that escalation protocols are effective and their repeated use identifies poor workforce planning. Concern is also articulated in our survey of staff being regularly and routinely moved from one area to another to make up the numbers. Robbing Peter to pay Paul has never been effective and masks real workforce gaps. Nothing in the national quality board guidance reassures us that this will not continue to occur on a regular basis.

**Scotland**

In 2012 the Scottish Executive published a series of workforce tools, to enable organisations to be more confident in ensuring that they have adequate nursing numbers in place to ensure quality care is sustained and maintained. The mandatory use of these has already led to a slight increase in the number of nurses employed and this is set to continue to rise. UNISON is monitoring with interest the impact of these tools as they are rolled out across Scotland. However, the different approach being taken by Scotland (in that the tools are mandatory) could lead to different levels of care being provided across the UK.

**Wales**

A debate has taken place in the Welsh Assembly to set a legal duty for safe staffing levels. The bill has now moved into committee stage. The debate in the assembly was based on other international countries including Australia and the USA, where nurse to patient ratios are enforceable. No assembly member opposed the bill, although there were a handful of abstentions.

---

10 Nursing Times. 23rd August 2013, Workforce tools behind a rise in nurse numbers
11 Nursing Times, 7th March 2014, Wales passes first hurdle towards law on nurse staffing levels
Survey background

“Neither qualified nurse had a break all night. The swapping of staff led to a rushed, incomplete handover and to medications being administered late.”

UNISON’s national health group has run an ongoing campaign to support safe staffing in levels in healthcare settings for a number of years. As reports, anecdotes and members’ stories of the consequences of too few staff began to pile up, UNISON’s nursing and midwifery committee elected to make safe staffing levels the group’s key priority. In early 2012 UNISON ran its first safe staffing levels survey and made public the issues that nursing staff are facing as a result of understaffing.

Throughout 2013 UNISON’s ‘Be Safe’ training was piloted across a number of our regions and is now in the process of being rolled out country-wide to enable activists and members to feel empowered to raise concerns. All of our regions are developing plans to roll the training out to all activists who in turn will work with their local employers in partnership to deliver the training to all staff in their organisation. The aim is to normalise staff raising concerns and for employers to see these as golden nuggets of opportunity to reflect, listen and act to improve patient care. Our campaign is built on four key principles:

– Staff have a right and responsibility to raise a concern
– They have the right to be listened to
– They have the right to be believed
– They have the right for their concerns to be acted upon.

The survey questions were written with assistance, suggestions and revision from UNISON’s nursing and midwifery committee, a panel of 20 UNISON activists from across the country with backgrounds across all major parts of nursing and midwifery including academia.

The survey asked respondents to record details about their shift during a particular 24 hour period. This type of ‘spot test’ survey, performed across the country on the same day, and remains the only one of its kind. What it unearthed was that nursing staff everywhere are feeling the pressure of service cuts, making care delivery more difficult.

The survey was chosen to run a second time in the same format one year later on Tuesday 5 March 2013. Much like the first survey (6 March 2012), the 2013 survey asked respondents to record details about their shift during the same 24 hour period. This is the third year this survey has been run. This year the on-line survey ran over a 24 hour period on Tuesday 4 March 2014. We chose this period as it would avoid pressures from emergency weekend admissions and wasn’t in the depth of winter when demand can be higher.

The survey contained 40 questions, including five that asked for details about the respondent such as their gender. Most of the questions were multiple choice and centred around three primary topics:

– Their workplace – the region, field in which they worked, whether the organisation already had minimum staffing levels, etc.
Their shift on 4th March 2014 – when was it, how long did it last, were there any problems due to understaffing, etc.

Their opinions on staffing levels – whether they supported minimum staffing levels for nurses and/or health care assistants, the anticipated impact on patient care, etc.

All responses to the survey were entered into the web survey.

UNISON received nearly 3,000 responses to the survey, of which 2,845 were analysed in detail as a statistically valid sample. A copy of the survey questionnaire is available in Appendix One of this report.

The survey and data collection were advertised through a variety of mediums.

For weeks before 4 March 2014 participation was advertised on the following UNISON channels: UNISON’s healthcare social media such as Facebook and Twitter, inclusion in UNISON weekly health circulars and two personalised mass emailings to all members working in the nursing family. Information was also posted on many UNISON branch webpages across the country and disseminated through the regional and specialist channels available to members of the UNISON nursing and midwifery committee.

The survey was open to non-members as well as UNISON members.

The survey questions were designed to provide UNISON with a richer picture of the situation faced by members working in the nursing family, as well as assess the concerns that arose in the 2012 and 2013 surveys to see if things have improved, stayed the same or worsened.

UNISON head office receives regular reports from activists and members about their frustrations with the inadequate ratio of nurses to patients in their workplaces across the country, and the effect they believe that this has on patient care. UNISON champions quality patient care as well as the fair treatment of staff. Set mandatory staffing levels have proven to have positive effects in both these areas internationally.
In February 2014 The Nursing Times published the results of their survey a year on from the publication of the Francis Report and its impact on the nursing profession. The Nursing Times wanted to gauge if the report has had an impact, for the better or worse and the Francis report’s legacy.

One key finding in this report was that 42% of respondents felt that the Francis report would improve things long term for the NHS. However, 39% of respondents warned that staffing levels have worsened where they work over the past 12 months. This finding echoes responses to UNISON’s survey, where 59% of respondents felt that on 4 March 2014 there were not adequate staff numbers to provide safe, compassionate and dignified care.

The Nursing Times survey suggests only a small improvement in staffing levels since last January, where 44% said there were 10 or more patients per nurse. This year 37% of respondent’s identified the average number of patients per nurse was 10 or more.

UNISON asked the same question with similar results which can be found from page 23; worryingly though 45% of respondents identified that the nurse to patient ratio on their shift on the 4 March 2014 was one nurse to eight or more patients.

Francis identified that the year on year financial savings which the trust made had an cumulative impact on patient care but Francis fell short of calling for national minimum standards, which UNISON believes is unfortunate.

The government’s response to the Francis report highlighted that it was committed to ensuring staffing levels were sufficient to provide safe, high quality care, however instead of recommending legislation around national minimum standards, they opted for nurse/patient ratios to be set locally, arguing that patient safety experts agree that this is the best way of ensuring safe, compassionate and dignified care is delivered. The government has since stated it will make sure that providers have the right levels of staff, set locally, to ensure patients are cared for and in order to support health care providers, the National Institute for Health and Care Excellence (NICE) has been asked by the Department of Health and NHS England to develop evidence-based guidelines on safe and cost-effective staffing, including doctors, nurses and midwives. NICE is currently reviewing acute adult in-patient wards, and guidance and accredited tools will be available from July 2014.

From August onwards, NICE will develop future guidelines making recommendations on safe staffing levels in other ward types and care settings including accident and emergency and maternity.
As previously discussed in this report, UNISON is deeply concerned that many organisations have not set in place local nurse to patient ratios and therefore we feel unless there is a mandatory minimum imposed on organisations, this issue will not be resolved. After all, it has always been the organisation’s responsibility to make sure they have adequate numbers of staff in place. To date, many of them have failed to achieve this. Much of the blame for this lies with the requirement for organisations to make year-on-year cuts. This places organisations in a position, where they need to choose between staffing levels and balancing their books.

In the response to the Mid-Staffordshire NHS Foundation Trust public inquiry, “Hard Truths: The Journey to Putting Patients First”, the government set out the expectation that from April 2014 and by June 2014 at the latest, national health service trusts will publish ward level information on whether they are meeting their staffing requirements, and every six months, trust boards will be required to undertake a detailed review of staffing using evidence-based tools. From our survey results we know this has started happening in some NHS organisations. Only 24% of respondents identified that their workplace is displaying intended number of staff on duty and nearly a third (32%) of respondents identified that their workplace displays the actual number of staff of duty; however staffing information for patients was less openly displayed with only 17% of respondents highlighting that their workplace displays this information in an easily accessible place for patients to see.

The Care Quality Commission, through its chief inspector of hospitals, will monitor this performance and take action where non-compliance puts patients at risk of harm and appropriate staffing levels will be a core element of the Care Quality Commission’s registration regime.

