UNISON’s staffing levels survey 2015

RED ALERT
UNSAFE STAFFING LEVELS RISING
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Foreword

It could be said that much has changed over the last four years since UNISON first started conducting this unique survey. However, most of that change has taken place internationally, with little impact being felt by front line nurses and midwives in the United Kingdom.

We have seen minimum nurse-to-patient ratios in other countries, notably Australia and the USA. Hard won ratios in these countries have continued to come under political interference, with state governments seeking to turn back the tide of achievement.

There is no doubt in UNISON members’ minds that a national minimum ratio should be set and legislated for. There has to be a level of care below which standards must not fall.

Every day, nurses and midwives are having to ration care, to decide on a shift by shift basis what care remains left undone. This is not a position they wish to be in, nor one of their choosing. Furthermore, despite working through their breaks and staying beyond the end of their shift on 10 February, they still did not have enough time to deliver the care which they felt patients needed.

Almost 45% of respondents told us that during their shift on 10 February there were insufficient levels of staff on duty to deliver dignified and compassionate care. It became worse as 43% described the organisation that they were working for on that day as being at risk of a serious care failing or that it was already happening in isolated parts or across their organisation.

I witnessed first hand late last year the daily pressures which nurses are under. As a patient, I saw them regularly put their own wellbeing at risk by working through their breaks to ensure that the needs of their patients came first. There was no sitting down, no real time to talk to patients, and all too often agencies were unable to provide the staff to care for a frail, elderly and confused person.

The sad reality is that the National Institute for Health and Care Excellence (NICE) guidance on safe staffing in an acute sector does not have the trust and confidence of front line nurses and midwives. At such an early point in its introduction it is already failing them.

For patient care to be delivered safely and effectively – and for staff to have a safe working environment for them and those in their care - government, politicians and leaders need to introduce minimum ratios urgently and without delay.

If we are to be the good ancestors of our profession, to ensure that it is fit for purpose and remains one which others aspire to be part of, we must not leave the next generation with a legacy of understaffing and low morale. If you need a stronger reason than this, look at the quotes from front line staff who worked on that day, which are included in this report.

The cuts which the NHS is currently being expected to make are detrimentally affecting patient care and service provision. Everything that can be cut has been cut. We have the opportunity to decide to create a fully funded health and social care system which meets the needs of those seeking its service and care. UNISON is clear that this is the only way forward.

Gail Adams
Head of Nursing UNISON

Ann Moses
Chair of UNISON’s Nursing and Midwifery Committee
Background

There is a lack of hospital capacity in terms of bed numbers and safe staffing levels. The country’s population has increased to 60 million yet the NHS bed base/capacity has been reduced. We have fewer frontline nurses who work in acute trusts than ever before. There are fewer beds as managers have shut desperately needed wards down for “efficiency savings.”

We’re desperate.” – Ward sister/charge nurse

UNISON is the largest public sector union in health with 450,000 members employed across the service. We represent members in jobs across 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. Two years 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.

There is no doubt that this government has presided

over the largest amount of economic cuts, made worse by the speed at which the cuts were made. Despite their rhetoric that the NHS was ring fenced and safe in their hands, the reality has been the complete opposite. The effect of this has been that NHS staff feel unable to deliver safe, dignified and compassionate care, despite their best efforts.

This survey is now running in its fourth 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’ staffing levels in place on a single, ‘typical’ 24 hour period for staff across the UK. This is the fourth year UNISON has run this survey and from across all four countries it asks what work was like on this day, Tuesday 10 February 2015, and what can we learn from the circumstances that nursing staff are facing. We received 5,100 responses (the largest response to date), 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.

Executive summary

“\textbf{The government should put patient care before money. We have positions to be filled, but it is not being done due to the use of bank staff. It is as though the system is using a ‘pay day loan’ attitude which is more expensive in the long run.}”
– Staff nurse (learning disabilities)

UNISON expected the results of this year’s survey to be more positive and to have indicated significant improvements in safe staffing levels because of the government’s claims that it has increased nursing numbers, the issuing of NICE guidance for safe staffing levels in acute settings in England, and the Francis, Keogh and Berwick recommendations to improve staffing levels.

However, when comparing previous year’s survey results with the 2015 results, it is clear that there has been no improvement in safe staffing levels. Still many nurses and health care assistants are having to care for eight or more patients – the ratio that research tells us it is when harm is occurring – on their shift. It’s unacceptable when elements of care are being left undone. This is despite staff working through all or some of their breaks and doing unpaid overtime on 10 February.

To ensure safe staffing levels, nationally set mandatory minimum nurse-to-patient ratios should be identified. This is essential because many of the “red-flag” events raised by staff under the NICE guidance have not been acted upon. NICE should immediately review its guidance to assess compliance with recommendations and the effectiveness of “red-flag” events.

Politicians would be foolhardy to underestimate the strength of feeling among nurses at all levels on this important issue. This is an opportunity for politicians to put the NHS and patient care front and centre by committing themselves to the introduction of nationally set mandatory minimum nurse-to-patient ratios.
Red alert – unsafe staffing levels rising
UNISON staffing level survey

Summary of main points

“As a student nurse I am not supposed to be taken into account with the staff numbers. However, on every ward I have worked on I have been used as a carer, working for free. Student nurses are used by staff on wards as free HCAs and this is very unfair for students and patients. When we qualify we are expected to know what to do as a nurse, but we don’t because we are used as carers and not allowed to follow staff nurses around. This is dangerous for our future patients. This situation and low staffing levels have put me off being a staff nurse. I would not encourage anyone to become a nurse and I wish I had chosen another patient based career.” – student nurse

Two-thirds of respondents reported that 10 February 2015 was a ‘typical’ day at work. The survey response rate was one of the highest in the four years that the survey has run, with 5,100 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.

Worryingly, the survey results from respondents working a ‘typical shift’ on 10 February 2015 mirrored many of the same results from the survey conducted 12 months ago, highlighting no significant changes in the areas around patient care.

Key findings

• 88% of respondents support nationally set mandatory minimum nurse-to-patient ratios

• 49% reported not having an adequate amount of time with each patient

• 65% reported that there was care left undone due to understaffing

• 45% of respondents felt there were not adequate staff numbers to deliver safe, dignified, compassionate care. This is especially worrying in a post Francis era

• 42% were caring for eight or more patients which is deeply concerning given the research that indicates that this is the point at which harm is occurring

• this percentage went up significantly (55%) 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

• 40% of respondents said that they worked with bank or agency staff on their shift on 10 February 2015

• 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

• the fewer patients a nurse was looking after on the 10 February, the better they were able to deliver care

• two years on from the publication of Robert Francis’s recommendations, nearly a third of respondents (31%) reported their organisations were at risk of a serious care failing developing and 12% of respondents indicated that care failings similar to Mid Staffs were happening in isolated parts of or across their organisation

• 37% of respondents worked over their contracted hours with 75% of those respondents working up to an hour of additional time – only 8% of staff were paid for this extra work. Assuming that they were at the top of band 5 of Agenda for Change, all nurse respondents that worked unpaid overtime are owed a total of £17,628.45, and assuming that they were at the top of band 2 of Agenda for Change, all health care assistant respondents are owed a total of £3,191.58. Staff said that 10 February was a normal day. If this day is replicated over the course of a year, nurses will be owed a total amount of £4,823,814.45 for working overtime for an additional hour a day.

• 70% of staff were unable to take all or some of their breaks that day

• 40% of respondents felt that they were not at all confident, not very confident or only somewhat confident to raise a concern at work, which in a post Francis era is deeply worrying

• 61% of staff that worked on an adult inpatient ward in an acute hospital in England felt that the NICE guidance had not made a noticeable
difference and had not led to improved staffing levels in their organisation since its introduction in July 2014. Seven months on from its introduction, this is deeply worrying.

- Alarmingly, 62% of respondents who had had a nursing “red-flag” event occur on their ward said that the ward was not immediately allocated additional staff. If staff raise “red-flag” events on staffing levels and their concerns are not acted upon, they may be unlikely to escalate them in the future because they could have no trust or confidence in the process.

**Recommendations**

1. Nationally set mandatory minimum nurse-to-patient ratios should be identified. We believe national ratios should be established which reflects the California model and is therefore one which is more proportionate to the type of patient dependency anticipated in those types of environments.

2. Until a minimum is established, NICE should immediately review its guidance to assess compliance with recommendations and the effectiveness of “red-flag” events. In doing this we believe it will establish trust and confidence of staff in the guidance. The NICE guidance should be changed to make caring for eight or more patients an automatic “red-flag” event. In addition to staffing reports, NHS boards should regularly receive data on the number of “red-flag” events, where they occurred, and what action was taken to ensure patient safety.

