Pushing the call button on unsafe staffing: who will come to our aid?
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Background</td>
<td>4</td>
</tr>
<tr>
<td>Executive summary</td>
<td>5</td>
</tr>
<tr>
<td>The main findings in brief</td>
<td>6</td>
</tr>
<tr>
<td>The evidence</td>
<td>8</td>
</tr>
<tr>
<td>Survey background</td>
<td>17</td>
</tr>
<tr>
<td>NHS Staff Survey in England 2015</td>
<td>18</td>
</tr>
<tr>
<td>Methodology and composition of respondents</td>
<td>19</td>
</tr>
<tr>
<td>Support for safe staffing levels</td>
<td>31</td>
</tr>
<tr>
<td>Do voluntary minimum staffing levels work?</td>
<td>33</td>
</tr>
<tr>
<td>Protocols for understaffing</td>
<td>34</td>
</tr>
<tr>
<td>Comparison to the 2015 survey</td>
<td>36</td>
</tr>
<tr>
<td>Overtime and skipping breaks</td>
<td>37</td>
</tr>
<tr>
<td>Bank and agency staff</td>
<td>40</td>
</tr>
<tr>
<td>Raising concerns</td>
<td>44</td>
</tr>
<tr>
<td>The effect of government policy on safe staffing levels</td>
<td>46</td>
</tr>
<tr>
<td>Conclusions</td>
<td>47</td>
</tr>
</tbody>
</table>
Politicians and the public need to make a decision about the sort of health and social care service this country needs. UNISON is clear that the way ahead is a properly funded service, with well trained and motivated staff that puts patients at the heart of everything it does. That is what UNISON is campaigning for and we take inspiration from Nelson Mandela who said: “Everything seems impossible until it is achieved”.

Gail Adams
Head of Nursing UNISON

Ann Moses
Chair of UNISON’s Nursing and Midwifery Committee

Pushing the call button on unsafe staffing: who will come to our aid?

Foreword

The ratio of staff to patients on our wards continues to be an important issue for UNISON members, NHS staff and the public. UNISON is clear that a national minimum ratio of staff to patients should be set and should be legally enforced. There has to be a level of care below which standards cannot fall. That is the care patients and their families expect and that staff want to provide.

Instead staff find themselves in the position of having to ration care, to decide daily, on a shift by shift basis, what care they give and what has to be left undone. This is not how they want to work, not what they are trained to do and not why they entered the profession.

Our 2016 annual staff survey, conducted on a normal day in February, again shows that even though staff work through their breaks and stay beyond the end of their shift, there is not enough time to deliver the care they feel their patients need.

Almost 64% of respondents said there were not enough staff on duty on 9 February to deliver dignified and compassionate care. Over 47% said that their organisation was at risk of a serious care failing, while over 15% indicated that care failings were already happening either across their organisation or in isolated parts of it.

We urgently need enough staff to deliver patient care safely and effectively, in a safe environment for staff, patients and their families.

That is the message our members are sending to employers and politicians. We need them to listen and take urgent action to ensure that we have minimum staff/patient ratios. This will allow staff the time to use their skills and training to deliver high levels of care which will improve patient outcomes and staff morale. We simply cannot go on like this.

We must ensure that our profession is fit for purpose and remains one which others aspire to join - not a profession plagued with understaffing and low morale. The comments in this report from front line staff who worked on that day make depressing reading and paint a picture of a service that is struggling.
Background

“Unsafe and unworkable staffing levels remove all reward from what should be a role in which you feel the value of your work.” – Staff nurse (general).

UNISON has over 450,000 members employed across the health service and represents members across the whole nursing family.

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. We speak on their behalf about issues that matter to them. Not just their pay, terms and conditions, but on key issues that affect how they do their jobs and the standards of care that they can provide.

We know that nurses feel very strongly about minimum staffing ratios because they are fundamental to patient safety and the quality of care. Three years on from the publication of his report into the care failings at Mid Staffordshire Foundation Trust, Sir Robert Francis identified the link between appropriate staffing levels and safe, compassionate care. This led to his recommendations which were accepted in full by the government and other organisations.

The National Institute for Health and Care Excellence (NICE) being asked to develop independent research and guidance on safe staffing in a variety of healthcare settings. Then last year without warning this work was suspended by NHS England and the government despite Sir Robert Francis expressing serious concerns over this decision.

UNISON is determined to ensure that nurses are given the opportunity to perform their caring role to the best of their ability and that their contribution to healthcare provision is recognised and valued.

There is no doubt that this government has presided over huge cuts which have been implemented with indecent haste. Despite their claim that the NHS was ring fenced and safe in their hands, the reality has been the complete opposite.

The effect of this has been to make it almost impossible for NHS staff to deliver safe, dignified and compassionate care, despite their best efforts and constantly going the extra mile.

This survey is now in its fifth 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. We asked what work was like on Tuesday 9 February 2016, and looked at what this tells us about the problems and challenges that nursing staff are facing. We received 2,708 responses, the majority of which were from UNISON members. There are several alarming similarities between this year and last year which are looked at more closely later in the report.

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

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Executive summary

“\textit{No one listens when you are concerned about unsafe levels. You are expected to just manage.” – Staff nurse (mental health).}"

As a result of NHS England and the Department of Health’s decision to suspend NICE’s work on safe staffing levels, we were expecting the results of this survey to show significant reductions in safe staffing levels.\textsuperscript{2} We also expected this to be further affected by the introduction of a cap on the amount that can be spent on agency staff in England\textsuperscript{3} and because we know that government policy decisions have led to the supply of nurses failing to keep up with growing demand\textsuperscript{4}.

So it came as no surprise that many staff are still having to care for eight or more patients – the ratio that research tells us it is when harm occurs – on their shift. The impact of having to look after so many patients means nurses are so busy that care is either having to be rationed or left undone – even when staff work through their breaks or do unpaid overtime.

The best way to ensure we have safe staffing levels is to identify and set mandatory minimum nurse-to-patient ratios that should be enforced nationally. This is essential because even where there is guidance many organisations are ignoring it. For example, only 17.7\% of respondents said that their organisation continues to use the NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England.

Nurse-to-patient ratios would also help to increase the supply of nurses in the UK. The government could do well to learn from the Australian experience where new improved nurse-to-patient ratios saw 20,000 nurses come back into the profession\textsuperscript{5}. A similar approach here could work wonders for the NHS.

\begin{itemize}
\item \textsuperscript{2} \url{https://www.nice.org.uk/news/article/nhs-england-asks-nice-to-suspend-safe-staffing-programme}
\item \textsuperscript{3} \url{https://www.gov.uk/government/news/clampdown-on-nhs-staffing-agency-costs}
\item \textsuperscript{5} \url{http://nurses.3cdn.net/f0da47b347e41bb03a_z1m6v1sd.pdf}
\end{itemize}
Pushing the call button on unsafe staffing: who will come to our aid?