Safe staffing levels were an issue in the Keogh review; he re-iterated some of the similarities from the Francis report in the balance of maintaining high standards of care in a financially challenging environment, stating that organisations needed to make decisions based on quality and not on finance. The gap in nursing numbers in the 14 organisations featured in the Keogh review was highlighted recently by the Nursing Times, where it reported that they had recruited over 600 posts.12

There is now clear evidence that nursing cutbacks are directly linked to higher patient death rates in hospitals13 and that when a nurse is responsible for eight or more patients harm is occurring.14

12 Nursing Times, 18th February 2014, Most challenged trusts beginning to boost nurse numbers
14 Safe Staffing Alliance - http://www.safestaffing.org.uk
The concerns and feelings voiced by respondents in UNISON’s survey echoed concerns in the recent NHS Staff Survey. The NHS Staff Survey is an annual survey which involved 265 NHS organisations in England. Full and part time staff directly employed by an NHS organisation on 1 September 2013 could participate and the survey received a response rate of 49% (over 203,000 members of NHS took part).

The NHS Staff Survey uncovered continued trends from the previous year in falling satisfaction with working for the NHS, understaffing and poor communication in the organisation between senior managers and staff. Among the highlights relevant to this survey, the NHS Staff Survey found that:

Only 41% of staff were satisfied that their trust values their work – there has been no improvement in this area over the past 12 months. Post Francis it is a continued concern there has been no change in staff feeling that their work is valued by their organisation. Thanking someone at the end of their shift costs the service nothing and can lead to improved levels of morale among the workforce.

Staff reporting that they were working extra hours increased to 70.5% from 69.7% the previous year.

Over a quarter of respondents felt pressure to attend work when feeling unwell.

Overall work pressure felt by NHS staff remained unchanged from last year’s NHS staff satisfaction survey. Again, it is a concern that there has been no reduction in work pressure felt by staff following the government’s response to Francis and their commitment to ensure that nurse to patient ratios would be set locally. This also echoed the results in UNISON’s pay survey as part of UNISON’s submission to the NHS Pay Review Body where we highlighted an increase in workload; respondents identified working longer hours unremunerated and a shortness of staff across the NHS.

Only 36% of NHS staff said that communication between senior managers and staff is effective and only 28% of staff reported that senior managers act on feedback from staff.

The NHS Staff Survey chose to ask some questions relating to raising concerns and about NHS staff being able to give the quality of care they would like to:

- 66% of NHS staff said that care of patients and service users in their organisations was a top priority.
- 89% of NHS staff who took part specified they would know how to report any concerns they have, although worryingly only 54% of staff felt confident that their organisation would address them.
- 77.8% felt satisfied with the quality of work and patient care they were able to deliver however only a third of staff (30%) felt that there was enough staff in their organisation to enable them to do their jobs properly.

Unfortunately the NHS staff satisfaction survey does not allow us to drill down the results in terms of job role (for example nurses and health care assistants) and this can give an overall different picture. There have been some slight improvements in some parts of the survey and we welcome the improvement in staff receiving appraisals.
UNISON would argue that employers need to be able to drill down into the survey results much more vigorously, including looking at outcomes by job group, which part of the organisation the respondent works in and protected characteristics, to enable them to develop action plans which address their outcomes.

Respondents to UNISON’s survey echoed the feelings in the NHS Staff Survey and showed little improvement in the last 12 months in terms of seeing a marked improvement in staffing levels, staff taking their allocated breaks and staff having adequate time to spend with each patient. It would appear across the health service staff continue to feel overworked and undervalued.
Methodology and composition of respondents

“Although this was a busier than average day, it is becoming busier and was not the worst day of this week. The constant demands on staff are resulting in low morale and high sickness and stress. This particular shift was fortunate in some ways as the other staff members were very experienced, if this day had fallen on a day when there was a poor skill mix I dread to think what the outcome would be.”

The majority of questions in this survey originated from the 2012 survey. While from the perspective of statistical analysis it would have been preferable to exactly replicate the previous surveys, several of the questions from the previous surveys proved to be confusing and needed simplification. Furthermore, it was deemed appropriate to add some questions a year on from the publication of the Francis report, to see if any trusts in England, health boards in Wales and Scotland and health and social care trusts in Northern Ireland have introduced any local arrangements regarding staff/patient ratio numbers. Before going ‘live’, the survey questions were given to UNISON’s national nursing and midwifery committee for review and comment.

The 2,845 analysed responses came from healthcare staff distributed fairly evenly across regions and shifts worked, while other factors such as gender reflected the percentage of that characteristic in the workforce.

Regions

Geographically, the largest percentage of respondents identified themselves to be from the Scotland (16%), the North West (14.6%), South East (10%) and South West (9%). The region with the fewest respondents was Northern Ireland, which made up 3.5% of the responses, although it is important to note that statistically nursing workforce numbers are lower in Northern Ireland, therefore this is a proportionate response. All regions responded to the survey.

These percentages roughly reflect the distribution of regional responses when this survey was run in 2013, even though this year we had a higher response rate to the survey. The largest increase in number of respondents came from Northern Ireland, which nearly doubled its total number of responses.

What region is your organisation in?
Workplaces

“I have discussed with managers that it is not acceptable for one trained nurse to be responsible for 30 patients, doing a 30 patient drug round, controlled drugs, insulin peg feeds, dealing with doctors and relatives, end of life patients and occasionally one patient that needs resuscitation. All trained staff here believe that this is too much. Manager’s reply is that we have to risk assess, but they can’t always find the staff.”

Half of the respondents worked in an acute setting and the next largest grouping was mental health trusts. The remaining third of respondents came from a mix of workplaces that included Scottish and Welsh Health Boards, NI health and social care trusts, community services (11%), learning disabilities and care homes. Only 2.3% of respondents identified themselves as working in the private sector.

Mirroring the results of the 2012 and 2013 surveys, over 67% of respondents worked for a large NHS organisation with more than 2,000 employees.

The areas of care in which respondents worked on 4 March were hugely varied and spread across the full spectrum of healthcare. This included: accident and emergency, paediatrics, care of the elderly, community, community mental health, critical care, general practice, learning disabilities, medical, mental health (inpatient as well as secure unit), obs and gynae, surgical, rehabilitation and theatre. A fifth of respondents chose ‘other’ and wrote in their response.

The greatest number of respondents for any area of care was care of the elderly at 14%, followed by medical at 11%, surgical at 10% and community including district nursing and health visiting at 9%.

“During the shift we had five discharges and two patients that needed one to one nursing, however only one of those patients could have one to one nursing, which meant the other patient was at a greater risk of a fall.”

Care settings become especially pertinent within this survey when we looked at those respondents who identified not having adequate time to spend with each patient. Unsurprisingly respondents working on those wards with patients with high dependencies indicated that they did not have enough time to spend with patients – medical (80%), followed by care of the elderly (75%), mental health: inpatient (74%) and surgical (70%).
It is important to note that 447 respondents (21.5%) identified their type or ward/field in the ‘others’ category. Some of these included stroke units, pre-operative assessment clinics, clinical trial wards and palliative care wards/hospices.

This is one reason – the vast dispersal of care areas and limited number of respondents in each – that this report does not make numerical recommendations on staffing levels for each of these areas. The determination of minimum staffing levels is an intricate process, requiring many variables that were outside the scope of this survey. UNISON supports the work done by NHS Scotland, in conjunction with trade unions such as UNISON, to develop a workable staffing levels matrix. We also recognise that use of this is mandatory; however it still requires time to bed down fully and be evaluated as a successful model.

**Shift**

The dispersal of shifts was roughly even, as shown in the graph below.

Nearly half (45%) of respondents worked a shift that was contracted to last for more than 10 hours, including 19% whose shifts were intended to last more than 12 hours. It’s worth noting that these figures are only for the shift’s contracted length. With more than half (54%) of respondents reporting that they worked overtime on the 4 March, with only 3% of respondents identifying that this extra work was paid, and only a third (39%) reporting that they took all their allotted breaks. This makes the length of these shifts long and increases the risk of mistakes occurring. Please refer to the section overtime and breaks later in this report for a further analysis.
Respondents and diversity

The survey’s primary audience was registered nurses, the work group for whom nurse-to-patient ratios are of greatest concern. However as staffing levels affect many roles within the nursing family, UNISON designed the survey to be inclusive of the other roles as well. In this way the survey benefited from a majority respondent group of nurses in addition to other key jobs, as demonstrated by the following chart.

As the survey was advertised primarily through UNISON’s own channels, the vast majority of respondents (94%) were UNISON members. The remainder belonged to another union (5%) or no union (1.2%).