3. All NHS organisations should establish joint nursing committees at a local level. 50% of its members should be frontline practicing nurses and health care assistants. They should assess the impact of the NICE guidance in their work environment and review all “red-flag” events to ensure learning across the service. UNISON members should automatically report situations when they are caring for eight or more patients and/or when they cannot deliver the standard of care required and/or care is left undone.

4. When reviewing information on staffing levels NHS organisations and boards should also receive reports on bank and agency usage, including as part of workforce planning reviews. This should include data on how much was spent and the types of shifts and departments which require agency staff, and consider in fact whether these units are under established.

5. UNISON believes that NHS organisations should work in partnership with union staff sides, in order to create a culture which encourages staff to raise concerns. Employers should see these as golden nuggets of information which enable them to reflect, review and improve patient care.

6. A non-executive 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.
The evidence

While UNISON nurses and midwives have always sought to use research based evidence to improve and inform care, many government policies have been introduced with little or no reference to this and some without even testing their effectiveness prior to introduction. The Health and Social Care Act 2012 is one such example. The necessity of evidence in this instance seemed more aligned to political will than research.

Many other commentators, including some senior nurses have argued that if you set a minimum it becomes the norm. We do not believe this to be the case. The evidence from California has shown that it is possible and practical to have a ratio set, which differs across different care settings (table 1).

Table 1: Proposed RN ratios by National Nurses United (NNU)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Nurse-to-patient ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive/critical care</td>
<td>1:2</td>
</tr>
<tr>
<td>Neonatal Intensive care</td>
<td>1:2</td>
</tr>
<tr>
<td>Emergency room</td>
<td>1:3</td>
</tr>
<tr>
<td>Trauma patient in ER</td>
<td>1:1</td>
</tr>
<tr>
<td>ICU patient in ER</td>
<td>1:2</td>
</tr>
<tr>
<td>Step down</td>
<td>1:3</td>
</tr>
<tr>
<td>Telemetry</td>
<td>1:3</td>
</tr>
<tr>
<td>Medical/surgical</td>
<td>1:4</td>
</tr>
<tr>
<td>Coronary care</td>
<td>1:2</td>
</tr>
<tr>
<td>Acute respiratory care</td>
<td>1:2</td>
</tr>
<tr>
<td>Burn unit</td>
<td>1:2</td>
</tr>
<tr>
<td>Other speciality care units</td>
<td>1:4</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>1:4</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>1:5</td>
</tr>
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</table>

In setting a minimum, UNISON nurses are simply stating that there should be a level below which standards should not fall. Francis⁴, in his report into the care failings at Mid Staffordshire Foundation Trust, used this phrase in various parts of his report to cite standards against patient care outcomes or experiences.

Australian staffing ratios have led to safer care and motivated nurses; “in the 13 years since the legislation was introduced in Australia⁵, the state of Victoria has seen an increase of 10,800 nurses and midwives working in public health system, more people are being treated and a motivated nursing workforce can deliver safe, reliable continuity of care”. Commenting on the publication of the NICE guidance, Lisa Fitzpatrick, Secretary of the Victorian branch of the Australian Nursing and Midwifery Federation said: “The NICE guidance will never be implemented without a legal obligation.” In the article she describes the struggle and financial pressures faced by organisations saying that because of this “if it is not mandated it simply will not happen.”

Lisa’s comment regarding the NICE guidance was echoed in our survey results this year. Despite the NICE guidance highlighting the impact of caring for eight or more patients on the 10 February 2015, 42% of respondents were in that very position of looking after eight and more patients during their shift.

Jane Cummings, Chief Nursing Officer for England said in an article in the Nursing Standard:³ “There has been debate about whether there should be defined staffing ratios in the NHS; my view is that it missed the point. We want the right staff with the right skills in the right place at the right time. There is no single ratio or formula that can calculate the answers to such complex questions.” Neither UNISON nor our members dispute the importance of much of the above statement, regarding people, time and place. Nor are our members saying that there should be one single ratio universally applied across all settings. Just like the model in California (table 1), minimum staffing levels would differ depending on the care setting.

What is more alarming among senior nurses is the reluctance to test the theory of nurse-to-patient ratios. Surely if we firmly believed in research based evidence, we would test to see if in a real terms setting a mandated minimal level of nurses is detrimental to patient care. The overwhelming majority in the UK are already convinced of this benefit from international evidence. However, they would be prepared to participate in a pilot it if reassured and provided an evidence base in the UK.

1 Francis report

What also might the impact of devolution be on this issue? Kirsty Williams AM is calling for a ratio of no more than one nurse to seven patients in Wales. The Safe Nurse Staffing Levels (Wales) Bill also calls for ward managers to be excluded from the ratios eg supernumerary and for a skill mix of 60 – 40 of registered nurses to healthcare assistants.

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.

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 medicine and surgery 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. The same is true in the UK, it’s always been an employer’s responsibility to ensure staffing levels are suitable for patient care. However, many have failed to date to achieve this, placing both patients and staff in vulnerable positions.

Current active campaigns led by NNU nurses are seeking to achieve state legislation in the District of Columbia and the states of Florida, Missouuri, Massachusetts, Illinois and Pennsylvania.

4 http://www.senedd.assembly.wales/mgConsultationDisplay.aspx?ID=143
5 The New South Wales Nursing Association became the New South Wales Nursing and Midwifery Association in 2012
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 studies including the 2009 Boorman Review into NHS Health and Wellbeing, 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.

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 journey. 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.

In November 2013, the National Quality Board published guidance on staffing levels, workforces tools can play a very important role. However, in the absence of them being a mandatory requirement UNISON would argue that national minimum nurse-to-patient ratios should be the default position.

Our members and many other nurses would argue strongly that a mandated minimum is better in many instances than their current workforce numbers.

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%.

**Research evidence**

The registered nurse forecast (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 is associated with a 7% increase in patient mortality. Safe Staffing Alliance, March 2014, Jane Lawless

Workforce tools can play a very important role. However, in the absence of them being a mandatory requirement UNISON would argue that national minimum nurse-to-patient ratios 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.

In November 2013, the National Quality Board 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 forecast (RN4Cast) published in the Lancet in February 2014 was the most comprehensive study in some time looking 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 in a shorter time frame and to manage the movement on and off of the ward.”
Almost two-thirds (62.3%) of respondents in Scotland and Wales said that mandatory workforce planning tools to set staffing levels did not make a noticeable difference and did not lead to improved staffing levels in their organisation (table 2).

<table>
<thead>
<tr>
<th>County</th>
<th>Patient number</th>
<th>Registered nurse number</th>
</tr>
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<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>
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</tr>
<tr>
<td>Switzerland</td>
<td>7.8</td>
<td>1</td>
</tr>
<tr>
<td>England</td>
<td>8.8</td>
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</tr>
<tr>
<td>Belgium</td>
<td>10.8</td>
<td>1</td>
</tr>
<tr>
<td>Spain</td>
<td>12.7</td>
<td>1</td>
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Over the last four years, 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 makeup 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 and Wales**

In April 2013, Scotland introduced mandatory nursing workforce planning tools with the aim of helping health boards to plan for the number of staff they require in a variety of service settings. The tools use statistical analysis to calculate the whole time equivalent (WTE) for current workload.

In April 2014, Wales introduced a suite of acuity workforce tools for organisations to locally determine the required nurse staffing levels at any given time. However, at the time of writing, the Welsh Assembly are debating the Safe Nurse Staffing Levels (Wales) Bill, which will maintain minimum staffing levels for adult inpatient wards in acute hospitals in the first instance. The Bill was introduced on 1 December 2014 by Kirsty Williams AM following her success in a legislative ballot in December 2013. UNISON Cymru/Wales responded to a consultation on the draft Bill.

UNISON welcomed the implementation of mandatory workforce planning tools in Scotland and Wales. If properly implemented and supported, the tools can help members to make the case for additional clinical resources at times of increased demand and peak acuity. However, we are concerned that the tools are not intuitive enough to ensure that sudden changes in workload or clinical pressure are identified and responded to quickly enough.

Local managers, staff and unions will need to commit to working together if the tools are to deliver what they originally promised.

Furthermore, although mandatory workforce planning tools have led to a rise in the size of the NHS workforce in Scotland, the vacancy rate for nurses and midwives is getting worse year-on-year. The total number of nursing and midwifery vacancies in December 2014 was 2,088 – a vacancy rate...
of 3.4% – compared to 1,514 WTE vacancies in December 2013 – a vacancy rate of 2.5%.\textsuperscript{11} It is not clear whether the increase in vacancies is due to a lack of supply of nurses and midwives in Scotland, or whether health boards are keeping posts vacant to reduce costs. Nevertheless, these vacancies need to be filled to ensure that the mandatory staffing tools deliver what they originally promised.

**Displaying staffing levels in England**

From April 2014, all hospitals in England were required to publish information about the number of nursing and midwifery staff working and planned to work on each ward.