The main findings in brief

“We have had crisis staffing levels for the past six months. We are currently under investigation to ensure our staffing levels improve. It has been very unsafe for the past six months for staff and patients. I am hoping this will improve as it has become extremely difficult to work in these circumstances”. – Staff nurse (general).

Over half (54.5%) of respondents reported that 9 February 2016 was a ‘typical’ day at work. We had 2,708 responses from staff in different roles across the nursing family from every UNISON region and across all shift and workplace types.

In some areas the survey results mirrored many of the same results from last year’s survey – so show no significant improvements in patient care. However, in other areas there has been a steady decline in standards over the last five years and this needs to be addressed by employers and the government.

Key findings

- 89.2% of respondents support nationally set mandatory minimum nurse-to-patient ratios.

- 69.7% of respondents reported not having an adequate amount of time with each patient.

- 74.6% of respondents said that because they did not have enough time, they were unable to comfort or talk to patients.

- 63.3% of respondents felt there were not adequate staff numbers to deliver safe, dignified, compassionate care. This is especially worrying in a post Francis era.

- 55.6% 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 (70.6%) 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.

- 43.1% of respondents said that they worked with one or more bank or agency staff on their shift on 9 February 2016.

- 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.

- Better care was able to be delivered when a nurse was looking after fewer patients.

- Three years on from the Francis recommendations, nearly half of respondents (47.3%) reported their organisations were at risk of a serious care failing developing and 15.3% of respondents indicated that care failings similar to Mid Staffs were happening in isolated parts of, or across, their organisation.

- 40.8% of respondents worked over their contracted hours with 74.8% working up to an hour of additional time – only 9.9% of staff were paid for this extra work.

- 60.5% of staff were unable to take all or some of their breaks that day.

- 52.3% of respondents felt that they were either not at all confident, not very confident or only somewhat confident about raising a concern at work, which in a post Francis era is deeply worrying.

- Following the decision of the Department of Health and NHS England to suspend the independent work NICE was doing on safe staffing, almost three-quarters (71.5%) of respondents told us they were worried that staffing levels will get worse and patient safety will suffer.

- Suppressed NICE safe staffing guidance for hospital emergency departments called for the NHS to implement minimum registered nurse ratios. The majority of respondents reported that their organisation did not meet the minimum nurse-to-patient ratios for hospital emergency departments recommended under this suppressed guidance.

- NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England should still be used by organisations to set safe staffing levels. However, only 17.7% of
respondents working on an adult inpatient ward in an acute hospital in England said that their organisation continues to use the guidance.

- 39.3% of respondents either strongly agreed or agreed that the introduction of the agency spend cap in England last year affected their organisation’s staffing levels.

- 68% of respondents said that they had considered leaving their role in the last six months. The service is haemorrhaging nurses at a time when it most needs them.

**UNISON recommendations**

1. Nationally set mandatory minimum nurse-to-patient ratios should be identified. We believe the best option is to establish national ratios which reflect the California model. This allows for different levels of patient dependency in different care settings. This would still allow for local decision making to increase the staffing numbers where required.

2. The eight working groups established by NHS Improvement should build on the NICE work but should also look at identifying minimum nurse to patient ratios. Evidence from inspections from the Care Quality Commission (CQC) should also be used to help identify the ratio of nurses-to-patients in organisations where high quality care is provided.

3. We want to see the introduction of a safety check list for staffing levels which builds on the World Health Organisation’s pre operative safety check. A safety meeting should take place at the beginning of each shift to go through the check, giving all members of the team an opportunity to comment and contribute. This should be reviewed at the end of the shift to reflect what happened during the shift. This information will help to inform the safety agenda at a local level but will also help create a culture where safety discussions at all levels are the norm. UNISON will be pushing this agenda by starting to work with independent experts to establish what this checklist could look like.

4. All NHS organisations should establish joint nursing committees at a local level. 50% of members should be frontline practicing nurses and health care assistants. They should review all red flag events and nurse sensitive safety markers including incidents of nurses caring for eight or more patients, times when staff are unable to deliver care needs and situations when staff are having to make decisions on rationing care.

5. NHS organisations and boards reviewing information on staffing levels should also look at bank and agency usage. This should include how much was spent and the types of shifts and departments which require agency staff. They will then be better able to consider whether these units are adequately staffed.

6. UNISON believes that NHS organisations should work in partnership with staff and unions 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.

7. 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 – sometimes without even testing their effectiveness first. The Health and Social Care Act 2012 is a good example.

Others, 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>1:1</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>
</tbody>
</table>

In setting a minimum, UNISON nurses are simply stating that there should be a level below which standards should not fall. Francis6, in his report into the care failings at Mid Staffordshire Foundation

Trust, used this phrase several times to cite standards against patient outcomes or experiences.

Australian staffing ratios have led to safer care and motivated nurses. “In the 14 years since the legislation was introduced in Australia7, the state of Victoria has seen an increase of 10,800 nurses and midwives working in the public health system, more people are being treated and a motivated nursing workforce can deliver safe, reliable continuity of care”.

When the NICE guidance was published in 2014, Lisa Fitzpatrick from the Australian Nursing and Midwifery Federation said: “The NICE guidance will never be implemented without a legal obligation.” In less than a year the groundbreaking work undertaken by NICE was suspended by the Department of Health and NHS England8. Simon Stevens, chief executive of NHS England announced this decision at the NHS Confederation conference, saying simply that Jane Cummings, chief nursing officer for England will be taking this work forward.

There was no evidence base for this decision and no evaluation of the NICE guidance either in terms of effectiveness or implementation9.

In June last year, Jane Cummings wrote to the NHS and stakeholders10 and made it clear that nothing she was doing was changing the work which NICE had undertaken but in addition she wanted to look at staffing levels beyond nursing and take account of multi-disciplinary teams.

However it is only now that NHS Improvement has started to take this work forward, setting up eight separate working groups looking across the service. During this time, there has been a lack of focus and confusion with senior nursing leaders remaining committed to safe staffing, while at the same time doubt about how this is to be achieved has been increasing. The result has been unhappiness among staff who are increasingly concerned about being able to deliver high quality care.

9 http://www.hsj.co.uk/news/exclusive-nice-suspends-work-on-nurse-staffing-levels/5085545.article
Academic studies and evidence show that the number of nurses on duty can make a dramatic difference to patient care and outcomes. However, what is alarming senior nurses is the reluctance to test the theory of nurse-to-patient ratios. Surely if we believe in research based evidence, we would test to see if a mandated minimum level of nurses is detrimental to patient care.

An overwhelming majority of people in the UK are already convinced of this benefit from looking at international evidence. And they would be prepared to participate in a pilot if it reassured them and provided a real evidence base in the UK.