Equality breakdown

The majority of respondents identified as female (81%), which is representative of the gender make-up in the NHS workforce and in UNISON’s membership.
One in 12 respondents (8%) described themselves as having a disability.

Nearly half (44.2%) of respondents identified themselves as between the ages of 35 and 50, with a further third (31%) as over the age of 50. Only 10% of respondents were age 27 or younger.

A large majority (87%) of respondents described themselves as being one of the following: White British/English/Scottish/Northern Irish, White Irish, or White Other. This percentage is roughly reflective of the NHS workforce and UNISON healthcare membership. 10% of respondents were from Black, and Minority ethnic groups and a small percentage described themselves as mixed race.

<table>
<thead>
<tr>
<th>Ethnical Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British / English / Scottish / Welsh / Northern Irish</td>
<td>82.3%</td>
</tr>
<tr>
<td>White Irish</td>
<td>2.6%</td>
</tr>
<tr>
<td>White Other</td>
<td>3.0%</td>
</tr>
<tr>
<td>Black British / English / Scottish / Welsh / Northern Irish</td>
<td>1.6%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1.0%</td>
</tr>
<tr>
<td>Black African</td>
<td>2.0%</td>
</tr>
<tr>
<td>Black Other</td>
<td>0.2%</td>
</tr>
<tr>
<td>Mixed or multiple ethnic groups</td>
<td>0.8%</td>
</tr>
<tr>
<td>Asian British / English / Scottish / Welsh / Northern Irish</td>
<td>1.6%</td>
</tr>
<tr>
<td>Indian</td>
<td>0.5%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.1%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.2%</td>
</tr>
<tr>
<td>Filipino</td>
<td>2.2%</td>
</tr>
<tr>
<td>Asian Other</td>
<td>0.4%</td>
</tr>
<tr>
<td>Arab</td>
<td>0.1%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1.7%</td>
</tr>
<tr>
<td>Any other background</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
The impact of staffing levels on care quality

“A&E is difficult to manage staff wise. We cannot account for the sheer volume of people walking through the door sometimes and this shift was particularly busy but this is becoming the norm.”

Respondents for the third consecutive year overwhelmingly felt that staffing levels in their workplaces were not sufficient to deliver the quality of patient care required. Across all respondent groups – including regions, job roles, shifts, and workplace – the majority (60%) felt that the number of staff present in their workplace on 4 March 2014 resulted in the delivery of a lower standard of care.

We asked respondents if 4 March 2014 was a typical day at work and three quarters (73%) of respondents indicated it was a typical day and that their workplace was busy as normal. We asked respondents if there was anything more they wanted to tell us about their shift on the 4 March 2014. Some of their comments are printed throughout this report, but they continually highlighted workplaces that were understaffed, staff not having the time to give the care to patients that they would like to due to lack of staff, pressure to complete, paperwork, use of bank and agency staff, community staff given extra patients to add to their caseloads and pressure being put on qualified staff to support less qualified staff with certain procedures.

This re-enforces the detrimental impact of cuts within the NHS. In his report Francis said that “not achieving foundation trust status was not a career enhancing move for chief executives.” We would argue that the same view applies to chief executives and managers who don’t achieve financial savings. The pressure to achieve financial balance and the challenge of doing so while retaining high standards of care remains in our opinion almost impossible.

### In your opinion, was this a typical shift? In other words, did everything run as usual or were half the staff off sick or was the unit filled with additional staff due to a recent massive accident, etc?

- It was slow: 4.5%
- It was unusually busy: 7.1%
- I don’t know because I haven’t worked there long enough to tell what’s typical: 2.5%
- It was not a typical day because: 12.6%

When looking at nurse to patient ratios on those working within a ward setting on the 4 March 2014, a majority of staff (45%) were caring for eight or more patients. This is a shocking figure as studies have now shown that where nursing staff are caring for eight or more patients harm is occurring. We also looked at nurse to patient ratios by shift type and it became apparent that half of all staff who responded were reporting to be caring for eight or more patients on a night shift.
Running on empty – NHS staff stretched to the limit

What was the nurse to patient ratio on your shift on 4 March 2014?

<table>
<thead>
<tr>
<th>Nurse to Patient Ratio</th>
<th>Early Shift</th>
<th>Late Shift</th>
<th>Long Day</th>
<th>Night Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1</td>
<td>5.1%</td>
<td>6.2%</td>
<td>7.2%</td>
<td>6.1%</td>
</tr>
<tr>
<td>1:2</td>
<td>7.2%</td>
<td>7.2%</td>
<td>8.5%</td>
<td>7.9%</td>
</tr>
<tr>
<td>1:3</td>
<td>6.1%</td>
<td>6.1%</td>
<td>6.1%</td>
<td>6.1%</td>
</tr>
<tr>
<td>1:4</td>
<td>5.1%</td>
<td>5.1%</td>
<td>5.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>1:5</td>
<td>9.2%</td>
<td>9.2%</td>
<td>9.2%</td>
<td>9.2%</td>
</tr>
<tr>
<td>1:6</td>
<td>8.6%</td>
<td>8.6%</td>
<td>8.6%</td>
<td>8.6%</td>
</tr>
<tr>
<td>1:7</td>
<td>10.9%</td>
<td>10.9%</td>
<td>10.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>1:8 or more</td>
<td>45%</td>
<td>45%</td>
<td>45%</td>
<td>45%</td>
</tr>
</tbody>
</table>

We then cross-analysed the types of ward that were reporting the highest nurse to patient ratio rates, 17% of all respondents who indicated that they worked on a medical and surgical wards reported that they were caring for eight or more patients. The highest other nurse to patient ratios by ward type were care of the elderly (19%), community mental health (including early intervention team, CAMHS, forensic) (15%), mental health: inpatient (5%) and those respondents who did not fall into any of UNISON’s ward or workplace categories so specified ‘other’ (18%). These are also the areas where patients often have higher care needs.

Respondents were asked: “Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?”

Mirroring last year’s result only three in 10 (31%) answered yes and over half (59%) indicated that there were not adequate staff numbers. This result shows there has been no change in the last 12 months in this area.
When asked “did you feel that you had an adequate amount of time to spend with each patient?” again only a quarter of respondents answered yes (28%).

Overwhelmingly, 66% of respondents indicated that they did not have adequate time. UNISON has consistently argued that there is a strong link between staff availability and the level of care that a patient receives. It also leaves staff in positions where they have to ration care, making difficult decisions as to what care gets left.

From the results to this question we looked at which staff roles were indicating that they did not have adequate time to spend with each patient. Three quarters of all midwives (78%) and nearly three quarters (71%) of all nurses (general and mental health) who responded to the survey indicated that they did not have adequate time with each patient. Other staff groups indicating lack of time to spend with patients included 64% of HCAs, APs and SWs, 63% of ward sisters and 54% of clinical nurse practitioners.

Much like the question regarding safe care, the percentage of respondents who felt they did not have enough time with each patient decreased slightly to 65% compared with 76% of last year respondents. In 2013, only 29% felt that they had enough time with each patient compared to 28% this year. Although it is important to acknowledge these decreases, it is still not acceptable when only three in 10 respondents report having had enough time with each patient.
Organisations need to address this issue urgently and re-examine the workloads that their nursing staff are dealing with.

Respondents were then asked “were there elements of care that you could not provide because you didn’t have time?” Over a half (54.3%) answered that because they did not have enough time, there were aspects of care they did not deliver. This is a slight improvement on last year’s survey where more than three quarters of respondents identified that they did not have enough time to deliver elements of care. We cross analysed those who answered ‘yes’ by role and worryingly 72% of Midwives and 60% of nurses (general and mental health), 49% of Health Care Assistants, 40% of Clinical Nurse Specialists / Practitioners and 39% of Ward Sisters indicated that they did not have enough time to provide elements of care. It is unacceptable to UNISON that year-on-year this survey is highlighting that midwives, nurses and care workers are continued to be put in this position; even working through their breaks and working unpaid overtime they could not deliver the care required. This re-enforces evidence that nursing family numbers are inadequate.

It is important to note that nurses and midwives are professionally accountable for their actions to the Nursing and Midwifery Council, whilst HCAs/APs are not. Regulated nurses are accountable for the supervision of HCAs/APs as well as ensuring that patients in their care receive safe, compassionate and dignified care.