A survey conducted by Nursing Times found that 39.7% of respondents felt that the new rules on staffing transparency introduced by NHS England had a negligible impact with staffing levels remaining the same. Because 44.6% of respondents said that it was not applicable to them, this means the majority said it had a negligible impact.\textsuperscript{12}

This is mirrored by respondents to our survey. Only four in 10 (40%) of respondents in an acute trust in England said that their organisation displayed the intended and actual level of staffing. Therefore, even though the requirement has been in place for a year, it is clear that many organisations are not displaying information as required.

However, UNISON believes that there is a risk of gathering utterly meaningless data. Because the requirement does not include any guidelines on what safe staffing means, people will not be able to make sense of the data. In a post-Francis world, organisations should not just be assessing numbers of staff in relation to planned staffing levels but also relative to the number of patients.

**NICE guidance on NHS safe staffing levels falls short**

In July 2014, the National Institute for NICE issued guidance\textsuperscript{13} on safe staffing for nursing in adult inpatient wards in acute hospitals in England. The guidance was commissioned by the government in response to recommendations in the Francis inquiry into the mid-Staffordshire NHS trust. NICE recommended a systematic approach to matching nurse staffing to patient need.

While it is recognised that the guidance was only issued in July last year, it is never too early to review the guidance in order to get an idea of how effective it is at ensuring safe nurse staffing levels. Therefore, we used the survey as an opportunity to find out how effective the guidance is at achieving its aims.

Almost two-thirds (61.4%) of respondents that work on an adult inpatient ward in an acute hospital in England felt that the NICE guidance had not made a noticeable difference and had not led to improved staffing levels in their organisation since its introduction in July 2014 (table 3). When the draft guidance was originally released, UNISON argued that guidance alone would not be enough to ensure safe nurse staffing levels. This evidence, which should act as a “red-flag” event in itself, echoes our original concerns and reinforces our view that the most effective mechanism to ensure patient safety is the introduction of national, mandatory, minimum staffing levels on wards.

\textsuperscript{11} http://www.nursingtimes.net/nursing-practice/specialisms/accident-and-emergency/rcn-deeply-concerned-at-rising-nurse-vacancy-rate-in-scotland/5082978.article
\textsuperscript{12} http://www.nursingtimes.net/nursing-practice/specialisms/occupational-health/full-survey-results-annual-health-check-on-nursing-2014/5077543.article
\textsuperscript{13} Reference
Table 3: NICE has produced guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England. In your opinion, has this guidance made a noticeable difference and led to improved staffing levels in your organisation?

Table 4: The NICE guidance sets out ‘red flag events’ which warn when nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on that ward. Has a nursing ‘red flag event’ ever occurred on your ward?

The NICE guidance sets out “red-flag” events which warn when nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on the ward. Although only 16.7% of respondents that work on an adult inpatient ward in an acute hospital in England said that a nursing “red-flag” event occurred on their ward, more worryingly almost half (45.5%) of respondents did not know whether a nursing “red-flag” event had occurred on their ward (table 4). This suggests a lack of communication and transparency. Organisations should do more to monitor “red-flag” events and inform their staff when they occur.

Following a “red-flag” event, the guidance states that those responsible for setting safe staffing levels must act immediately. Alarmingly, almost two-thirds (62.1%) of respondents who had had a nursing “red-flag” event occur on their ward said that the ward was not immediately allocated additional staff (table 5). When staff are raising “red-flag” events, they will be unlikely to raise them in the future because they will have no trust or confidence in the process. Therefore, following a “red-flag” event, it is essential that the ward is immediately allocated additional nursing staff to ensure adequate patient care.
Red alert – unsafe staffing levels rising
UNISON staffing level survey

Table 5: Following the occurrence of a nursing “red-flag event”, was the ward immediately allocated additional nursing staff?

The guidance has only been out for a short period of time (only 7 months). However, already staff do not have trust and confidence in it. These survey findings raise a number of questions; was enough time and energy put into explaining the guidance to organisations? Did they understand it and the importance of raising “red-flag” events? UNISON recommends that NICE do an urgent review of the guidance and evaluates its effectiveness at ensuring safe staffing levels. We think this particularly important as NICE continue to develop guidance for other parts of the service. We feel it is vital that we learn and ensure these are implemented successfully.
Survey background

“We had many patients on end of life care - five continuous subcutaneous infusions in progress. Four patients needed turning twice hourly. It’s a great ward but all nurses are under great stress. We have a fast turnover due to this. Nurses constantly deal with death or end of life situations. However, no support is given to nurses who I believe should have counselling.” – ward sister/charge nurse

UNISON's health service group has run an ongoing campaign to support safe staffing 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. The survey’s findings led to the development of UNISON’s ‘Be Safe’ Campaign. The campaign’s 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.

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.

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, remains the only one of its kind. What it’s unearthed consistently over the last four years is that nothing has changed; nursing staff everywhere are still feeling the pressure of service cuts, making care delivery more difficult. Government rhetoric that there are more nurses than ever working in the NHS is the opposite of what nurses are feeling on the frontline.

The survey has maintained a consistent format over the last four years with a few additional questions on 10 February 2015. Much like the first survey (6 March 2012), the 2015 survey asked respondents to record details about their shift during the same 24 hour period. This is the fourth year this survey has been run. This year the on-line survey ran over a 24 hour period on Tuesday 10 February 2015.

We chose this period to ensure that the data would not be skewed by the pressures from emergency weekend admissions or the higher demand for services during the depths of winter pressure.

The survey contained 60 questions, including ten 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 10 February 2015 – 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 5,100 unique responses to the survey. 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 10 February 2015 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 emails 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 also advertised on the Nursing Times’ and Nursing Standards’ websites.

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, 2013 and 2014 surveys to see if things have improved, stayed the same or worsened.

UNISON 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. Mandatory staffing levels have proven to have positive effects in both these areas internationally.
NHS Staff Survey in England 2014

The concerns and feelings voiced by respondents in UNISON’s survey echo concerns in the recent NHS Staff Survey\(^\text{14}\). The NHS Staff Survey is an annual survey which this year involved nearly 290 NHS organisations in England. Full and part time staff directly employed by an NHS organisation on 1 September 2014 could participate and the survey received a response rate of 42% (over 255,000 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 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.
- 67% of NHS staff said that care of patients and service users in their organisations was a top priority.
- 93% of NHS staff who took part specified they would know how to report any concerns they have, although worryingly only 57% of staff felt confident that their organisation would address them.
- 76.3% felt satisfied with the quality of work and patient care they were able to deliver however almost a third of staff (29%) felt that there was enough staff in their organisation to enable them to do their jobs properly.

Unfortunately, because the NHS Staff Survey is completed by all staff, it is not possible for UNISON to compare its results with the findings of this year’s safe staffing level survey. This is because we’re unable to drill down into 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.

This year, we expected to see an improvement because of the government’s claims of more nurses working in the NHS than ever before, the issuing of the NICE guidance and the increase in the use of agency staff. However, despite all these measures, there has been no improvement in staffing levels, staff taking their allocated breaks and staff having adequate time to spend with each patient over the last 12 months. It would appear across the health service staff continue to feel overworked and undervalued.

\(^\text{14}\) NHS Staff Survey 2014
\(^\text{15}\) NHS Pay Review Body Evidence
Methodology and composition of respondents

“...I rarely feel I am able to give the standard of care that I am motivated to give and capable of giving. I did not wash people as thoroughly or have time to encourage them to drink and eat regularly. There’s not enough time to create a caring environment and treat people how they should be treated.” – staff nurse (general)

The overwhelming 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, it was deemed appropriate to add some questions following the issuing of the NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England and the introduction of mandatory workforce planning tools in Scotland and Wales to see how effective they have been at ensuring safe staffing levels. Before going ‘live’, the survey questions were given to UNISON’s national nursing and midwifery committee for review and comment.

The 5,100 analysed responses came from nursing family 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 North West (16.5%), Scotland (15.5%), the South East (9.6%), Yorkshire and Humberside (8.2%) and the South West (8.1%). The region with the fewest respondents was Northern Ireland, which made up 4.5% 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 (table 6).

Table 6: What region is your organisation in?

These percentages roughly reflect the distribution of regional responses when this survey was run in 2014, even though this year we had a higher response rate to the survey (table 6).

Workplaces

“I didn’t have time to talk or even look after the patients properly. I was too rushed and there were not enough staff.” – HCA/AP/SW

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 (9.5%), NI health and social care trusts (3.7%), community services (10.1%), learning disabilities and care homes. Only 2.2% of respondents identified themselves as working in the private sector (table 7).
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 – medicine (73.7%), followed by care of the elderly (70.9%), surgery (67.1%), and accident and emergency (66.4%) (table 8).