The instructions communicated in a joint letter by Monitor and the Trust Development Authority\(^\text{11}\) (NHS Improvement from 1 April 2016) make it clear that head count reductions on staffing must be made to reduce deficits within organisations. This runs contrary to all other communication from NHS leaders since the Francis report. Safe staffing costs money but is an investment that prevents harm being caused to patients and their families. Sir Robert Francis said in his letter to the then Secretary of State for Health\(^\text{12}\); “If there is one thing I can be certain of it is this; people come before money”. In a very short space of time that simple yet telling message from Francis has been forgotten.

It was clear from leaked NICE guidance that their suspended work in accident and emergency was going to specify safe staffing levels. In January 2016, following an appeal by the Health Service Journal (HSJ) into the rejection of their Freedom of Information requests\(^\text{13}\), two non executive directors were tasked with the responsibility of reviewing the decision taken by Andrew Dillon, chief executive of NICE, not to publish the incompleated staffing levels work.

The reports were released to the HSJ\(^\text{14}\) and the cost of the work undertaken by NICE was estimated at £1million. The research based evidence highlighted “low nursing skill mix and low staff numbers will have a negative impact on outcomes” – for example more patients leaving without being seen, higher occupancy rate in A&E departments etc.

The guidance went on to stipulate that “minimum ratios for areas of A&E departments and registered nurse-to-patient ratios for particular situations was recommended in this guidance, based on the evidence available and the safe staffing advisory committee’s knowledge and experience.”

It made it clear that these were minimum numbers allowing for local professional judgement to be used to increase them where it was felt appropriate.

**The recommended nurse ratios were**

<table>
<thead>
<tr>
<th>Area</th>
<th>Recommended nurse ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage</td>
<td>One registered nurse to one cubicle in triage</td>
</tr>
<tr>
<td>Majors</td>
<td>One registered nurse to four cubicles in majors</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>One registered nurse to two cubicles</td>
</tr>
<tr>
<td>Major Trauma</td>
<td>Two registered nurses to one major trauma patient</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>Two registered nurses to one cardiac arrest patient</td>
</tr>
<tr>
<td>Ambulance</td>
<td>One registered nurse to one priority ambulance patient</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Every A&amp;E shift should have a registered childrens nurse, or at least a nurse trained in caring for children</td>
</tr>
</tbody>
</table>

While the NHS in England seem to be backing away from the issue, Wales will be the first country in Europe to establish specific legislation\(^\text{15}\). We are still waiting for the detailed implementation guidance which will cover this legislation but it will be ground breaking in its approach and demonstrates the clear difference in thinking between Westminster and the Welsh Assembly.

The Bill will places a duty on health service bodies to ensure that nurse staffing levels on adult acute wards do not fall below certain levels – minimum levels to be included in statutory guidance as minimum ‘registered nurse-to-patient ratios’. There is provision for this to be extended to other healthcare settings in the future.


\(^{13}\) http://www.hsj.co.uk/topics/workforce/directors-to-review-nice-chiefs-decision-not-to-release-staffing-guidance/7001340.article

\(^{14}\) http://www.hsj.co.uk/topics/workforce/nice-releases-safe-staffing-evidence-reviews-to-hsj/7001690.article

\(^{15}\) http://www.senedd.assembly.wales/mgissueHistoryHome.aspx?id=11778
It will include a duty on local health boards/NHS trusts in Wales to designate a person to calculate the nurse staffing level, exercising professional judgement, giving additional local flexibility to take account of patient acuity.

Each board to which the duty applies must submit regular nurse staffing levels reports to Welsh ministers, to allow oversight and political scrutiny.

The situation in Australia

Victoria was the first state to achieve nurse-to-patient ratios in Australia. The New South Wales Nursing Association16 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.

The US campaign

National Nurses United (NNU), a new body in the United States 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 with the necessary skill mix to ensure patients receive high quality care. However, in the US with its 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 achieve this, placing both patients and staff in vulnerable positions.

Workforce tools or mandated minimum – the UK debate

In the UK, research has been undertaken linking nurse-to-patient ratios to patient mortality. A study by Professor Rafferty in 2006 reported 26% higher mortality rates for patients in hospitals that had the highest number of patients per nurse. In other words, more patients die where there are fewer nurses to care for them. Nurses in these hospitals were also more likely to report low or deteriorating quality of care on their ward or in their hospital. A further study in 2013 confirmed these findings when it was found that the 14 trusts in England with the highest levels of patient mortality rates had, on average, six fewer nurses per 100 beds than other trusts.17

Studies, including the 2009 Boorman Review into NHS Health and Wellbeing18, 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 bed occupancy is ineffective and many people would argue that you should manage hospital beds in the way hotels measure availability. However, this fails to take into account the patient journey19. Research highlights the inaccurate interpretation by organisations of the impact of patients staying in hospital for a shorter time. They think this means you require less nursing staff, but in fact the opposite is true as patients who stay for a shorter time are more dependent on staff while they are there.

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16 The New South Wales Nursing Association became the New South Wales Nursing and Midwifery Association in 2012
17 Nursing Times. Study suggests link between fewer nurses and higher death rates. 12 March, 2013. http://www.nursingtimes.net/5055934. article?referrer=e1
19 Nursing Economics, May-June 2009/vol27/No.3 Churn: Patient Turnover and Case Mix, Duffield, Diers, Aisbett and Roche
in the Lancet in February 2014 was the most comprehensive study for a while that looked at and considered nurse numbers and education and their impact on patient mortality. It looked at almost one million patients in 300 hospitals analysing data across Norway, Ireland, Netherlands, Finland, Sweden, Switzerland, England, Belgium, and Spain. The research carried out over a number of years found that an increase in a nurse’s workload by one patient was associated with a 7% increase in patient mortality.

The number of patients to an individual nurse cared for varied across the countries:

<table>
<thead>
<tr>
<th>County</th>
<th>Patient number</th>
<th>Registered nurse number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>5.2</td>
<td>1</td>
</tr>
<tr>
<td>Ireland</td>
<td>6.9</td>
<td>1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>7.0</td>
<td>1</td>
</tr>
<tr>
<td>Finland</td>
<td>7.6</td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td>7.6</td>
<td>1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>7.8</td>
<td>1</td>
</tr>
<tr>
<td>England</td>
<td>8.8</td>
<td>1</td>
</tr>
<tr>
<td>Belgium</td>
<td>10.8</td>
<td>1</td>
</tr>
<tr>
<td>Spain</td>
<td>12.7</td>
<td>1</td>
</tr>
</tbody>
</table>

Over the last four years, UNISON’s staffing levels survey has found nurses reporting that they are regularly looking after eight or more patients. This 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.