We also looked at the nurse to patient ratio where respondents indicated that care was left undone. Unsurprisingly over half (53%) of the respondents that indicated that there were elements of care they could not provide due to lack of time, were caring for eight or more patients. The survey highlighted that the smaller the ratio of nurse to patient, the lower the percentage of respondents reported not having time to deliver elements of care, clearly identifying a link between quality of patient care and lower nurse to patient ratios.

“In the community we have to prioritise our visits if we have few staff, this means that patients who need referrals to other agencies, and assessments have to wait until we have sufficient time to complete them, which could be several weeks.”
Correspondingly, we looked at the shift type where respondents reported that there were elements of care they were unable to give. 59% of all Nurse respondents who worked a night shift said there was elements of care they were unable to give compared to 55% of nurses that worked an early shift on the 4 March 2014. Nearly half of all HCA/AP (41%) respondents on an early shift indicated there were elements of care they could not provide due to lack of time, compared to 47% of HCAs/APs on a night shift. These results highlight that there are still staffing issues occurring on night shifts.

Respondents were also asked if they felt that their shift had “an adequate skill mix.” 39% of respondents felt their shift’s skill mix was inadequate to the care they needed to deliver. This has significantly deteriorated from last year’s survey where almost 50% of respondents felt that the shift’s skill mix was adequate.

“I and others in my team are unclear if we have a minimum staff to patient ratio. We believe that it may be set at 35 patients on a caseload for a full time member of staff, however this is often exceeded. What is also not taken into consideration is the complexity of some people and we feel that this should be taken into account, not just numbers”.
Many respondents reported suffering numerous symptoms of stress due to their unreasonable workloads. Low morale was attributed to an uncaring attitude from managers, an over-burdensome workload and bullying.

“Simply not enough staff for the ever increasing workload and an increase in patient complaints has already been noted due to staff being over stretched and unable to deliver the care patients deserve. It is mentally as well as physically exhausting and can result in very experienced nurses making serious drug errors.”

“Usual day but staff skill mix was very poor. As I was the only trained nurse, I had to scrub for every case on the list. I had no coffee/toilet break, only 10 minute lunch break to keep the list running. I was scrubbed from 9am until 8.30pm (due to an emergency) I worked an hour over my 11.5 hr shift”.

“Management are aware of the chronic staff shortage... just nothing is done”.

“Staff overworked due to many days of staff shortages; ward staff getting very tired with extra work load and then going off sick”

“Many of us feel that those in charge look only at patient numbers and give no thought to the behaviour exhibited by some of the patients and how challenging it is on many occasions.”

This survey continues to identify links between stress, job satisfaction and productivity are measurable.

The following points remain the case in the NHS:

- understaffing, unreasonably high workloads and frequent unpaid overtime lead to stress
- workers who are stressed and generally unhappy in their jobs perform their roles to a much lower standard than happy workers
- in effect, happy staff deliver improvements in standards of care and the quality of patient outcomes.

UNISON, as the trade union that looks after people who spend their lives caring for others, has been campaigning to reduce workplace stress for many years. No one should be made to work in an environment that leaves them feeling undervalued, stressed or miserable. Although some employers will refuse to improve their workplace just to improve employee welfare, they need to wake up to the fact that the knock-on effect to patients is both considerable and measurable.
Mid Staffordshire Trust

“I am a bank nurse and I was expected to care for 14 elderly patients, several with dementia, with the help of two very good auxiliary nurses. In the afternoon one auxiliary nurse was taken away to cover staff shortages elsewhere. The other staff nurse on the ward (permanent staff) was also responsible for 14 patients. This staff nurse was inexperienced and very stressed and I therefore had to give her a great deal of support. The ward manager was in but on a management day. A very difficult exhausting shift but this is not unusual.”

Respondents were asked to evaluate their organisation against the care failings at Mid Staffordshire Foundation Trust, and specifically whether they thought that a similar situation could happen where they work. Shockingly, only one out of 13 respondents (7%) felt very confident that a similar situation would never happen at their organisation. And appallingly, nearly one fifth of respondents (17%) felt that a similar situation is already happening either across or in isolated parts of their organisation.

When reviewing all the responses, almost half (49%) described their organisation as either ‘at risk’ of becoming a situation similar to Mid Staffs, that it was already happening in isolated areas or across their whole organisation.

“There was a gentleman who passed away – his last offices were not carried out until eight hours after his passing because the previous shift hadn’t had time”.

Respondents in every region reported that care failings were already occurring in their organisations.

The regions with the highest percentages of reported care failings were Northern Ireland

How confident are you that a similar situation as the care failings at Mid Staffs could never happen at your trust?

- Very confident, a situation similar to Mid Staffs could never happen at my trust 7.3%
- Fairly confident, a situation similar to Mid Staff is unlikely to happen at my trust 31.7%
- Not very, we are at risk of a situation similar to Mid Staffs developing 31.1%
- Not at all, it’s already happening in isolated parts of the organisation 8.6%
- Not at all, it’s already happening across the organisation 8.5%
- Don’t know 12.8%
(16.4%), Scotland (12%) and the South West of England (9.5%). The following graph depicts the percentage of respondents in each region who categorised their workplace as having situation(s) similar to the care failings at Mid Staffordshire across their organisation.

“Theatres regularly low staffed. Poor skills mix and I am asked to cover more and more. On occasions staffing levels are bordering on dangerous. We are in a Mid Staffs situation and I don’t believe we are the only ones. The NHS is struggling to survive and in my opinion being destroyed by poor and sometimes incompetent managers and politicians who have no understanding and frankly don’t care”.

One of the answer choices to this question was “don’t know.” 13% of respondents chose this option, and it is not reflected in the percentages above. In a post Francis era where raising concerns and whistle-blowing has been in the media, it is concerning that many still feel not enough has been done to highlight how important it is to raise concerns.

Steps UNISON has taken

Where UNISON has been able to identify the organisation, the relevant region has been asked to work with the local UNISON branch to raise these concerns formally with the trust. They have also been asked to look in detail at the core questions outlined in the NHS Staff Satisfaction Survey.
All members were emailed with a reminder of the importance of raising concerns to protect themselves, those in their care and their colleagues.

UNISON has also shared this information with the Care Quality Commission and has cross-referenced these highlighted failing organisations with last year’s list; requesting they ask inspectors to routinely meet with local UNISON representatives as part of their inspection processes.

**Support for safe staffing levels**

“I have been pressured to take admissions when due to lack of staff it has not been safe to do so. When I have raised this point I have been told, ‘what do you want me to do about it’. When my ward is staffed adequately to the minimum staff to patient ratio, I have been told that we need to send a nurse to another area as they are short.”

Respondents were asked their opinions for or against set minimum nurse-to-patient ratios. When asked “Do you think there should be a set national minimum nurse to patients ratio?” the overwhelming majority (65%) responded yes. UNISON agrees that organisations should set their own staffing levels but ultimately be required to maintain a minimum ratio. When we analysed who responded ‘yes’ in relation to job roles, 65% of nurses (general and mental health) agreed that organisations should have a legally enforced minimum nurse-to-patient ratio.

There is no support for organisations to set their own staffing levels without any legal enforced minimum. Only 3% of respondents supported organisations in setting their own staffing levels locally, without having these legally enforced.

This means there continues to be high support for legally enforced minimums of nurse-to-patient ratios, but recognition that workforce tools can prove beneficial just so long as they are enforceable.
High levels of support (81%) were also present for minimum healthcare assistant to nurse ratios. Although percentages were roughly the same across job roles, the highest level of support (81%) came from nurses (general and mental health) and 79% of healthcare assistants/assistant practitioner/support worker.

“It is very difficult to address skills mix issues in my area. Sometimes it may look like we have enough staff in terms of numbers, but inexperienced staff cannot be left on their own. Staff are expected to adapt at a moment’s notice. It is difficult to cover emergencies and unsafe practices are now common.”

UNISON supports a considered approach to staffing levels which takes into account patient dependencies, the area of care and the team/workplace skills mix. Clearly what is appropriate and safe for a city centre A&E will be different from a low secure mental health ward. And even within different areas of care, requirements are going to change from day to day in unpredictable ways as new patients arrive, the health of existing patients improves or deteriorates, and the projected number of discharges changes.

As discussed earlier UNISON is disappointed that the government did not take the opportunity to introduce statutory minimum nurse to patient ratios across all four counties following the publication of the Francis report and Keogh review.¹

Furthermore, UNISON does not believe that just because something requires planning and thought that it should be abandoned.