The areas of care in which respondents worked on 10 February 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, medicine, mental health (inpatient as well as secure unit), obs and gynae, surgery, rehabilitation and theatre. 6.2% 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 11.9%, followed by medicine at 11.2%, surgery at 10.1% and community mental health (including Early Intervention Team, Children and Adolescent Mental Health Services (CAHMS), and Forensic) at 8.9%.

“There weren’t enough health care support workers. They are the ones who work hard at their job, but don’t get appreciated.” – student nurse

Care settings become especially pertinent within this survey when we looked at those respondents who

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**Table 7: How would you best describe the organisation that you work for?**

<table>
<thead>
<tr>
<th>Organisation Type</th>
<th>Percentage Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td>50%</td>
</tr>
<tr>
<td>Mental Health Trust</td>
<td>40%</td>
</tr>
<tr>
<td>N Health and Social Care Trust</td>
<td>30%</td>
</tr>
<tr>
<td>Scottish Health Board</td>
<td>20%</td>
</tr>
<tr>
<td>GP Surgery Trust</td>
<td>10%</td>
</tr>
<tr>
<td>Community Services Trust</td>
<td>5%</td>
</tr>
<tr>
<td>Private Sector provider</td>
<td>5%</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>5%</td>
</tr>
<tr>
<td>Care home</td>
<td>5%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>5%</td>
</tr>
</tbody>
</table>

---

**Table 8: Did not feel that you had an adequate amount of time to spend with each patient (by care setting)**

It is important to note that 878 respondents (21%) 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. Please refer to the research section earlier in this report where we explore this in more detail.
Shift

Roughly one-third (32.1%) worked a long day, as shown in table 9 below. The number of staff working long days has increased substantially since 2013.

Table 9: Which shift did you work?

<table>
<thead>
<tr>
<th>Shift</th>
<th>2015</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>20</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Late</td>
<td>10</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Long day</td>
<td>25</td>
<td>35</td>
<td>45</td>
</tr>
<tr>
<td>Night</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Did not work (e.g. Outpatients/Community)</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Not employed (e.g. Off-duty, etc)</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Nearly half (47.2%) of respondents worked a shift that was contracted to last for more than 10 hours, including 26.2% whose shifts were intended to last 12 hours or more. The number of staff working shifts contracted to last for 12 or more hours has increased significantly since 2013 (table 10).

Table 10: How many hours is that shift contracted to be

<table>
<thead>
<tr>
<th>Hours</th>
<th>2015</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 6 hours</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>6 – 7:59 hours</td>
<td>10</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>8 – 9:59 hours</td>
<td>20</td>
<td>35</td>
<td>50</td>
</tr>
<tr>
<td>10 – 11:59 hours</td>
<td>30</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>12 or more hours</td>
<td>40</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Unknown</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>

However, 36.8% respondents reported that they worked overtime on the 10 February, with only 8.4% of respondents identifying that this extra work was paid, and only 41.7% reported 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 table 11.
As the survey was advertised primarily through UNISON’s own channels, the vast majority of respondents (96%) were UNISON members. The remainder belonged to another union (2.7%) or no union (1%).

**Equality breakdown**

The majority of respondents identified as female (65.4%), which is almost representative of the gender make-up in the NHS workforce\(^\text{(16)}\) and in UNISON’s membership (table 12).

4.8% of respondents described themselves as having a disability (table 13).

33% of respondents identified themselves as between the ages of 36 and 50, with a further 23.9% as over the age of 50. Only 8.8% of respondents were age 27 or younger (table 14).
The impact of staffing levels on care quality

“I could not offer adequate food or fluids due to workload. I did not have time to explain what was happening to the patient. I had no time to explain their diagnoses or treatment. I was unable to provide time to alleviate anxieties or to allow the patient to discuss properly their concerns or worries.” – staff nurse (general)

Respondents for the fourth consecutive year overwhelmingly felt that staffing levels in their workplace were not sufficient to deliver the quality of patient care required. Across all respondent groups – including regions, job roles, shifts, and workplace – over half (52.7%) felt that the number of staff present in their workplace on 10 February 2015 resulted in the delivery of a lower standard of care. Although this is a small reduction from the 60% of respondents in 2014, we were surprised as we had hoped to see a significant improvement in this because of the Francis, Keogh and Berwick reports, government claims that more nurses are working in the NHS than ever before, and the issuing of NICE guidance which is 7 months old. We would have expected to see a differentiation in the ratios from last year’s findings.

We asked respondents if 10 February 2015 was a typical day at work and two-thirds (63.4%) of respondents indicated it was a typical day and that their workplace was busy as normal (table 16).
We asked respondents if there was anything more they wanted to tell us about their shift on the 10 February 2015. 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 felt they needed 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.

“Medication was not given on time or missed, no nurse triage was completed, and there was no time to actually talk to clients who were distressed.” – nurse manager

“Often patients who require assistance of two staff have only one. I find it difficult so I often have to leave those patients till another staff member is free to help me, which means their 3 hourly turns are never on time.” – HCA/AP/SW

“I was unable to give pain relief immediately as it is a controlled drug and two nurses are rarely available to check drugs for long periods of time.” – staff nurse (general)

When looking at nurse to patient ratios on those working within a ward setting on the 10 February 2015, almost half (42%) were caring for eight or more patients. This is a deeply alarming figure as studies have now shown that where nursing staff are caring for eight or more patients harm is occurring (table 17). We also looked at nurse to patient ratios by shift type. Over half (55.2%) of all staff who worked on a night shift on 10 February 2015 reported caring for eight or more patients compared with only 40.8% on a day shift (table 18). This is deeply worrying as the Keogh Review of the 14 hospitals in special measures also found issues around safe staffing on night duties. Just because it is a night shift, there cannot be an assumption that all patients go to sleep and no caring is required given the level of patient dependency and patient turnover.
We cross-analysed the types of ward that were reporting the highest nurse to patient ratio rates. 62% of respondents who indicated that they worked on a medical ward and 56% of respondents who indicated that they worked on a surgical ward 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 (59.7%), community mental health (including early intervention team, CAMHS, forensic) (45%), mental health: inpatient (24.7%) and those respondents who did not fall into any of UNISON’s ward or workplace categories so specified ‘other’ (41.3%).

These are also the areas where patients often have higher care needs (table 19).

Table 19: What was the nurse to patient ratio on your shift on 10 February 2015 (by ward type)?

<table>
<thead>
<tr>
<th>Nurse to patient ratio</th>
<th>1:1</th>
<th>1:2</th>
<th>1:3</th>
<th>1:4</th>
<th>1:5</th>
<th>1:6</th>
<th>1:7</th>
<th>1:8 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>0.0</td>
<td>2.2</td>
<td>6.7</td>
<td>6.7</td>
<td>11.1</td>
<td>24.4</td>
<td>8.9</td>
<td>40.0</td>
</tr>
<tr>
<td>Care of the elderly</td>
<td>0.5</td>
<td>1.4</td>
<td>5.7</td>
<td>7.9</td>
<td>7.6</td>
<td>8.8</td>
<td>10.4</td>
<td>59.7</td>
</tr>
<tr>
<td>Medicine (including orthopaedic)</td>
<td>0.0</td>
<td>0.8</td>
<td>1.3</td>
<td>4.0</td>
<td>6.3</td>
<td>11.5</td>
<td>14.3</td>
<td>62.0</td>
</tr>
<tr>
<td>Surgery</td>
<td>0.6</td>
<td>0.8</td>
<td>2.0</td>
<td>6.4</td>
<td>5.6</td>
<td>14.3</td>
<td>14.3</td>
<td>56.0</td>
</tr>
</tbody>
</table>

Respondents were asked: “Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?” Mirroring last year’s result almost one-third (30.9%) answered yes and almost half (44.5%) indicated that there were not adequate staff numbers (table 20). This result shows there has been little change in the last 12 months in this area. The lack of improvement is even more alarming given the issuing of NICE guidance last July, which aimed to ensure safe staffing levels on adult inpatient wards in acute settings.

Table 20: Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents</td>
<td>30.9%</td>
<td>44.5%</td>
<td>9.1%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

"Not enough time to speak or chat with patients who clearly needed nurses for reassurance."
– Midwife

Overwhelmingly, almost half (48.5%) of respondents indicated that they did not have adequate time to spend with each patient. 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 undone (table 21).
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. Half of all general nurses (57.8%) and mental health nurses (50.3%) and just under half of all midwives (47.6%) who worked on 10 February 2015 indicated that they did not have adequate time with each patient. Other staff groups indicating lack of time to spend with patients included 46.4% of health care assistants (HCA), assistant practitioners (AP) and support workers (SW), 54.3% of ward sisters and 32.2% of clinical nurse practitioners (table 22).

Table 22: Did not feel that they had an adequate amount of time to spend with each patient (by staff group)?