The introduction of the World Health Organisation surgical check list has proven to be an international success. One of the unanticipated associated impacts

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20 Safe Staffing Alliance, March 2014, Jane Lawless
21 Ball, JE et al. BMJ Qual Saf 2013;0:1-10 doc10.1136/bmjqs-2012-001767
22 Lancet, 26th February 2014, Nurse Staffing and education and hospital mortality in nine European countries; a retrospective observational study, Aikens, Sloane, Bruneel, Van den Heede, Rafferty, Griffiths, Busse & others

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Pushing the call button on unsafe staffing: who will come to our aid?

has been the cultural impact, which has legitimised the ability for anyone in the team to raise an issue which could be pertinent to the patient or team’s safety.

The outcome of implementation has been shown to raise awareness about patient safety but also recognises the value of time out. 64% of respondents to their study felt it had improved patient safety. We believe this is something which could benefit the safety of patients during shifts.

Scotland, Wales and Northern Ireland

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.

Almost two-thirds (67.3%) of respondents in Scotland, Wales and Northern Ireland 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).

UNISON welcomed the implementation of mandatory workforce planning tools in Scotland, Wales and Northern Ireland. If properly implemented and supported, these 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. 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 an increase 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%. 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

Table 2: In Scottish, Welsh and Northern Irish 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 | 9.4% |
| I DON'T KNOW | 23.3% |
| NO | 67.3% |

24 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3776503/

need to be filled to ensure that the mandatory staffing tools deliver what they originally promised.

**The Safe Nurse Staffing Levels (Wales) Bill**

Wales has become the first country in the UK to introduce legislation mandating nurse staffing in its hospitals. In February 2016, the Welsh Assembly voted to approve the Nurse Staffing Levels (Wales) Bill which received royal assent in March 2016. The law will require local health boards, and English NHS trusts with services in Wales, to calculate and agree minimum nurse levels. They will have to provide indicators of where failure to provide a sufficient number of nurses has compromised patient care in the past.

However, UNISON wants these safe minimum staffing levels to be extended to all groups of staff and all settings. This is a view supported by those who completed the survey; nine out of 10 (87.5%) respondents think that the Bill should be extended to cover other clinical areas and not just adult inpatient wards in acute hospitals (table 2A).

**Table 2A: In Wales, the Safe Nurse Staffing Levels (Wales) Bill will first apply to adult inpatient wards in acute hospitals. Do you think the Bill should be extended to cover other clinical areas?**

- **YES** 87.5%
- **NO** 3.8%
- **I DON’T KNOW** 8.8%

**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.

This is mirrored in our survey. Just over a quarter (27.7%) 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 in relation to the number of patients.

**The impact of the suspension of NICE work on safe staffing levels**

NICE issued guidance on safe staffing in two settings: adult acute wards and maternity. The guidance was commissioned in 2013 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.

However, NHS England decided to suspend NICE’s independent work on safe staffing levels and announced that they would take forward the issue of staffing in accident and emergency departments and in mental health and community settings as part of a wider programme of service improvements. Sir Robert Francis expressed serious concerns over the decision to suspend the programme of work that he

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Pushing the call button on unsafe staffing: who will come to our aid?

Table 2B: Suppressed NICE safe staffing guidance for hospital emergency departments called for the NHS to implement minimum registered nurse ratios. If you worked in A&E on 9 February 2016, please answer the questions below about your shift.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>My shift had at least 1 registered nurse to 1 priority ambulance patient</td>
<td>YES</td>
<td>40</td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 1 cardiac arrest patient</td>
<td>NO</td>
<td>30</td>
</tr>
<tr>
<td>My shift had at least 2 registered nurses to 1 trauma patient</td>
<td>KNOW</td>
<td>20</td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 2 cubicles in resuscitation</td>
<td>DON'T</td>
<td>10</td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 4 cubicles in majors</td>
<td>DON'T</td>
<td>10</td>
</tr>
</tbody>
</table>

In January 2016, the Health Service Journal (HSJ) reproduced the NICE guidance on safe staffing in accident and emergency departments from a leaked document\(^2^8\). For the first time, the guidance recommended nurse to patient ratios for a healthcare setting. However, when asked whether their accident and emergency department met the ratios in the guidance, the majority of respondents working in an accident and emergency department on 9th February said it did not (table 2B).

Following the decision of NHS England to suspend the work NICE were doing on safe staffing, almost three-quarters (71.5%) of respondents feel worried that staffing levels will get worse and patient safety will suffer (table 2C).

Although the guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England should still be used by organisations to set safe staffing levels, only 17.7% of respondents that work on an adult inpatient ward in an acute hospital in England said that their organisation continues to use the guidance. Worryingly, almost two-thirds (61.5%) of respondents don’t know whether their organisation is continuing to use it or not (table 3). It is clear that the decision to suspend the work of NICE on safe staffing has created mass confusion in the acute setting.

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28  http://www.hsj.co.uk/7001696.article
Where the guidance is still being used, we asked respondents whether they are still encouraged to record ‘red flag events’. Disappointingly, less than half (44.9%) of respondents said that they are encouraged to do so (table 4).

Although only a quarter (24.2%) 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 two in 10 (19.7%) respondents did not know whether a nursing ‘red flag event’ had occurred on their ward (table 4A). This suggests a lack of communication and transparency. Organisations should do more to monitor ‘red flag events’ and inform their staff when they occur.

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. Where the guidance is still being used, we asked respondents whether they are still encouraged to record ‘red flag events’. Disappointingly, less than half (44.9%) of respondents said that they are encouraged to do so (table 4).
Pushing the call button on unsafe staffing:
who will come to our aid?

Table 4A: Did a nursing ‘red flag event’ occur on your ward on 9 February 2016?

Table 5: Did the occurrence of the nursing ‘red flag event’ prompt an immediate escalation response by the registered nurse in charge?

Following a ‘red flag event’, the guidance states that it must prompt an immediate escalation response by the registered nurse in charge. Worryingly, almost two in 10 (18.8%) respondents who had a nursing ‘red flag event’ occur on their ward said that it did not prompt an immediate escalation response by the registered nurse in charge (table 5). When staff are raising ‘red flag events’ that are not responded to, 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 there is an immediate escalation response by the registered nurse in charge to ensure adequate patient care.
Survey background

"On night shifts, staff nurses are still having 1:18 ratios which is dangerous and unsafe practise. This also includes HCAs. Not to mention patients who require 1:1 care who have no staff to support them. This results in falls, injuries or putting other patients at risk". – HCA/AP/SW.

UNISON has been campaigning on safe staffing levels in healthcare settings for a number of years. The reports, anecdotes and members’ stories of the consequences of too few staff continue to pile up which means this campaign continues to be a priority for the union.

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

The survey asked people 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 has unearthed consistently over the last five 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 five years with a few new additional questions on 9 February 2016. Much like the first survey (6 March 2012), the 2016 survey asked respondents to record details about their shift during the same 24 hour period. This year the on-line survey ran over a 24 hour period on Tuesday 9 February 2016. 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 68 questions, including 10 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 9 February 2016 – 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 2,708 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 extensively on UNISON’s healthcare social media such as Facebook and Twitter, in UNISON weekly health circulars to branches and via two 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 by 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 clear picture of the situation faced by members working in the nursing family, as well as give us the opportunity to see how things have changed from previous survey results.