It’s true that it took Australia and the USA a lot of work to get the formulas right which indicate what an appropriate nurse-to-patient ratio should be in a particular area of care. It required the input of many experts from many fields, and the process wasn’t finished before tea.

Fortunately, the NHS has the benefit of being able to evaluate how other countries have set and implemented staffing ratios. NHS Scotland has developed its staffing levels matrix, which is mandatory across the devolved nation. It’s now time for the NHS to make use of the work that’s already been done\(^2\), and set minimum nurse-to-patient ratios for the entire UK.

\(^2\) Linda H. Aiken, Douglas M. Sloane, Jeannie P. Cimiotti, Sean P. Clarke, Linda Flynn, Jean Ann Seago, Joanne Spetz, and Herbert L. Smith, 2010, University of Pennsylvania, Implications of the California Nurse Staffing Mandate for Other States
Do voluntary minimum staffing levels work?

“Within a community setting our workplace can never be full or caseloads cannot be closed. We often start out at the beginning of our shift with a manageable amount of patients to see but throughout the day we pick up further calls which have to be responded to, which is the main reason why nurses don’t get breaks and work over their finishing times”.

Only one in three respondents (36%) worked in a ward or team that has already set a minimum nurse-to-patient ratio. The regions with the highest percentage of respondents working in wards or teams with set ratios were the West Midlands (40%), Eastern (36%), Scotland (34%) and Northern (32%). The region with the lowest percentage of respondents for the second year running was Cymru/Wales (25%).

Those respondents that reported a set minimum nurse-to-patient ratio in their workplace highlighted the average nurse to patient ratio was one nurse to six patients (14%), however a third (33%) reported that their minimum nurse to patient ratio was one nurse to eight patients or more. Clearly it is alarming that in the third year of running this ‘spot test’, little has been done by organisations to set minimum nurse to patient ratios. There are still many workplaces running ratios of eight or more patients to one nurse, which increases the risk of harm occurring to patients as well as increasing stress and demands of staff working on those wards.

“I agree that the organisation should be allowed to set its own ratio as long as it is safe and not just changed because they are busy that day to make it look a safe environment. Critical care should be one to one and never changed due to the nature of work, however unfortunately the ratio does change when it suits the unit, as they do not have the staff skills mix to care for the ward that day.”

This is the first year that we asked respondents whether the set nursing staffing levels in their organisations were flexible and if they were altered to take into account patient dependency. Nearly two thirds (60%) of respondents confirmed that their organisation did not take this into account and only 21% confirmed that their workplace did take this into account.
Are the set nursing staffing levels in your organisation flexible and easily altered to take account of patient dependency?

- Yes: 21.6%
- No: 60.0%
- I don’t know: 18.3%

“Both my staff and I frequently have to work alone, which is very unsafe.”

One third (37%) of respondents did not know if their ward, unit, department or team had a protocol or policy for staff to use in the event of a shortage of nurses and this is compared with 37% of staff that were aware that their workplace had a protocol for if they had a shortage of nurses. This percentage is still alarmingly high and is unchanged from last year. It suggests that many of the respondents are not consulted or engaged with when there are problems of understaffing – despite how this affects their day to day work.

The respondents who reported that their workplace had a protocol or policy to address short staffing were then asked if they had ever had to use it. Only half of all respondents (51%) answered that they had. Respondents were then asked how they viewed the outcome of using this protocol or policy. Less than two out of five respondents (23%) felt that their concerns were listened to and acted upon.
**Comparison to the 2013 survey**

“I did not feel able to provide the type of care I would have liked to the patients. It felt more like a conveyer belt. No compassion, little dignity, I left at the end of the shift feeling distraught and that perhaps I have made a huge mistake training as a registered nurse”.

This year the focus of stories told by respondents has been primarily on the impact of more junior staff – specifically healthcare assistants, who find themselves expected to take on additional work and responsibilities when nursing numbers are short. They may not always feel confident to do this. Qualified nurses highlighted the need to support less experienced nurses on wards, especially with certain procedures, and this meant less time with other patients and to deliver some elements of care.

The lack of workforce planning by organisations, staff shortages due to high sickness rates and respondents reporting that staff are ‘borrowed’ from one ward (or unit or department) to help another area achieve its minimum ratio, have all continued to be key themes in this survey for a third consecutive year. Unfortunately this practice of moving staff around to different areas continues to be the norm and is only rotating the problem as it tended to leave the first area understaffed, with the most highly skilled nurses being sent to support other under staffed wards and leaving less qualified staff on duty.

Although this area of the survey has seen minor improvements since the 2012 survey, in 2014 over the last 12 months there has been a reduction in the number of respondents who had used a protocol or policy to address understaffing. A reduction in those respondents who felt that their concerns had been listened to and acted upon swiftly. Any fall in figures around staff being listened to and having their concerns acted on regarding staffing levels is clearly significant and has an impact on patient safety. Again, UNISON reiterates that one of the key recommendations made by Francis was that, it is fundamental that staff in the NHS raising concerns about patient safety issues should have their concerns acted on and that this should be part of the culture of the NHS. This survey highlights that there is still much work to be done in this area.
“I leave all shifts absolutely exhausted and stressed because I feel like I haven’t done all the things I wanted to do due to being busy.”

“My department is running at VERY UNSAFE levels due to inadequate staffing”.

“The staffing levels in my opinion are dangerous and this is an accident waiting to happen”.

Since the 2012 survey ran, the percentage of respondents aware of minimum nurse-to-patient ratios in their ward or team have increased by only 6%. In 2013, almost two in 10 respondents (18%) were unsure whether their ward or team had a minimum nurse-to-patient ratio. In 2014, the percentage had risen to 23%.

It is unclear whether this drop illustrates a lack of communication among organisations with teams and wards regarding minimum ratios. UNISON believes that it is critical that there should be an increase in staff awareness of what the minimum staffing ratios are and make staff aware of any organisational protocols or policies that are in place to address shortages in nurses.
“Having no ward clerk impacts on my work load and although we have high ratio of staff to patient, we are still very busy and not taking full breaks to try and complete care for patients so they feel cared for”.

“We all worked through our lunch and worked over our hours.”

On 4 March 2014, half (53%) of the survey’s respondents worked over their contracted hours. Of those who worked beyond their contracted hours, almost one in five (19%) worked up to 60 minutes extra.

A respondent’s job appeared to have an effect on the amount of overtime they worked. Almost twice as many staff nurses reported working overtime (46%) than healthcare assistants (26%).

The following graph shows the percentage of respondents in each role who reported working any overtime as well as the percentage who worked for more than an hour.

Again, mirroring last year’s results the overwhelming majority of this time was unpaid. Only 3% of respondents reported that they were paid for their overtime. These figures represent an improvement from the survey conducted in 2013, where 93% of respondents worked overtime and only one in 10 reported having been paid for it.

It should be noted that there were not many respondents for all of these roles. There were fewer respondents working as a matron, nurse manager, midwife or health visitor, which may account for the higher percentages.

The majority of respondents were also unable to take all of their breaks. Three out five respondents (58%) skipped some or all of their breaks during their shift on 4 March.
2014. This figure mirrored last year’s 2013 survey where 59% of all respondents reported not being able to take all their breaks.

“No one got their break.”

“I didn’t get a break due to staffing issues, which is becoming a regular occurrence”.

When we looked at staff roles that did not have time to take any breaks, nearly a quarter of all nurses (22%) and 17% of HCAs/APs/HSWs identified being in this category. The highest percentages by role were nurse managers (50%), Midwives (37%), and clinical nurse practitioners (37%).

Did you have time to take your allocated breaks?

<table>
<thead>
<tr>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurse</td>
</tr>
<tr>
<td>HCA / AP</td>
</tr>
<tr>
<td>Ward Sister / Charge Nurse</td>
</tr>
<tr>
<td>Matron (only 11)</td>
</tr>
<tr>
<td>Nurse Manager (31)</td>
</tr>
<tr>
<td>Health Visitor (only 14)</td>
</tr>
<tr>
<td>Matron (only 11)</td>
</tr>
<tr>
<td>Nurse Manager (31)</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

UNISON has continuously highlighted that nursing staff are delivering the best care they can in an environment of dwindling resources. UNISON and external academic research has continued to demonstrate the link between a well motivated workforce and better patient outcomes1. UNISON surveys, including this one, over the last 12 months have identified staff in the NHS working unpaid hours, a decreasing morale among the NHS workforce and staff skipping their rest and meal breaks due to lack of staff and inadequate skills mix on wards.