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 48.5% compared with 65% of last year’s respondents. Although it is important to acknowledge this decrease, it is still not acceptable that only three in 10 (30.5%) respondents report having had enough time with each patient. This indicates systemic understaffing. 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?” Two-thirds (64.6%) answered that because they did not have enough time, there were aspects of care they did not deliver. We cross analysed those who answered ‘yes’ by role and worryingly 66.7% of midwives, 60% of general nurses, 67% of mental health nurses, 57.2% of health care assistants, 58.1% of clinical nurse specialists / practitioners and 66.3% of ward sisters indicated that they did not have enough time to provide elements of care (table 23).

Table 23: elements of care could not be provided because they didn’t have time (by staff group)

It is unacceptable to UNISON that year-on-year this survey is highlighting that midwives, nurses and care workers are continuing 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.

In addition, a survey of 1,830 nurses conducted jointly by Nursing Times and ITV between 22 April 2014 and 1 May 2014 found that 8 out of 10 nurses did not have enough time to give patients adequate care and a quarter (26%) believed they had put a patient’s life at risk because they were too busy or overworked. Staff shortages were the most common factor stopping nurses from doing their job properly.17

Although organisations are doing something to address issues, more still needs to be done. This was further confirmed in May 2014 when unsafe staffing levels were cited as a major factor for Heatherwood and Wexham Park Hospitals Foundation Trust (now Frimley Health NHS Foundation Trust) being placed in “special measures” by the CQC.18

We also looked at the nurse to patient ratio where respondents indicated that care was left undone. Unsurprisingly over half (56.2%) 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 (table 24).

Correspondingly, we looked at the shift type where respondents reported that there were elements of care they were unable to give. 41.1% of all nurse respondents who worked a night shift said there were elements of care they were unable to give compared to 40.3% of nurses that worked an early shift on the 10 February 2015. Nearly one-third of all HCA/AP (30.8%) respondents on an early shift indicated there were elements of care they could not provide due to lack of time, compared to 30.6% of HCAs/APs on a night shift. These results highlight that there are still staffing issues occurring on night shifts. However, it’s not surprising when staff working a night shift are more likely to care for eight or more patients than those on a day shift.

Respondents were also asked if they felt that their shift had “an adequate skill mix.” Half (49.5%) of respondents felt their shift’s skill mix was adequate to the care they needed to deliver (table 25).

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Workforce wellbeing

Many respondents reported suffering numerous symptoms of stress due to their unreasonable workloads. Low morale was attributed to an uncaring attitude from managers, an overburdensome workload and bullying.

“There is a lack of support plus nurses. The job is stressful and emotionally, physically and mentally draining.” – District Nurse

“I feel constantly unable to manage and fear reprisals of not being able to perform all my duties properly which causes me to suffer high levels of stress and frustration.” – staff nurse (general)

“Staff are off sick due to work pressures and stress, resulting in more pressure on remaining staff.” – clinical nurse specialist/nurse practitioner

“Those in post are stressed and exhausted and there is a high sickness rate and resignations.” – staff nurse (general)

“Staff felt very stressed and many could not take a break. Agency staff have begun to cancel their future shifts as they don’t want to work in such a stressful environment again.” - HCA/AP/SW

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.

With a significant number of respondents working 12 hour long shifts or longer if working overtime, it is not surprising that more than seven in ten (71%) NHS workers in a recent UNISON survey said they had a poor work life balance. Increased working hours are having an important effect on the lifestyle of a huge number of nurses, which is likely to prove damaging to their physical and mental well-being, personal development, relationships and home life.

Roughly 10 million working days are lost a year in the NHS in England because of sickness absence, with the average worker taking 9.5 working days off sick a year. By setting safe staffing levels, employers could reduce sickness absence by ensuring that staff are not overworked and stressed.

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Table 25: Did you feel that there was an adequate skill mix on this shift?

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>29.6%</td>
</tr>
<tr>
<td>Not sure</td>
<td>5.7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>15.1%</td>
</tr>
<tr>
<td>Yes</td>
<td>49.5%</td>
</tr>
</tbody>
</table>

---

19 [http://www.hscic.gov.uk/staffsicknesspr](http://www.hscic.gov.uk/staffsicknesspr)
Red alert – unsafe staffing levels rising
UNISON staffing level survey

Risk of serious care failings

“Very stressful and soul destroying as I know patient care is compromised.” – HCA/AP/SW

Respondents were asked whether a serious care failing similar to those at Mid Staffordshire Trust could happen where they work. Shockingly, only 8.2% of respondents felt very confident that a serious care failing could never happen in their organisation. And appallingly, over one tenth of respondents (11.9%) felt that a serious care failing is already happening either across or in isolated parts of their organisation. When reviewing all the responses almost half (43.1%) described their organisation as either ‘at risk’ of a serious care failing, that it was already happening in isolated areas or across their whole organisation (table 26). This is a slight reduction from 49% of respondents in 2014.

Table 26: How confident are you that serious care failings similar to those at Mid Staffs and Winterbourne View could never happen at your organisation?

<table>
<thead>
<tr>
<th>Response count percentage</th>
<th>Very confident, a serious care failing could never happen at my organisation</th>
<th>Fairly confident, a serious care failing is unlikely to happen at my organisation</th>
<th>Not very, we are at risk of a serious care failing at my organisation</th>
<th>Not at all, it’s already happening in isolated parts of the organisation</th>
<th>Not at all, it’s already happening across the organisation</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Midlands</td>
<td>6.0%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Greater London</td>
<td>7.1%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>North West</td>
<td>10.2%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Scotland</td>
<td>7.1%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>South East</td>
<td>7.1%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>South West</td>
<td>7.1%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humberside</td>
<td>6.0%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Wales</td>
<td>7.1%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>7.1%</td>
<td>12.9%</td>
<td>31.2%</td>
<td>35.8%</td>
<td>8.2%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

“Precarious and teetering on dangerous. It’s very stressful for all involved.” – clinical nurse specialist/nurse practitioner

“We are working at dangerous staffing levels with no management support. I am thinking of leaving as I believe that we are all in danger of losing our registration” – ward sister/charge nurse

One of the answer choices to this question was “don’t know.” 11% 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, our relevant region has been asked to work with the local UNISON branch to raise these concerns formally with the organisation. 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 and to protect themselves, those in their care and their colleagues as required under the revised NMC Code.

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 witnessed unsafe staffing levels at ward level with junior members of staff in tears because they are overwhelmed and under supported in charge of a shift with maybe one other agency nurse who is not allowed to administer IV drugs.” – staff nurse (general)

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-patient ratio?” the overwhelming majority (88.3%) responded yes. The response is almost identical to percentage of respondents in 2013 (88.1%) (table 28) and the survey by Nursing Times and ITV which found that 88% of respondents said they thought the government should introduce mandatory minimum nurse-to-patient ratios.

UNISON recognises that there needs to be flexibility to increase staffing levels to take account of local patient dependency data. However, a statutory minimum is required to maintain a safe nurse-to-patient ratio.

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.

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, and set minimum nurse-to-patient ratios for the entire UK.

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 accident and emergency department 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.

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.

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Do voluntary minimum staffing levels work?

"I felt much less under pressure during this shift because of the smaller ratio of nurse-to-patient. Also I was able to get adequate tea breaks and have more time to talk to the patients." – staff nurse (mental health)

Only 39.6% of respondents 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 Greater London (34.9%), East Midlands (34.5%), South West (33.7%) and Eastern (33.5%). The region with the lowest percentage of respondents was Northern Ireland (25.6%). 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 (13.6%). However, 11.9% reported that their minimum nurse to patient ratio was one nurse to eight patients or more (table 29). Clearly it is alarming that in the fourth 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.

Table 29: What is the minimum nurse-to-patient ratio for your ward or team?

<table>
<thead>
<tr>
<th>Ratio</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:2</td>
<td>6.3%</td>
</tr>
<tr>
<td>1:1</td>
<td>9.3%</td>
</tr>
<tr>
<td>1:3</td>
<td>6.8%</td>
</tr>
<tr>
<td>1:4</td>
<td>10.3%</td>
</tr>
<tr>
<td>1:5</td>
<td>7.7%</td>
</tr>
<tr>
<td>1:6</td>
<td>13.6%</td>
</tr>
<tr>
<td>1:7</td>
<td>7.6%</td>
</tr>
<tr>
<td>1:8 or higher</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

"Care of the elderly can be stressful. If I had time I could talk to the patients, help them keep calm, and ensure they’re not so scared of not being in there own environment." – HCA/AP/SW

Almost half (47.9%) of respondents that worked on a ward or team with a minimum nurse-to-patient ratio had all their breaks on their shift compared with only one-third (34%) of respondents that did not work on a ward or team with a minimum nurse-to-patient ratio. Almost two-thirds (64.1%) of respondents that worked on a ward or team with a minimum nurse-to-patient ratio did not work longer than their contracted hours compared with only half (53.4%) of respondents that did not work on a ward or team with a minimum nurse-to-patient ratio. Therefore, if minimum nurse-to-patient ratios are set, staff are more likely to have all of their breaks and not work longer than their contracted hours, and care is less likely to be left undone.