UNISON receives regular reports from members about their frustrations with the inadequate ratio of nurses to patients in their workplaces, 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.
Pushing the call button on unsafe staffing: who will come to our aid?

NHS Staff Survey in England 2015

The concerns and feelings voiced by respondents in UNISON’s survey echo concerns in the recent NHS Staff Survey. The NHS Staff Survey is an annual survey which this year involved nearly 297 NHS organisations in England. Full and part time staff directly employed by an NHS organisation on 1 September 2015 could participate and the survey received a response rate of 41% (over 299,000 members of NHS took part).

The NHS Staff Survey showed 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 38% of NHS staff said that communication between senior managers and staff is effective and only 30% 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:

- 73% of NHS staff said that care of patients and service users in their organisations was a top priority.
- 68% of NHS staff felt secure in raising concerns, although worryingly only 56% of staff felt confident that their organisation would address them.
- 71% felt satisfied with the quality of work and patient care they were able to deliver however almost a third (31%) of staff felt that there was enough staff in their organisation to enable them to do their jobs properly.
- Somewhat fewer staff (58%) reported feeling able to deliver the care they aspire to.

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 a decline in safe staffing levels because of the government’s decision to suspend the NICE work on safe staffing and

and a shortage of staff across the NHS.

- Only 42% of staff were satisfied that their trust values their work – there has been no improvement in this area over the past 12 months. Post Francis it is a continued concern there has been no change in staff feeling that their work is valued by their organisation. Thanking someone at the end of their shift costs the service nothing and can lead to improved levels of morale among the workforce.

- Staff reporting that they were working extra hours increased to 72.7% from 63.5% in 2011.

- 58.7% of respondents felt pressure to attend work when feeling unwell.

- Although overall work pressure felt by NHS staff reduced slightly from last year’s NHS staff satisfaction survey, the change is not significant. Again, it is a concern that there has been very little reduction in work pressure felt by staff following the government’s response to Francis and their commitment to ensure that nurse-to-patient ratios would be set locally. This also echoed the results in UNISON’s pay survey as part of UNISON’s submission to the NHS Pay Review Body where we highlighted an increase in workload; respondents identified working longer hours unremunerated

29 http://www.nhsstaffsurveys.com/Page/1010/Home/NHS-Staff-Survey-2015/

30 https://www.unison.org.uk/content/uploads/2015/01/TowebUNISON-Evidence-to-the-NHSPRB-2015-16-seven-day-services2.pdf
introduce the agency spend cap. Unsurprisingly, there has been a decline in safe 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.

Methodology and composition of respondents

“We constantly Datix unsafe staffing levels but are constantly ignored!”

– Midwife

The overwhelming majority of questions in this survey originated from the 2012 survey. It was deemed appropriate to add some questions last year, 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, Wales and Northern Ireland to see how effective they had been at ensuring safe staffing levels. This year, we added more questions relating to the decision to cap agency spending in England and to suspend the work NICE were doing on safe staffing levels. Before going 'live', the survey questions were given to UNISON’s national nursing and midwifery committee for review and comment.

The 2,708 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 (16.4%), the South East (10.9%), the South West (8.3%) and Yorkshire and Humberside (7.9%). The region with the fewest respondents was Northern Ireland, which made up 3.7% 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).

These percentages roughly reflect the distribution of regional responses when this survey was run in 2014 and 2015 (table 6).

Table 6: What region is your organisation in?

<table>
<thead>
<tr>
<th>Region</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Midlands</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Cymru/Wales</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Yorkshire &amp; Humberside</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>South West</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>South East</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Scotland</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>North West</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Greater London</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>East Midlands</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Midlands</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Northern</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>South West</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>South East</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Scottish and Welsh Health</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Boards</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>NI Health and Social care</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>trusts</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Community services</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Care homes</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Private sector</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Workplaces

“I believe due to unsafe staffing levels and increased volume of patients my work place in A&E has become unsafe.” – Staff nurse (general).

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 (9.9%), NI health and social care trusts (3.7%), community services (9.3%), learning disabilities and care homes. Only 3.0% of respondents identified themselves as working in the private sector (table 7).
Pushing the call button on unsafe staffing: who will come to our aid?

Unsurprisingly respondents working on those wards with patients with high dependencies indicated that they did not have enough time to spend with patients – medicine (76.8%) followed by rehabilitation (74.8%), care of the elderly (73.0%), general practice (including Trauma) (68.7%), mental health: inpatient (68.0%), and accident and emergency (66.3%). The number of people who identified not having adequate time to spend with each patient has increased in most care settings each year since 2014 (table 8).

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 399 respondents (19.1%) 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.

The areas of care in which respondents worked on 9 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. 19.1% 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 15.1%, followed by medicine at 13.6%, surgery at 11.7% and mental health: inpatient at 9.7%.

“No time to read risk assessments or careplans for patients before having to see them due to five staff going off sick around the same time.” – Senior nurse practitioner.

Care settings become especially pertinent within this survey when we looked at those respondents who identified not having adequate time to spend with each patient. Unsurprisingly respondents working on those wards with patients with high dependencies indicated that they did not have enough time to spend with patients – medicine (76.8%) followed by rehabilitation (74.8%), care of the elderly (73.0%), general practice (including Trauma) (68.7%), mental health: inpatient (68.0%), and accident and emergency (66.3%). The number of people who identified not having adequate time to spend with each patient has increased in most care settings each year since 2014 (table 8).

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

- A&E
- Child health
- Community Mental Health
- Critical Care
- Community Practice (Including Outreach)
- Learning Disabilities
- Dental & Community Health
- Rehabilitation
- Other (please specify)
- Mental Health Secure Unit (Including Low, Medium and High)
- Mental Health Inpatient
- General Practice (Including Trauma)
- Critical Care
- Community Mental Health
- Community
- Children
- Care of the Elderly
- A&E
- Other (please specify)

PERCENTAGE RESPONSE

RESPONSE COUNT PERCENTAGE

RESPONSE OF PERCENTAGE

PERCENTAGE RESPONSE

2016

2015

2014
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 (33.3%) worked a long day, as shown in table 9 below. The number of staff working long days has increased substantially since 2014.

**Table 9: Which shift did you work?**

<table>
<thead>
<tr>
<th>Shift Description</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Late</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Long Day</td>
<td>33.3%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Late/Early</td>
<td>10%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Not Shift Working (Outpatients)</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Did Not Work (Sickness, Day Off, Etc)</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Other (Please Specify)</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Did Not Work (Etc)</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Over half (54.5%) of respondents worked a shift that was contracted to last for more than 10 hours, including almost one-third (31.1%) of respondents 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 2014 (table 10).