1 The Effectiveness of Health Care Teams in the National Health Service – Aston University - homepages.inf.ed.ac.uk/jeanc/DOH-final-report.pdf
“I am the only qualified nurse on a 13 hour shift, so I don’t get a break during these shifts. You get tired. It’s unsafe.”

Furthermore, any individual who feels unsupported, unrecognised and uncared for themselves cannot deliver the highest quality of care they are capable of. Feeling burnt out, ignored and neglected does not aid anyone’s motivation – except to motivate them to escape the situation.

“The situations faced by nurses in my trust on a daily basis are causing increasing stress and nurses are actively looking to change jobs or are going off on long term sick due to stress related illness. Nurses are not getting breaks and are often working past their finish time just to get through their daily work. I feel this is becoming the expected rather than the occasional odd overtime.”

It continues to be of great concern to UNISON that healthcare staff are not able to take their breaks and are still working overtime without pay. UNISON understands that sometimes patient safety will require staff to work some overtime, and supports flexible working patterns to allow for such necessary but unpredictable events.

It is dangerous to the health of employees to work extended periods of time without breaks. As this survey has highlighted the number of nursing family staff working longer shift patterns is on the increase and staff should not be expected to work an 8, 10 or 12 hour shift without adequate break(s). All workplaces need to be in line with the Working Time Regulations, both for the sake of the staff as well as the patients. Patient safety is clearly more are risk if they are in a ward where the staff are overworked and have not taken their statutory rest breaks. This result was even more alarming because we asked respondents if the 4 March 2014 was a typical day in their workplace/organisation and a vast majority of respondents deemed the 4 March 2014 to be a ‘typical’ day.

“This was a typical day in a receiving unit. We were short staffed. I left work late and we didn’t get all our breaks. I am stressed from all the above plus constantly being given an unrealistic timescale to move patients out the ward so new patients can come from A&E before targets get breached.”

“Unable to take adequate breaks.”
Bank and agency staff

“I was totally exhausted at the end of the shift, doing a job that is meant for two people due to staff sickness.”

“I was moved out of my regular theatre and into another theatre due to poor skill mix. This only moved the problem to someone more senior.”

“We were lucky as there was permanent bank staff used within the unit, so these staff know how the unit works. The day unit that copes with patients from endoscopy and theatre was down in the number of staff required which impacted on smooth running of ours and theatre staff lists, this is a frequent event and not isolated to today.”

Bank and/or agency staff are often used within organisations when too few permanent staff are available. UNISON has always supported the use of bank and/or agency staff for when the unexpected happens and a shift is left with too few staff as this can be both unfair and unsafe for both patients and staff.

UNISON does not however, support the use of bank or agency staff as a regular replacement for vacancies or long term absences/leave, which is a practice that many respondents reported happening in their organisation. A very high percentage (88%) of respondents answered that their employer frequently makes use of bank or agency staff for one or more of the following reasons:

- long term unfilled vacancies (23%)
- chronic short staffing problems (38%)
- permanent colleagues on frequent or long term illness/disability/maternity leave (27%)

Of the respondents who replied that their organisation frequently made use of bank or
Running on empty – NHS staff stretched to the limit

agency staff, the percentages who selected each reason are reflected in the graph below. In this group, a majority of respondents indicated all of the reasons listed above. Respondents were allowed to choose from multiple answers.

From these results it continues to be the case that the addition of bank and/or agency staff does not necessarily solve the problem of understaffing. While it’s unclear why more staff who worked with bank and/or agency staff reported the problems above, what is clear is that employers need to look at other ways of addressing understaffing than regularly using temporary staff that are unfamiliar with the workplace.

“My ward has been recently increased to 14 beds from eight. There are not enough regular staff and we are reliant on inexperienced staff, bank and/or agency staff. This is becoming the norm and is increasingly stressful and dangerous.”

Nearly a quarter (24%) of respondents reported that they worked with one bank and/or agency staff member and 19% of respondents indicated that they worked with between two and five bank and/or agency members of staff. Mirroring last year’s survey, of respondents who worked with multiple bank/agency staff on their shift, an even higher percentage felt they did not have enough time with patients (73%) or adequate numbers to deliver safe, dignified and compassionate care (70%).

Do your shifts frequently make use of bank or agency staff?

Were there any bank or agency staff working on your shift?

I’m not sure 4.1%
Yes, one 24.2%
Yes, between two and five 19.4%
No 51.4%
Yes, between six and ten 0.8%
Yes, more than ten 0.2%
“More than 60% of the permanent staff have either resigned or left the ward and there have been no replacements. Some shifts are now 100% bank staff.”

“This is happening everyday now; on another secure ward they were operating with four staff, two of which were bank, just one qualified and two patients on 2:1.”

“There are staffing shortages and my trust relies on bank, overtime and agency workers and does not increase staff numbers on a permanent basis. This increases risks and continuity of care.”

The overuse of bank and agency staff to plug the gaps on wards with long-term unfilled vacancies and wards reporting chronic short staffing problems is a false economy and is a strong indication that the established staffing levels are inadequate.

UNISON continues to highlight this ineffective strategy. The continuous use of bank and/or agency staff can be an indication of staff turnover but also it proves to be an ineffective saving, firstly due to the cost per shift for the agency member of staff and secondly the supervision they require which results in the lack of continuity of care.

UNISON recognises that bank and agency staff do play a vital role in plugging gaps in temporary staffing issues however they should never be used to fill what in effect should be a substantive post, as this leads to a cycle of poor workforce planning and management.
Raising concerns

“We were relentlessly badgered by bed managers. This could cause unsafe discharges due to the pressure put on us. They constantly phone the ward and turn up on the ward expecting staff to drop everything they are doing to give them undivided attention. If they left us to continue with our work we will be able to sort out the discharges (safely) and a lot quicker.”

Many respondents wrote about poor staffing levels in their workplace, raising concerns and then when they speak up about unsafe staffing levels their concerns were not acted on. This survey highlights that over half of respondents (51%) felt that they were not at all confident, not very confident or only somewhat confident to raise a concern at work.

The survey’s comments sections were filled with examples of chronic understaffing and the increased risk of errors occurring due to staff not having enough time with each patient and not being able to deliver elements of care because of lack of time. For the second year running many of the comments included counting supernumerary staff in official staffing levels, achieving a particular minimum staff ratio with student or unfamiliar bank/agency staff.

“I felt that I was being bullied to take extra patients from A&E. As a staff nurse, we have no say in refusing extra patients, even when we feel our patient’s safety and care is being compromised. In reality we are not allowed to be the patient’s advocate.”

“I feel our ward is often run on unsafe staffing levels. Management seem to think a safe staffing level applies to every ward and say things like if other wards can manage so can we. However, this isn’t the case because most of our patients have very high dependency levels. We have patients that need to be monitored closely following procedures or during therapy, with many needing to be checked on an hourly basis. That cannot be done when there is a ratio of one nurse to 11 patients.”

“During the 12 hours I was on, I walked nine miles, according to my pedometer. Another staff nurse and I shared 12 patients. I felt that we did not have enough time to care for them as well as possible. I am leaving this ward soon and I am glad as every shift, including this one, leaves me exhausted, mentally and physically. I am currently breastfeeding and...”
my charge nurse encourages me to take extra breaks to express but I was not able to do that and even missed usual breaks because we were so busy. However, the level of business is normal for this ward and in my opinion is unsafe.”

UNISON condemns bullying, harassment and victimisation in the workplace, and all members are asked to report incidences of workplace bullying, harassment and victimisation to their local UNISON representative.

UNISON members and activists are encouraged to use the Be Safe pack in the event that they are put in an unsafe working condition. This pack provides guidance on where to go for help, how to report problems effectively and how to use the Nursing and Midwifery Code of Conduct⁹ to maintain professional responsibility. It can be accessed either from the local UNISON branch or on the website at unison.org.uk/at-work/health-care/key-issues/be-safe/home. The pack includes copies of this report, as well as Be Safe reporting forms for branches and small credit card sized advice cards, with details of how to raise concerns.