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. Over half (52.6%) of respondents confirmed that their organisation did not take this into account and only 35% confirmed that their workplace did take this into account (table 30).

Table 30: Are the set nursing staff levels in your organisation flexible and easily altered to take account of patient dependency?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>52.6%</td>
</tr>
<tr>
<td>Yes</td>
<td>35%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>11.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

“Couldn’t get patients back to bed when they requested as we didn’t have enough staff” – Staff nurse (general)
Protocols for understaffing

“...The caseload varies from day to day, at present it is manageable, but over the last few months it has been extremely busy. Team members have worked while being ill, and some have cancelled their holidays. Nurses were exhausted but remain dedicated.” – district nursing sister

Roughly one third (30.8%) 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 29.9% of staff that were aware that their workplace had a protocol for if they had a shortage of nurses (table 31). This percentage is still alarmingly high and has got worse since 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.

Table 31: If there is a shortage of nurses, is there a workplace protocol/policy that address this?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29.9%</td>
<td>17.6%</td>
<td>30.8%</td>
<td>21.6%</td>
</tr>
</tbody>
</table>

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. The vast majority of respondents (69.1%) answered that they had (table 32). Respondents were then asked how they viewed the outcome of using this protocol or policy. Just over one-third of respondents (40.4%) felt that their concerns were listened to and acted upon (table 33).

Table 32: If you answered yes to the previous question, have you had cause to use it?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>69.1%</td>
<td>21.3%</td>
<td>8.0%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Table 33: If you answered yes to the previous questions, were your concerns listened to and acted upon swiftly?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40.4%</td>
<td>45.4%</td>
<td>13.2%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Since the 2014 survey, there has been an increase in the number of respondents who had used a protocol or policy to address understaffing. Although there was an increase in those respondents who subsequently felt that their concerns had been listened to and acted upon swiftly, this survey highlights that there is still much work to be done in this area. UNISON reiterates that one of the key recommendations following the Freedom to Speak Up review by Sir Robert Francis QC was that it is fundamental that staff in the NHS raising concerns about patient safety issues should have their concerns acted on – the sense that nothing happens is a major deterrent to speaking up – and that this should be part of the culture of the NHS.
Comparison to the 2014 survey

Almost two in 10 respondents (18%) were unsure whether their ward or team had a minimum nurse-to-patient ratio (table 34). This is the same figure as in our 2012 survey.

Table 34: Does the ward or team that you work on have set minimum ratios for nurses to patients?

- Yes 30.5%
- Unknown 23.1%
- Not sure 18.0%
- No 28.4%

It is clear that there have not been sufficient communication improvements by organisations within 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.

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 (15.3%) 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 fourth 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.

On at risk list for staffing, yet staff still get moved to support other wards / departments.” – staff nurse (general)

We have been, and currently are, very short of staff because of long term sickness and nurses leaving the ward. Currently we don’t have an official ward manager or a deputy manager either. In addition, the unfinished work is added to future shifts, adding a lot of stress to staff and increasing the risk of failure to provide the best care to the patients.” – staff nurse (general)

Staff are sometimes borrowed to help out for an hour or two to cover breaks.” – staff nurse (general)
Overtime and skipping breaks

It was very stressful. I had to work excess hours to ensure patients received the care needed. This happens daily.” – staff nurse (general)

“All staff work extremely hard to ensure the patients care is not compromised and whilst I do get my allocated break time the majority of the rest of the nurses do not due to work load pressures.” – student nurse

Over one-third (36.8%) of survey respondents worked over their contracted hours on 10 February 2015. Of those who worked beyond their contracted hours, three-quarters (75.2%) worked up to 60 minutes extra (Table 35). Furthermore, the larger the nurse-to-patient ratio, the more likely they were to work over their contracted hours.

Table 35: How many extra hours did you work?

<table>
<thead>
<tr>
<th>Extra Hours</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 30 minutes</td>
<td>48.0%</td>
</tr>
<tr>
<td>Between 30 and 60 minutes</td>
<td>17.4%</td>
</tr>
<tr>
<td>Between 1 and 2 hours</td>
<td>6.0%</td>
</tr>
<tr>
<td>More than 2 hours</td>
<td>14.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Again, mirroring last year’s results the overwhelming majority of this time was unpaid. Only 8.4% of respondents reported that they were paid for their overtime (table 36). The TUC estimates that NHS staff in England are ‘donating’ £1.5 billion to the government each year as unpaid overtime. These figures represent an improvement from the survey conducted in 2014, where 53% of respondents worked overtime and only 3% reported having been paid for it.

Table 36: Was this additional time paid?

<table>
<thead>
<tr>
<th>Was this additional time paid?</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, one</td>
<td>43.4%</td>
</tr>
<tr>
<td>Yes, two and five</td>
<td>2.5%</td>
</tr>
<tr>
<td>Yes, between six and ten</td>
<td>22.2%</td>
</tr>
<tr>
<td>Yes, more than ten</td>
<td>14.1%</td>
</tr>
<tr>
<td>Not sure</td>
<td>16.9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1.5%</td>
</tr>
</tbody>
</table>
Table 37: The percentage of respondents in each role who reported working any overtime as well as the percentage who worked for more than an hour

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage who worked overtime</th>
<th>Percentage who worked &gt;1 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurse (General)</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td>Staff Nurse (Mental Health)</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Senior Manager</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>HCA / AP / SW</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Midwife</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Student Nurse</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>40%</td>
<td>30%</td>
</tr>
</tbody>
</table>

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.

Over two-thirds of respondents (70%) skipped some or all of their breaks during their shift on 10 February 2015. This figure has increased since last year’s survey where 58% of all respondents reported not being able to take all or some of their breaks (table 38). This should act as a “red-flag” event. Furthermore, the larger the nurse-to-patient ratio, the more likely they were to skip some or all of their breaks during their shift.

Table 38: Did you have time to take your allocated breaks?

<table>
<thead>
<tr>
<th>Break Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not have time to take any breaks</td>
<td>18.5%</td>
</tr>
<tr>
<td>My shift did not include a break</td>
<td>5%</td>
</tr>
<tr>
<td>because it was shorter than 6 hours</td>
<td>1.7%</td>
</tr>
<tr>
<td>I had all my breaks</td>
<td>41.7%</td>
</tr>
<tr>
<td>I had some of my breaks</td>
<td>34.8%</td>
</tr>
<tr>
<td>Un-known</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

“I’m always exhausted, dehydrated and hungry when I finish my shift.” – other

“I was working to my maximum level of activity and speed without taking my breaks and leaving late, but I still left my shift feeling despondent and that my best just wasn’t good enough for my patients and their families.” – ward sister/charge nurse

When we looked at staff roles that did not have time to take any breaks on 10 February 2015, roughly one in seven (14.7%) of general nurses and 12.2% of HCA/APs/HSWs identified being in this category. The highest percentages by role were matrons (44.4%), mental health nurses (39.7%), nurse managers (40.7%) and health visitors (38.5%) (table 39).
Red alert – unsafe staffing levels rising

UNISON staffing level survey

“Colleagues were unable to take breaks or ate as they worked. I felt relieved to go home knowing nothing major had gone wrong. I can’t remember the last time I went home feeling happy that I had had a positive shift.” – staff nurse (general)

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.

“Constantly pushed. No breaks. Care compromised. Management tell you to just get on with it.” – staff nurse (general)

“High levels of bank and agency support workers were used across the service due to increased levels. However, no qualified staff were able to have a break off their own ward as there was no spare qualified to cover.” – staff nurse (mental health)

“Working overtime because [my employer was] unable to fill [the] shift with regular staff.” - clinical nurse specialist/nurse practitioner

It continues to be of great concern to UNISON that nursing family 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.

Over half (54.6%) of respondents that were contracted to work a 12 hour shift or more said that they did not take any or some of their breaks, and over one-third (37.3%) said they worked overtime. Over a quarter (27.9%) of respondents that were contracted to work a 12 hour shift or more said that they had worked overtime and not taken any or some of their breaks.

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 eight, 10 or 12 hour shift without adequate breaks. All workplaces need to be in line with the Working Time Regulations, both for the sake of the staff as well as the patients.

Almost three-quarters (70.9%) of respondents that said there were elements of care they could not provide because they did not have time did not take some or all of their breaks, and over half (51%) worked over their contracted hours. Four in 10 (43.8%) of respondents said they did both. This means that despite staff working through all or some of their lunch breaks and working overtime, they still do not have enough time to deliver the minimum level of care.

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 outcomes. 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.

Table 39: Did not have time to take any breaks (by staff group)?