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

<table>
<thead>
<tr>
<th>Shift Description</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer than 6 hours</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>6 – 7:59 hours</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>8 – 9:59 hours</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>10 – 11:59 hours</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>12 or more hours</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
</tr>
</tbody>
</table>

However, 40.8% respondents reported that they worked overtime on the 9 February, with only 9.9% of respondents identifying that this extra work was paid, and only 38.2% 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.
Pushing the call button on unsafe staffing: who will come to our aid?

Table 11: Respondents to survey by job role

Table 12: Do you identify as?

As the survey was advertised primarily through UNISON’s own channels, the vast majority of respondents (95.8%) were UNISON members. The remainder belonged to another union (3.4%) or no union (0.8%).

Equality breakdown

The majority of respondents identified as female (60.6%), which is almost representative of the gender make-up in the NHS workforce and in UNISON’s membership (table 12).

Almost one-third (31.3%) of respondents identified themselves as between the ages of 36 and 50, with a further 23.3% as over the age of 50. Only 7.4% of respondents were age 27 or younger (table 14).
The impact of staffing levels on care quality

"Good staffing levels allow a nurse to deliver quality care." – Staff nurse (general).

Respondents for the fifth consecutive year overwhelmingly felt that staffing levels in their workplaces were not sufficient to deliver the quality of patient care required. Across all respondent groups – including regions, job roles, shifts, and workplace – almost half (49.6%) felt that the number of staff present in their workplace on 9 February 2016 resulted in the delivery of a lower standard of care. This is a small reduction from the 52.7% of respondents in 2015. If what the government is saying is true and there are more nurses working in the NHS than ever before, we’d expect to see a significant decline in the number of respondents saying that the number of staff in their workplace resulted in the delivery of lower standards of care. However, respondents continue to tell us that there aren’t enough staff to deliver the safe standards of care. Even if there were enough staff to deliver a safe standard of care, this is not a very aspirational goal. The government should be striving to improve standards to ensure good quality of care and not just safe care. This coupled with the publication of the Government’s Migration Advisory Committee report demonstrates the lack of available nurses to work in the service; if our supply chain of staff were sufficient nursing would not be on the occupational shortage list.

Table 14: What is your age?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 28</td>
<td>26.8%</td>
</tr>
<tr>
<td>28-35</td>
<td>11.2%</td>
</tr>
<tr>
<td>36-50</td>
<td>31.3%</td>
</tr>
<tr>
<td>51-66</td>
<td>23%</td>
</tr>
<tr>
<td>Over 67</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

A large majority (73.7%) of respondents described themselves as being one of the following: White British/English/Scottish/Northern Irish, White Irish, or White Other. This percentage is roughly reflective of the NHS workforce (80%) and UNISON healthcare membership. 16.1% of respondents were from Black and Minority ethnic groups, and a small percentage described themselves as mixed race (table 15).

Table 15: How do you describe yourself?

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British / English / Scottish / Welsh / Northern Irish</td>
<td>73.7%</td>
</tr>
<tr>
<td>White Irish</td>
<td>2.4%</td>
</tr>
<tr>
<td>White Other</td>
<td>4.0%</td>
</tr>
<tr>
<td>Black British / English / Scottish / Welsh / Northern Irish</td>
<td>2.0%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1.1%</td>
</tr>
<tr>
<td>Black African</td>
<td>4.0%</td>
</tr>
<tr>
<td>Black Other</td>
<td>0.3%</td>
</tr>
<tr>
<td>Mixed or multiple ethnic groups</td>
<td>1.0%</td>
</tr>
<tr>
<td>Asian British / English / Scottish / Welsh / Northern Irish</td>
<td>2.3%</td>
</tr>
<tr>
<td>Indian</td>
<td>0.7%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.3%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.2%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.2%</td>
</tr>
<tr>
<td>Filipino</td>
<td>3.4%</td>
</tr>
<tr>
<td>Asian Other</td>
<td>0.5%</td>
</tr>
<tr>
<td>Arab</td>
<td>0.2%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>3.3%</td>
</tr>
<tr>
<td>Any other background</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

We asked respondents if 9 February 2016 was a typical day at work and over half (54.5%) of respondents indicated it was a typical day and that their workplace was as busy as normal (table 16).

Pushing the call button on unsafe staffing: who will come to our aid?

Unsafe staffing ratios imply overworked and stressed staff; higher staff sickness and low morale; feeling under valued and unable to retain staff; less time for patient care and diminished quality of care to patients: vulnerable to pressure sores, undernutrition, medication errors, abuse and negligence of care; more expenses on agency staff.” – Ward Sister / Charge Nurse.

“I recently left my former trust in November 2015 due to horrendous staffing, unsafe workloads, poor support from managers and very high use of agency staff.” – Midwife.

When looking at nurse to patient ratios on those working within a ward setting on the 9 February 2016, over half (55.6%) were caring for eight or more patients (table 17). 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. Additionally, table 17 shows that there has been no improvement in five years and that the percentage of nurses caring for eight or more patients has increased.

We also looked at nurse to patient ratios by shift type. Almost three-quarters (70.6%) of all staff who worked on a night shift on 9 February 2016 reported caring for eight or more patients (table 18A) compared with only 60.4% 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 duties33. 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.

Table 16: 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 3%
- It was typical or as busy as normal 54.5%
- It was unusually busy 7.6%
- I don’t know because I haven’t worked there long enough to tell what’s typical 2.4%
- It was not a typical day because: 10.2%
- Unknown 22.3%

We asked respondents if there was anything more they wanted to tell us about their shift on the 9 February 2016. 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.

“It is always short of staff and over worked. One is not able to provide the appropriate care that mother and babies require due to poor staffing levels. I have lost all hope and faith in the management team in the NHS. They are more concerned about balancing the books as opposed to quality of patient care.” – Midwife.

33 http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/Overview.aspx
We cross-analysed the types of ward that were reporting the highest nurse to patient ratio rates. 75.0% of respondents who indicated that they worked on a medical ward and 65.5% 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 (80.4%), accident and emergency (70.6%), mental health: inpatient (55.9%), community (52.4%), and community mental health (including early intervention team, CAMHS, forensic) (43.8%). These are also the areas where patients often have higher dependency needs (table 19).