The Be Safe training is now being rolled out across all regions and we are encouraging health branches to work in partnership with their organisations to jointly endeavour to deliver this training to as many members of NHS staff as possible. You can get details of this training from your local, area or regional UNISON organisers.

1  Nursing and Midwifery Council, 2010, The Code
Blame culture

“Concerns raised with ward manager and duty sister but to no avail.”

“I was doing a bank shift. However, it was in an area I had previously worked and had moved from because of my concerns about staffing levels. The nurse to patient ratio involved employing more health care assistants and less qualified nurses. I am glad I moved.”

“We have no support from our team leaders/managers. We have written a letter stating our concerns and were basically made to feel guilty for “complaining” when others are worse off than ourselves.”

People who respond to the survey continue to highlight that they are made to feel guilty for raising concerns and are still aware that their employers would not be held to account for any mistakes contributed to by unreasonable workloads or lack of staff.

A blame culture continues to exist in the health service. Respondents felt they would be held completely accountable for all mistakes, regardless of any contributing circumstances. Respondents reported feeling stressed and that their workloads were becoming overwhelming. The survey also highlighted a lack of support at senior levels from staff reporting concerns and identified increasing levels of sickness in organisations, as staff become overburdened and worn out.

UNISON continues to monitor these trends and calls on all NHS organisations to do more to ensure that a ‘no blame’ culture exists within the NHS and that staff should be able to raise concerns without feeling guilty and that their concerns will be listened to and acted on.

Clearly nursing family staff, in all different areas of nursing, are under increasing amounts of pressure and an organisation that does nothing or little to deal with a negative blame environment, will have repercussions in the negative impact this is likely to have on staff morale, their confidence to raise concerns in their first instance and the lowering quality of patient care delivered in that organisation.
Conclusions

"By reducing staffing levels the standard of care is set to fail."

The survey results show a continued problem with understaffing which exists nationwide, meaning that patient care is suffering across the country.

On a randomly selected day the overwhelming feedback revealed that there were not enough staff available to deliver all elements of safe, dignified and compassionate care, as a result of which, care was left undone. The concerns were evenly divided across all groups, regions, shifts, roles organisational types, fields and so forth.

Both British and international research show that low nurse-to-patient ratios are linked to high patient mortality rates.

Only half of respondents felt their shift had the right skill mix. Many supplemented this with the explanation that healthcare assistants are being told to take on nurse responsibilities without either appropriate training or pay. Bank and agency staff are being used to cover long term vacancies, resulting in teams which can’t make the best use of each member.

UNISON believes that there should be a legally enforceable minimum nurse to patient ratio. We support and recognise the role which workforce tools have to play in helping organisations to identify the right levels for their organisation but the use of these must be mandatory and in the absence of this the default position should be a legal minimum.

Almost 92% supported minimum staffing levels, with 65% supporting a legally enforceable minimum.

Over half of respondents (58%) reported working overtime and through their breaks. Although UNISON recognises that flexibility is necessary at times in a healthcare environment, we strongly disagree with what appears to be an institutional practice that takes advantage of workers who put their patients’ needs before their own.

66% reported inadequate time to spend with patients and that as a result 55% stated that care was left undone.

Almost half (41%) of respondents were looking after eight or more patients for the duration of their shift, this increased to 53% on night duty. UNISON believes that looking after eight or more patients should be an automatically reportable incident if the person isn’t able to deliver the care which is required for that patient.

51% of respondents felt unconfident in raising concerns locally, which in a post Francis era is deeply worrying.

Despite the National Quality Boards guidance only 24% of workplaces displayed indented numbers of staff on duty. While they have until June to undertake this UNISON found it surprising that not more areas met this requirement already as it takes little effort – unless your numbers are routinely below those which are needed to meet care requirements.

Most worrying was that 31% of respondents stated that they were at risk of a situation similar to Mid Staffs developing in their organisation. 17% said it was already happening in isolated areas or across the organisation.

Almost 92% supported minimum staffing levels, with 65% supporting a legally enforceable minimum.
Appendix 1

### Nurse to patient ratios on 4 March 2014 survey

Welcome to UNISON’s nursing ratios survey. The ratio of nurses to patients (how many patients there are per nurse, in other words) is an issue of utmost importance to patient safety, staff welfare and the service as a whole. International research as well as common sense tells us that the ratio of nurses to patients is going to have an effect on patient care.

In most areas of healthcare in the UK there are no set minimum nurse-to-patient ratios. A few areas (such as ITU and A&E) have set minimum ratios and some departments or Trusts choose to set their own, but most areas operate without set minimum ratios.

Thanks for taking the time to record your organisation’s nurse-to-patient ratio on 4 March 2014 and filling in this survey. This is our second year running this type of ‘spot test’ and we want to know what has or has not changed. With your help, UNISON can continue to tackle this important issue.

Please note that this survey is about your experience on 4 March 2014. If you fill it in before 4 March we will not count your response on the assumption that you are not a time traveller.

The survey will take about 15 minutes to complete. It’s not mandatory to fill in every question, but it will help us if you do!

**1. Did you work on 4 March 2014?**

- [ ] Yes
- [ ] Yes, but I worked in a new/different role or workplace than usual
- [x] No
1. First, a few questions about your work. The information you enter will be kept confidential and completely non-attributable. No one will know what you enter here. What is the name of the organisation that you work for?

2. How would you best describe the organisation that you work for?

- Acute Trust
- Care home
- Community Services Trust
- GP Surgery
- Learning Disabilities
- Mental Health Trust
- NI Health and Social Care Trust
- Private Sector provider
- Scottish Health Board
- Welsh Health Board
- Other (please specify)

*3. What region is your organisation in?

- Eastern
- East Midlands
- Greater London
- Northern
- Northern Ireland
- North West
- Scotland
- South East
- South West
- Yorkshire & Humberside
- Cymru/Wales
- West Midlands
4. What is your role?

- Staff Nurse (General)
- Staff Nurse (Mental Health)
- Ward Sister / Charge Nurse
- Clinical Nurse Specialist / Nurse Practitioner
- Matron
- Nurse Manager
- Health Care Assistant / Assistant Practitioner / Support Worker
- Health Visitor
- Midwife
- Student Nurse
- Other (please specify)

5. Are you a UNISON member?

- Yes
- Yes and I’m also a workplace representative or activist
- No and I belong to another union
- No and I don’t belong to any union
Your shift on 4 March 2014

The following questions will help us get an accurate picture of how your ward/unit/department was staffed on 4 March 2014. If you have anything additional to add, there is a text box at the end of the survey in which you can write.

Did you work night shift? If yes, please record the shift during which more hours fell on the 4th. This means if you work 22:00 - 6:00, then you should record the shift on 3/4 March. Or if you work 18:00 - 03:00, then record the shift on 4/5 March.

Did you work night shift on both 3 and 4 March? Choose one of the two shifts to report about.

1. On 4 March 2014, which shift did you work?
   - Early (ie 07:00-15:00 or 06:00-14:00, etc)
   - Late (ie 12:00-20:00 or 15:00-22:00, etc)
   - Long Day (ie 11:00-23:00 or 09:00-20:00, etc)
   - Night
   - Not shift working, ie Outpatients or Community, etc
   - Did not work (ie sickness, day off, annual leave, maternity, etc)
   - Other (please specify)

2. How many hours is that shift contracted to be?
   - Fewer than 5 hours
   - 5 - 5:59 hours
   - 6 - 6:59 hours
   - 7 - 7:59 hours
   - 8 - 8:59 hours
   - 9 - 9:59 hours
   - 10 - 10:59 hours
   - 11 - 11:59 hours
   - 12 - 12:59 hours
   - 13 or more hours

3. Did you work longer than those hours? Please tick all that apply.
   - I worked my contracted hours and no more
   - Additional time, fewer than 30 minutes
   - Additional time, between 30 and 60 minutes
   - Additional time, between 1 and 2 hours
   - Additional time, more than 2 hours
   - This time was unpaid
   - This time was paid
4. Did you have time to take your allocated breaks?