<table>
<thead>
<tr>
<th>Staff Nurse (General)</th>
<th>Staff Nurse (Mental Health)</th>
<th>Ward Sister / Charge Nurse</th>
<th>CNS / AP</th>
<th>Matron</th>
<th>Nurse Manager</th>
<th>VCA / AP</th>
<th>Swr</th>
<th>Healt Visitor</th>
<th>Midwife</th>
<th>Student Nurse</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
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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 outcomes. 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.

23 The Effectiveness of Health Care Teams in the National Health Service – Aston University - homepages. inf.ed.ac.uk/jeanc/DOH-final-report.pdf
Over [the] past few years due to unfilled posts a high percentage of agency staff have been used.” – staff nurse (mental health)

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 (97.5%) 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 (22.6%)
- chronic short staffing problems (30.8%)
- permanent colleagues on frequent or long term illness/disability/maternity leave (20.6%).

Of the respondents who replied that their organisation frequently made use of bank or agency staff, the percentages who selected each reason are reflected in table 40 below. In this group, a majority of respondents indicated all of the reasons listed above. Respondents were allowed to choose from multiple answers.

“No breaks for any of staff.”
– staff nurse (general)

“Meal breaks are missed on a daily basis and it is necessary to complete nursing documentation in our own time.” – staff nurse (general)

Patient safety is clearly more at 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 10 February 2015 was a typical day in their workplace/organisation and a vast majority of respondents deemed the 10 February 2015 to be a ‘typical’ day.
Red alert – unsafe staffing levels rising
UNISON staffing level survey

Table 40: Do your shifts frequently make use of bank or agency staff?

Table 41: Were there any bank or agency staff working on your shift?

Nearly a quarter (22.2%) of respondents reported that they worked with one bank and/or agency staff member and 16.9% of respondents indicated that they worked with between two and five bank and/or agency members of staff (table 41).

Mirroring last year’s survey of respondents who worked with multiple bank/agency staff on their shift, a higher percentage felt they did not have enough time with patients (64.1%) or adequate numbers to deliver safe, dignified and compassionate care (57.8%) than those who did not work with multiple bank/agency staff on their shift (49.3% and 46.3% respectively) (tables 42 and 43).

Many respondents explained that the reason for this was due to the greater level of supervision agency staff require and their unfamiliarity with the unit they’re working on. This additional time spent supervising agency staff and making them familiar with their surroundings takes time away from the amount of care they can deliver.
Agency used on many wards, but they cannot access our computer. Therefore, they cannot issue medication or complete documentation or care planning. Instead, it is left to other nurses to do extra above their own work load.” – staff nurse (general)

“Record numbers of regular staff off short term and long term sick. Place is being propped up at huge financial expense with bank and agency workers who fail to provide continuity. This is an accident just waiting to happen.” – staff nurse (general)

The overuse and frequency 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.

According to the Department of Health, £2.58b was spent on agency staff by the NHS in 2013/14 – a 40.2% increase on 2011/12. Although this figure includes all staff, the Royal College of Nursing estimate that trusts were spending £980m on agency nursing staff this year and that this would be enough to fill 28,000 permanent posts. NHS England chief executive, Simon Stevens called on trusts to invest the vast amount of money spent on temporary staff into recruiting permanent posts with good working conditions and career progression.

He said that the bringing down of agency spend was necessary to improve quality patient 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.

“Our staffing levels are very frequently filled with agency staff who are unable to give the specific care needed in our specialty.” – staff nurse (general)
Raising concerns

“I raised concerns due to poor staffing levels and went off sick due to stress. On return to work it was just as bad as when I went on sick leave and I am currently off sick with stress again.” – district nurse

It is important to note that nurses and midwives are professionally accountable for their actions to the Nursing and Midwifery Council (NMC). Under section 16(1) of the revised NMC Code, registrants must raise, and if necessary, escalate any concerns they may have about patient safety or the level of care people are receiving in their workplace.

However, many respondents said that when they spoke up about unsafe staffing levels their concerns were not acted on. This survey highlights that just under half of respondents (40.2%) 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 third year running many of the comments included counting supernumerary staff in official staffing levels, achieving a particular minimum staff ratio with students or unfamiliar bank/agency staff.

“Management did not listen to our concerns and made inappropriate decisions.” – staff nurse (general)

“Every day is the same regardless [of] how often concerns are raised” – staff nurse (general)

“Management do not take nurses concerns seriously. [They] tell us to improve time management and/or work better as a team.” – staff nurse (general)

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
from staff reporting concerns and identified increasing levels of sickness in organisations, as staff become overburdened and worn out.

This reflects the findings of the Freedom to Speak Up review by Sir Robert Francis QC. Contributors frequently described a culture of fear, blame, defensiveness and ‘scapegoating’ when concerns were raised. These perceptions of the culture, real or otherwise, result in some staff refraining from raising concerns.

This was reinforced to some extent by the Freedom to Speak Up staff survey, where a worrying number of staff indicated that they had not raised a concern about wrongdoing in the NHS due to a lack of trust in the system or a fear of being victimised.

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 know 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 lowering the quality of patient care delivered in that organisation.

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

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24 Nursing and Midwifery Council, 2015, The Code
Safe staffing tops wish list ahead of election

“All I can say [is] it is getting worse. If unsocial rates are changed I for one will not volunteer for extra shifts and I will not swap shifts to cover shortages over a week.” – staff nurse (general)

When asked whether they thought that staffing levels have got worse, better or stayed the same since May 2010, almost half (48.9%) of respondents believed that they have got worse. This compares with only 4.9% of respondents who felt that staffing levels have got better.

This is not surprising when policy decisions by the executive have resulted in chronic understaffing. Firstly, the government’s decision to cut nursing places across England in 2010/11 and 2011/12 led to a dramatic shortage of supply. Secondly, public service cuts resulted in many nurses being made redundant. Finally, a series of policy changes relating to overseas workers has made it more difficult for non-EU nurses to enter the UK.

For example, the government changed immigration rules which made it difficult or impossible for organisations to recruit from outside the EU. This has led to a dramatic increase in the number of nurses being recruited from the European Economic Area (EEA). We don’t know whether EU nurses are likely to stay in the UK and this has an impact on workforce planning.

However, many other countries across the EU have a shortage of nurses. Overseas recruitment also poses moral and ethical questions and issues; should a developed country like the UK continue to deplete other countries valuable nursing resource.

The supply of nurses could reduce even further if the government does nothing to ensure safe staffing levels. When asked whether staffing levels had got so bad that they’d considered leaving their profession, half (50%) of respondents said yes.

In its response to the NHS Pay Review Body, the government expressed its intention to cut unsocial hours payments severely. It argued that this is necessary to deliver the seven-day services vision. When asked whether the government proposals to cut unsocial hours rates would have a detrimental effect on nurse-to-patient ratios if implemented, two-thirds (67%) of respondents said it would.

As already demonstrated, a nurse is more likely to care for eight or more patients – the ratio at which it is known harm is occurring – on a night shift. Therefore, not only would cutting unsocial hours payments place serious limits on the ability of the NHS to deliver the seven-day services vision, it would have a detrimental effect on safe staffing levels and patient care especially on night shifts.

According to a survey by Nursing Standard, 40% of nurses could vote for Labour at the next election in May. They are more likely to vote for Ukip or Green than for the Lib Dem party, with 14% likely to vote for the Conservatives. Almost one-quarter (24%) have not yet decided who to vote for. Nursing Standards’ poll shows that 40% of nurses intend to change their vote compared to how they voted in 2010.

When asked what they want the next government to priorities, ensuring safe staffing was the most important to almost half (45.6%) of respondents. All political parties and their candidates need to listen to nurses by committing to the introduction of legally enforceable standards and a legal minimum nurse-to-patient ratio to ensure safe staffing levels if they wish to secure the vote of nurses.
Conclusions

“A newly qualified staff nurse in her third shift as a qualified nurse worked with only two other staff nurses in a 30 bed acute medical receiving unit. They did not receive adequate supervision or support and they were definitely not supernumerary.” – staff nurse (general)

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.

The majority of respondents reported that staffing levels are not sufficient to deliver the minimum standard of patient care required. This is not surprising when almost half of the respondents are caring for eight or more patients at a time – the ratio at which harm is known to occur. Respondents were more likely to care for eight or more patients if they work night shifts or if they work in a surgery, medicine or care of the elderly setting. 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.

Furthermore, the survey found that the higher the nurse-to-patient ratio is the more likely staff are unable to deliver all aspects of care. Organisations need to address this issue by introducing minimum staffing levels and re-examining workloads.

Over the last three years, the number of respondents contracted to work 12 or more hours on their shift has increased significantly. What is more, over two-thirds of respondents are not taking some or all of their breaks and over one-third are working over their contracted hours without pay. This means that longer shifts are on the increase. With longer shifts comes a higher risk of fatigue, and with fatigue comes an increased risk of mistakes being made. Therefore, organisations need to immediately address this issue if they are to ensure patient safety.