### Table 18A: What was the nurse to patient ratio on your shift on 9 February 2016 (night)?

<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>0.0</td>
<td>0.0</td>
<td>5.9</td>
<td>5.9</td>
<td>5.9</td>
<td>11.8</td>
<td>70.6</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td>0.4</td>
<td>0.0</td>
<td>1.3</td>
<td>0.9</td>
<td>2.2</td>
<td>6.7</td>
<td>8.0</td>
<td>80.4</td>
</tr>
<tr>
<td>Community</td>
<td>9.5</td>
<td>0.0</td>
<td>4.8</td>
<td>4.8</td>
<td>14.3</td>
<td>9.5</td>
<td>4.8</td>
<td>52.4</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>0.0</td>
<td>6.3</td>
<td>6.3</td>
<td>12.5</td>
<td>0.0</td>
<td>12.5</td>
<td>18.8</td>
<td>43.8</td>
</tr>
<tr>
<td>Medicine (including Orthopaedics)</td>
<td>0.0</td>
<td>0.0</td>
<td>1.2</td>
<td>2.4</td>
<td>3.2</td>
<td>8.7</td>
<td>9.5</td>
<td>75.0</td>
</tr>
<tr>
<td>Mental Health: Inpatient</td>
<td>0.6</td>
<td>3.4</td>
<td>4.5</td>
<td>9.5</td>
<td>7.3</td>
<td>10.1</td>
<td>8.9</td>
<td>55.9</td>
</tr>
<tr>
<td>Surgery</td>
<td>0.5</td>
<td>0.5</td>
<td>2.5</td>
<td>2.5</td>
<td>6.9</td>
<td>13.3</td>
<td>8.4</td>
<td>65.5</td>
</tr>
</tbody>
</table>
Respondents were asked: “Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?” Last year, over one-third (36.5%) of respondents answered yes and just over half (52.7%) indicated that there were not adequate staff numbers. This year, almost two-thirds (63.3%) of respondents indicated that there were not adequate staff numbers (table 20). This result shows there has been a decline in adequate staffing levels. This decline may be due to a number of different factors, including the government’s decision to cut student nursing places in 2011, the refusal of the government to add nurses to the Occupational Shortage List until late last year, the introduction of the agency spend cap in England, and the suspension of the NICE work on safe staffing levels. The reality is it’s probably a combination of all of these, and little helped by a complete lack of evidence base to inform government decision.

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

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. Over two-thirds (69.2%) of all mental health nurses and general nurses (65.6%) and almost two-thirds (62.5%) of all midwives who worked on 9 February 2016 indicated that they did not have adequate time with each patient. Other staff groups indicating lack of time to spend with patients included 60.6% of health care assistants (HCA), assistant practitioners (AP) and support workers (SW), 65.0% of ward sisters and 36.5% of clinical nurse practitioners (table 22).

Table 21: Did you feel that you had an adequate amount of time to spend with each patient?

Overwhelmingly, over two-thirds (69.7%) 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 which places them in a vulnerable position as it directly contradicts their professional code of conduct (table 21).

Poor staffing levels easily increases our chances to deliver unsafe care.”
– Staff nurse (general).
Much like the question regarding safe care, the percentage of respondents who felt they did not have enough time with each patient increased significantly to 61.2% compared with 48.5% of last year’s respondents. It is not acceptable that only two in 10 (21.4%) respondents report having had enough time with each patient. Nurses should not be put in a position where they have to make decisions about what care gets left undone and this should act as a ‘red flag event’ to employers that there is understaffing in their organisation. Organisations need to address this issue urgently and re-examine the workloads that their nursing staff are dealing with. Episodes of care being left undone should also be recorded on Datix to enable organisations to look in close scrutiny and put plans in place if necessary.

Complaints about staffing levels are only listened to after something goes wrong”. – Staff nurse (mental health).

Respondents were then asked “which of the following activities were necessary but left undone because you lacked the time to complete them.” Three-quarters (74.6%) answered that because they did not have enough time, they were unable to comfort or talk to patients. These questions were taken from a study (Ball et al, 2015) and the responses in that study do not differ much from our respondents (table 23).

Table 23: On 9 February, which of the following activities were necessary but left undone because you lacked the time to complete them? Please tick all that apply.

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 reinforces 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.

34 http://qualitysafety.bmj.com/content/23/2/116
Pushing the call button on unsafe staffing: who will come to our aid?

Although organisations are doing something to address issues, more needs to be done. This was further confirmed in March 2016 when Southend University Hospital NHS Foundation Trust was forced into significant bed closures by the CQC after inspectors raised concerns about staff ratios as indicated in the NICE guidance.36

We also looked at the nurse-to-patient ratio where respondents indicated that care was left undone. Unsurprisingly, almost nine in 10 (86.4%) 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).

Table 24: Nurse to patient ratio where respondents indicated that care was left undone

Poor staffing ratios mean over worked staff, poor delivery of care, higher sickness, higher resignations or poor staff retention, patients suffer and are more vulnerable to neglect: pressure sores, under nutrition, higher complaints and errors in nursing cares”. – Ward sister / Charge nurse.

Respondents were also asked if they felt that their shift had “an adequate skill mix.” Over one-third (35.8%) of respondents felt their shift’s skill mix was adequate for the care they needed to deliver (table 25). Respondents to our survey are clearly saying that even in areas where the proportion of skill mix is correct the overall numbers are not. This indicates that while the skill mix can be correct, there are not the numbers of staff required to ensure safe staffing.

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

Workforce wellbeing

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

“You feel you can’t give optimum care to your patients because you are so busy getting round everyone. I feel the staffing has become worse over the last year. More people are going off sick due to stress of the job and everyone else is left to deal with the shortfall. It makes the clinical area unsafe.” – Staff nurse (general).

“We are being stretched to our limits and morale is bottom-of-the-barrel-low. Several very experienced members of the team are hoping to reduce their working hours or take early retirement as they cannot stand the level of stress and two members of our

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.

In total, 16.4 million working days were lost to sickness absence in 2014/15, with the average worker taking 15.5 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.

**Risk of serious care failings**

Several patients across the trust have fallen and fractured bones despite incident reports being produced and one of the many contributing factors being insufficient staffing levels.” – Ward sister / Charge nurse.

Respondents were asked whether a serious care failing similar to those at Mid Staffordshire Trust could happen where they work. Shockingly, only 7.7% of respondents felt very confident that a serious care failing could never happen in their organisation. And appallingly, 15.3% of respondents 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 (47.3%) 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 an increase from 43.1% of respondents in 2015.

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 10 (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.
Pushing the call button on unsafe staffing: who will come to our aid?

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 27: Percentage who felt that serious care failings are already happening in isolated parts or across their organisation (by region)

Respondents in every region reported that serious care failings were already happening either across or in isolated parts of their organisation. The regions with the highest percentages of reported care failings were Northern Ireland (23.7%), West Midlands (18.0%) and Cymru/Wales (16.1%). The following graph depicts the percentage of respondents in each region who categorised their workplace as having situation(s) similar to the care failings at Mid Staffordshire across their organisation (table 27).

“Consistent understaffing in older adult settings, unable to meet the needs of patients in hospital, such as basic fundamental needs i.e. toileting or maintaining safety where there are increased risks to staff and peers. Consistently neglecting patient needs.” – Staff nurse (mental health).

“Dangerous for patient safety and putting my registration at risk on a regular basis.” – Clinical nurse specialist / Nurse practitioner.

One of the answer choices to this question was “don’t know.” 12.4% 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.