- I had all my breaks
- I had some of my breaks
- I did not have time to take any breaks
- My shift did not include a break because it was shorter than 6 hours

5. What type of ward/field were you working in on 4 March 2014? Please tick as many as apply

- A&E
- Care of the Elderly
- Children
- Community (including District Nursing and Health Visiting)
- Community Mental Health (including Early Intervention Team, CAMHS, Forensic)
- Critical Care
- General Practice (including Trauma)
- Learning Disabilities
- Medical (including Orthopaedic)
- Mental Health: Inpatient
- Mental Health: Secure Unit (including Low, Medium and High)
- Obs & Gynae
- Surgical
- Rehabilitation
- Theatre
- Other (please specify)
1. Did you or a colleague count and record the exact nurse to patient ratio on your shift on 4 March 2014?
   - Yes, I know the exact ratio
   - No, but I paid close attention and am almost certain I know the accurate ratio
   - No, I am estimating based on what I remember from this shift
   - No, I am estimating based on a typical shift

2. What was the nurse to patient ratio on your shift on 4 March 2014?

   This means that for every 1 nurse, how many patients were they taking care of? (For example if on your shift there were 2 nurses and 12 patients, the ratio would be 1:6.)

   - 1:1
   - 1:2
   - 1:3
   - 1:4
   - 1:5
   - 1:6
   - 1:7
   - 1:8
   - 1:9
   - 1:10
   - 1:11
   - 1:12
   - 1:13
   - 1:14
   - 1:15
   - 1:16
   - 1:17
   - 1:18
   - 1:19
   - 1:20
   - More than 1:20

3. If you DO NOT work on a ward, what was your caseload on 4 March 2014? Please note this question requires a numerical answer and will not accept letters.
4. Were there any bank or agency staff working on your shift?

- Yes, one
- Yes, between two and five
- Yes, between six and ten
- Yes, more than ten
- No
- I'm not sure

5. Do your shifts frequently make use of bank or agency staff? Please tick all that apply.

- Yes, due to long-term unfilled vacancies
- Yes, due to chronic short staffing problems
- Yes, due to permanent colleagues on frequent or long-term illness/disability/maternity leave
- Yes, due to other reasons
- Occasionally, when no one can cover a colleague's absence
- Rarely
- Never

6. Did you feel that you had an adequate amount of time to spend with each patient?

- Yes
- No
- I'm not sure

7. Were there elements of care that you could not provide because you didn’t have time?

- Yes
- No
- I don’t know

If yes, please give an example:

8. Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?

- Yes
- No
- I'm not sure
9. Did you feel that there was an adequate skill mix on this shift?
   - Yes
   - No
   - I'm not sure

10. How confident are you that a similar situation as the care failings at Mid Staffs could never happen at your trust?
   - Very confident, a situation similar to Mid Staffs could never happen at my trust
   - Fairly confident, a situation similar to Mid Staffs is unlikely to happen at my trust
   - Not very, we are at risk of a situation similar to Mid Staffs developing
   - Not at all, it's already happening in isolated parts of the organisation
   - Not at all, it's already happening across the organisation
   - Don't know

11. In your opinion, was this a typical shift? In other words, did everything run as usual or were half the staff off sick or was the unit filled with additional staff due to a recent massive accident, etc?
   - It was slow.
   - It was typical or as busy as normal.
   - It was unusually busy.
   - I don't know because I haven't worked there long enough to tell what's typical.
   - It was not a typical day because:

12. Is there anything else you would like to add about the shift?
### Your place of work (ward/unit/etc)

1. **Does your clinical workplace openly display information about the staff on duty?** Tick all the answers below which your workplace does:
   - [ ] My workplace displays the intended numbers of staff on duty.
   - [ ] My workplace displays the actual numbers of staff on duty.
   - [ ] My workplace displays the skill mix of staff on duty.
   - [ ] My workplace displays information about staff on duty in an easily accessible place for patients to see.
   - [ ] My workplace writes the name of the nurse looking after each patient by their bed.
   - [ ] I work in a community or other setting where this is not applicable.
   - [ ] Other (please specify)

2. **Does the ward or team that you work on have set minimum ratios for nurses to patients?**
   - [ ] Yes
   - [ ] No
   - [ ] I'm not sure

3. **If yes, what is the minimum nurse-to-patient ratio for your ward or team? (For example if there are 2 nurses for every 12 patients, the ratio would be 1:6.)**
   - [ ] 1:1
   - [ ] 1:2
   - [ ] 1:3
   - [ ] 1:4
   - [ ] 1:5
   - [ ] 1:6
   - [ ] 1:7
   - [ ] 1:8
   - [ ] 1:9
   - [ ] 1:10
   - [ ] 1:11
   - [ ] 1:12
   - [ ] 1:13
   - [ ] 1:14
   - [ ] 1:15
   - [ ] 1:16 or higher
4. Are the set nursing staffing levels in your organisation flexible and easily altered to take account of patient dependency?
   - Yes
   - No
   - I don't know

5. If there is a shortage of nurses, is there a workplace protocol/policy that addresses this?
   - Yes
   - No
   - I'm not sure

6. If you answered yes to the previous question, have you had cause to use it?
   - Yes
   - No
   - I'm not sure

7. If you answered yes to the previous questions, were your concerns listened to and acted upon swiftly?
   - Yes
   - No
   - I'm not sure

8. If you felt you had to raise a concern at work, how confident would you feel doing it?
   - Very confident
   - Fairly confident
   - Somewhat confident
   - Not very confident
   - Not at all confident

9. Would you feel more or less confident raising a concern at work now compared to last year at this time?
   - More confident raising a concern this year than last.
   - More confident raising a concern last year.
   - Equally confident (or not confident) both years.
   - I don't know.
# Staffing ratios - a good or a bad thing?

1. **UNISON supports organisations to use best practice guidance to set their own staffing levels, and also supports a legally-enforced minimum nurse-to-patient ratio that organisations must comply with in the event they fail to achieve best practice staffing numbers. Do you agree with this position?**

- [ ] Yes, I agree that organisations should set their own staffing levels but ultimately be required to maintain a minimum ratio.
- [ ] No, I think organisations should be told what staffing levels they are required to have, and not be able to change them.
- [ ] No, I think organisations should be able to set their own staffing levels without a legally enforced minimum they must adhere to.
- [ ] I don’t know
- [ ] Other (please specify)

2. **Do you believe that minimum ratios should be set for healthcare assistants to nurses?**

- [ ] Yes
- [ ] No
- [ ] I’m not sure

3. **Is there anything else you would like to add? Have you had any experiences with staffing ratios that you would like to describe?**
### About you

1. Do you identify as a...
   - Woman
   - Man

2. Is your gender identity the same as the sex you were assigned at birth?
   - Yes
   - No

3. Do you have a disability?
   - Yes
   - No

4. How do you describe yourself?
   - White British / English / Scottish / Welsh / Northern Irish
   - White Irish
   - White Other
   - Black British / English / Scottish / Welsh / Northern Irish
   - Black Caribbean
   - Black African
   - Black Other
   - Mixed or multiple ethnic groups
   - Asian British / English / Scottish / Welsh / Northern Irish
   - Indian
   - Pakistani
   - Bangladeshi
   - Chinese
   - Filipino
   - Asian Other
   - Arab
   - Prefer not to answer
   - Any other background
5. What is your age?

- Under 27
- 28 - 35
- 36 - 50
- 51 - 66
- Over 67
Thank you for taking the time to complete this survey! Your time and contribution will help us understand what the situation looks like nationally – and then UNISON can begin to tackle the issue of low staff-to-patient ratios.

If you have any further questions, please don't hesitate to contact the UNISON Health Group by emailing health@unison.co.uk. You can also visit us on our website at http://www.unison.org.uk/healthcare. If you are not a member of a trade union and would like more information about joining UNISON go to http://www.unison.org.uk/membership/.

1. We'd like to ask you for your contact details in case we have any questions about the day. These details will be kept confidential and used only for this purpose.

<table>
<thead>
<tr>
<th>Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Telephone:</td>
<td></td>
</tr>
</tbody>
</table>

2. Would you like to be kept updated on our campaign by email?

- [ ] Yes
- [ ] No

3. It can be really helpful to members to read about similar situations in other workplaces. Would you be willing to be contacted by us to share your story as a UNISON case study? If we contact you, you can specify that you want the case study to be anonymous.

- [ ] Yes, I don't mind being contacted.
- [ ] No, please do not contact me.
Running on empty – NHS staff stretched to the limit
UNISON has more than a million members delivering essential services to the public. Services that protect, enrich and change lives.

We want to see changes that put people before profit and public interest before private greed. Join our campaign to create a fairer society.

To find out more go to unison.org.uk/million

Join UNISON online today at unison.org.uk/join
or call 0800 171 2193