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

Almost one-third 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. The overwhelming majority (88.3%) of respondents supported our view. We support and recognise the role which workforce tools and guidance have to play in helping organisations to identify the right levels for their organisation.

However, these will have little effect at ensuring safe staffing levels unless they are mandatory. For example, almost two-thirds (61.4%) of respondents that work on an adult inpatient ward in an acute hospital in England felt that the NICE guidance had not made a noticeable difference and had not led to improved staffing levels in their organisation since its introduction in July 2014. In the absence of legally enforceable standards the default position should be a legal minimum.

Over a quarter (28%) of respondents reported working overtime and through all or some of 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.

Almost half (48.5%) reported not having an adequate amount time to spend with patients and that as a result almost two-thirds (64.6%) stated that care was left undone.

Four in ten respondents (40.2%) felt that they were not at all confident, not very confident or only somewhat confident to raise a concern at work, which in a post Francis era is deeply worrying.

Despite the National Quality Board’s guidance, only...
four in ten (40%) of respondents in an acute trust in England said that their organisation displayed the intended and actual level of staffing. Although the requirement has been in place for a year, it is clear that many organisations are not displaying information as required. UNISON found it surprising that not more areas met this requirement as it takes very little effort – unless your numbers are routinely below those which are needed to meet care requirements.

Most worryingly was that nearly a third of respondents (31.2%) reported their organisations were at risk of a serious care failing developing in their organisation, and 11.9% of respondents indicated that care failings similar to Mid Staffs were happening in isolated parts of or across the organisation.

When asked what they want the next government to prioritise, ensuring safe staffing was the most important to almost half (45.6%) of respondents. All political parties and their candidates need to listen to nurses by committing to the introduction of legally enforceable standards and a legal minimum nurse-to-patient ratio to ensure safe staffing levels.
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.

This is our fourth year running this type of 'spot test'. Last year's survey evidence led to policy changes regarding safe staffing levels. For example, Scotland and Wales introduced mandatory tools for safe staffing levels and NICE developed guidance for safe staffing levels for adult inpatient wards in acute hospital settings in England. This year, we require evidence to assess what impact these changes have had on safe staffing levels in your workplace, and whether the situation is getting better, worse, or staying the same.

Thanks for taking the time to record your organisation's nurse-to-patient ratio on 10 February 2015 and filling in this survey.

Please note that this survey is about your experience on 10 February 2015. If you fill it in before 10 February 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!
Red alert – unsafe staffing levels rising
UNISON staffing level survey
About your organisation

Firstly, 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.

1. 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
UNISON's Staffing Levels Survey 2015

*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
1. Did you work on 10 February 2015?

- Yes
- Yes, but I worked in a new/different role or workplace than usual
- No
If on 10 February you worked in a new or different workplace or role, you should fill out this survey based on your experience on the 10th only.
The following questions will help us get an accurate picture of how your ward/unit/department was staffed on 10 February 2015. 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 a night shift? If yes, please record the shift if the majority of hours fell on the 10th. For example, if you work from 22:00 on the 9th until 06:00 on the 10th, then you should record the whole shift because the majority of hours fell on the 10th.

Did you work a night shift on both 9 and 10 February? Choose one of the two shifts to report about.

1. What type of ward/field were you working in on 10 February 2015? 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)
2. On 10 February 2015, which shift did you work?

☐ Early
☐ Late
☐ Long day
☐ Night
☐ Not shift working (ie Outpatients or Community)
☐ Did not work (ie sickness, day off, annual leave, maternity, etc)
☐ Other (please specify)

3. How many hours is that shift contracted to be?

☐ Fewer than 6 hours
☐ 6 - 7:59 hours
☐ 8 - 9:59 hours
☐ 10 - 11:59 hours
☐ 12 or more hours

*4. Did you work longer than those contracted hours?

☐ Yes
☐ No
1. How many additional hours did you work?

- Fewer than 30 minutes
- Between 30 and 60 minutes
- Between 1 and 2 hours
- More than 2 hours

2. Was this additional time paid?

- Yes
- No

*3. Why did you work these additional hours? Please select the most influential reason.

- The ward would have been left unsafe
- Unable to document
- Too busy
- In the middle of doing something for a patient
- Not enough staff
- Not given enough time to do a handover

Other (please specify)
1. How long were you given to do a handover?
- 15 minutes or less
- 16 - 30 minutes
- More than 30 minutes

2. How long did the handover take in reality?
- 15 minutes or less
- 16 - 30 minutes
- More than 30 minutes
1. Did you have time to take your allocated breaks during your shift?

- 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
1. Did you work on a ward on 10 February 2015?

- Yes
- No
1. Did you or a colleague count and record the exact nurse to patient ratio on your shift on 10 February 2015?

☐ 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 10 February 2015? 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. Where any staff moved from another ward to work on your ward?

- Yes, 1 staff member
- Yes, 2 staff members
- Yes, 3 staff members
- Yes, more than 3 staff members
- No
- I don't know
1. What was your caseload (i.e. the number of patients you're expected to see in a non-ward setting) on 10 February 2015? Please note this question requires a numerical answer and will not accept letters.

2. How many hours of your shift were spent delivering patient care?

- Less than one hour
- Between one and two hours
- Between two and three hours
- Between three and four hours
- Between four and five hours
- Between five and six hours
- Between six and seven hours
- Between seven and eight hours
- Between eight and nine hours
- Between nine and ten hours
- Between ten and eleven hours
- Between eleven and twelve hours
- More than twelve hours

3. 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
4. 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

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

- [ ] Yes
- [ ] No
- [ ] I’m not sure

6. 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:

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

- [ ] Yes
- [ ] No
- [ ] I’m not sure

8. Did you feel that there was an adequate skill mix on this shift?

- [ ] Yes
- [ ] No
- [ ] I’m not sure
9. How confident are you that serious care failings similar to those at Mid Staffs and Winterbourne View could never happen at your organisation?

- Very confident, a serious care failing could never happen at my organisation
- Fairly confident, a serious care failing is unlikely to happen at my organisation
- Not very, we are at risk of a serious care failing at my organisation
- 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

10. 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:

11. Is there anything else you would like to add about the shift?
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. If your workplace openly displays information about staffing levels, does the figure displayed include agency staff and/or staff moved from other wards?

- [ ] Yes
- [ ] No
- [ ] Don't know

3. Does the ward or team that you work on have set minimum ratios for nurses to patients?

- [ ] Yes
- [ ] No
- [ ] I’m not sure
4. 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

5. 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

6. If there is a shortage of nurses, is there a workplace protocol/policy that addresses this?

- Yes
- No
- I'm not sure

7. If you answered yes to the previous question, have you had cause to use it?

- Yes
- No
- I'm not sure
UNISON’s Staffing Levels Survey 2015

8. If you answered yes to the previous questions, were your concerns listened to and acted upon swiftly?

- Yes
- No
- I’m not sure

9. 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

10. 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.

*11. NICE has produced guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England. In your opinion, has this guidance made a noticable difference and led to improved staffing levels in your organisation?

- Yes
- No
- I don’t know
- Not relevant because I don’t work on an adult inpatient ward in an acute hospital in England
*1. The NICE guidance sets out 'red flag events' which warn when nurses in charge of shifts must act immediately to ensure they have enough staff to meet the needs of patients on that ward. Has a nursing 'red flag event' ever occurred on your ward?

☐ Yes
☐ No
☐ I don't know
1. Following the occurrence of a nursing 'red flag event', was the ward immediately allocated additional nursing staff?

- Yes
- No
- I don't know

2. In Scottish and Welsh hospitals, mandatory workforce planning tools to set staffing levels were introduced. In your opinion, has this made a noticeable difference and led to improved staffing levels in your organisation?

- Yes
- No
- I don't know

- Not relevant because I do not work in a Scottish or Welsh Hospital
1. In your opinion, do you think that staffing levels have got worse, better or stayed the same since May 2010?

- Better
- Worse
- Stayed the same
- Don't know

2. If government proposals to cut unsocial hours rates were implemented, do you think it would have a detrimental effect on nurse-to-patient ratios?

- Yes
- No
- Don't know

3. Have staffing levels got so bad that you've considered leaving your profession?

- Yes
- No
- Don't know

4. UNISON 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
- No, I don't agree
- I don't know
- Other (please specify)

5. 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
UNISON’s Staffing Levels Survey 2015

Contact details

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.

   | Name:   |   |
   | Email:  |   |
   | Telephone: |   |

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

   - Yes
   - No

3. The UNISON workplace rep is the most important link between the union and its members. Are you interested in becoming a workplace rep?

   - Yes, please contact me by email with more information
   - No

4. Do you receive the UNISON nursing sector e-newsletter?

   - Yes
   - No, but I would like to receive it. Please add my email address to your distribution list.
   - No
   - I don’t know

5. 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.