We draw no conclusion or allegation of care failings we have simply sought to accurately reflect the views of respondents. However, UNISON recognises that the response rate from staff working for some organisations was quite low. Therefore, we advised UNISON branches to use this information to begin to have discussions at a local level with employers and to consider whether there were care failings currently happening in the relevant organisation. We have a proven track record of our health branches working together in a proactive manner to address local issues.

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

UNISON please keep on supporting safe staffing levels.”
– 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 (89.2%) responded yes. The response is almost identical to the percentage of respondents in 2015 (88.3%) (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 – a level of care below which we must not fall, as Francis said.

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. Staff are overwhelmingly saying they want a minimum and currently there appears to be a gulf in difference of opinion from a small number of senior nursing leaders in comparison with nurses on the frontline.

Pushing the call button on unsafe staffing: who will come to our aid?

just because something requires planning and thought that it should be abandoned.

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

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

Table 28: Do you think there should be a set national minimum nurse-to-patient ratio?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, I agree</td>
<td>89.2%</td>
</tr>
<tr>
<td>No, I don't agree</td>
<td>1.6%</td>
</tr>
<tr>
<td>I don't know</td>
<td>7.7%</td>
</tr>
<tr>
<td>Other</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

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


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

"Constantly moving staff to cover other wards leaving my department short with acutely unwell patients. Constant pressure and stress is experienced daily. When staffing is safe and in ratio we are moved to other wards which are out of our level of speciality which leads to increased stress and is seriously damaging staff morale. Patients are not being given the care that they deserve and staff are extremely unhappy and undervalued". – Staff nurse (general).

Only 30.5% of respondents worked in a ward or team that had 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 East Midlands (37.1%), Wales/Cymru (35.0%), Yorkshire and Humberside (34.4%) and Greater London (34.2%). The region with the lowest percentage of respondents was Scotland (25.0%).

Those respondents that reported a set minimum nurse-to-patient ratio in their workplace highlighted the average nurse to patient ratio was one nurse-to-six patients (14.4%). However, 47.1% 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 fifth 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.

Over two-thirds (39.5%) 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 just over one-quarter (27.6%) of respondents that did not work on a ward or team with a minimum nurse-to-patient ratio. 58.5% 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 almost half (49.8%) 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 (52.9%) of respondents confirmed that their organisation did not take this into account and only 34.3% confirmed that their workplace did take this into account (table 30).
Pushing the call button on unsafe staffing: who will come to our aid?

Too much responsibility on nurses and very little time to deliver patient care and document”. – Ward sister / Charge nurse.

Protocols for understaffing

Over one-quarter (27.0%) 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 29.7% of staff that were aware that their workplace had a protocol for if they had a shortage of nurses (table 31). Although this figure has improved slightly from last year, the percentage of those who did not know is still alarmingly high. 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 addresses this?

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 (74.5%) answered that they had (table 32). Respondents were then asked how they viewed the outcome of using this protocol or policy. Just under one-third (31.6%) of respondents felt that their concerns were listened to and acted upon (table 33). Table 33 also shows that this has got considerably worse since last year.
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.

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

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

Since the 2015 survey, there has been an increase in the number of respondents who had used a protocol or policy to address understaffing. Because there was a decrease 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
Comparison to the 2015 survey

“Staff are too overworked in care homes. There is not always a high enough ratio between carers and residents”. – HCA/AP/SW.

16.1% of respondents were unsure whether their ward or team had a minimum nurse-to-patient ratio (table 34).

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

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. Leaving any episode of care undone or staff having to consider which care is left undone should be a requirement to Datix it.

I feel you are unable to provide a high, safe level of care when staffing levels are low. It results in lots of problems i.e. falling behind on paperwork and training due to more patient visits. Finishing work late and being overworked results in ill health as well due to being run down”. – Staff nurse (general).

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

The lack of workforce planning by organisations, staff shortages due to high sickness rates and respondents reporting that staff are ‘borrowed’ from one ward (or unit or department) to help another area achieve its minimum ratio, have all continued to be key themes in this survey for a fifth 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.

“I work in critical care and we are chronically understaffed. It is so desperately unsafe at times. Only recently, I had to care for four patients at once. Intensive Care Society guidelines would have recommended a 1:2 ratio based on their level of need. I fear that now management realise this was ‘doable’ it will be allowed to happen again and again. I still love my job but I desperately worry for the future and safety of patients”. – Staff nurse (general).

Staffing levels are getting worse and leads to unsafe patient care, overwork, stress and pressure”. – Staff nurse (general).
Overtime and skipping breaks

“I feel that chronic shortages are now just accepted as normal and staff are usually just left to get on with it, missing breaks - that we don’t get paid for in the first place - and staying late to complete documentation is a very regular occurrence if you want to deliver a decent standard of care”. – Staff nurse (general).

“Registered nurses on my ward nearly always work through their breaks trying to keep paperwork up to date. Some of the paperwork is repetitive; we are required to enter the same info several times on different forms”. – HCA/AP/SW.

Four in ten (40.8%) of survey respondents worked over their contracted hours on 9 February 2016. Of those who worked beyond their contracted hours, three-quarters (74.8%) 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 additional hours did you work?

<table>
<thead>
<tr>
<th>Hours</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 hour</td>
<td>74.8%</td>
</tr>
<tr>
<td>Up to 2 hours</td>
<td>17.1%</td>
</tr>
<tr>
<td>More than 2 hours</td>
<td>7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1%</td>
</tr>
</tbody>
</table>

Again, mirroring last year’s results the overwhelming majority of this time was unpaid. Only 9.9% 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 overtime41. These figures represent an improvement from the survey conducted in 2015, where 36.8% of respondents worked overtime and only 8.4% reported having been paid for it.

To calculate the cost of the hours of unpaid overtime we have assumed that they were on top of band 5 of Agenda for Change in England. All nurse respondents that worked up to an hour unpaid overtime are owed a total of £4,855.20, and assuming that they were on top of band 2 of Agenda for Change in England, all HCA/AP/SW respondents are owed a total of £1,095.60. Staff said that 9 February was a normal day. If this day is replicated over the course of a year, nurses will be owed a total amount of £1,772,148 for working overtime for an additional hour a day. Many of our respondents were in more senior positions. The government and Service needs to stop taking the hard work, dedication and commitment of the nursing family and others to patient care for granted.

Table 36: Was this additional time paid?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9.9%</td>
</tr>
<tr>
<td>No</td>
<td>89.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1%</td>
</tr>
</tbody>
</table>

A respondent’s job appeared to have an effect on the amount of overtime they worked. Almost twice as many staff nurses reported working overtime (47.9%) than healthcare assistants (23.4%) (table 37).

Pushing the call button on unsafe staffing: who will come to our aid?

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

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.

Almost two-thirds (60.5%) of respondents skipped some or all of their breaks during their shift on 9 February 2016 (table 38). This figure has decreased since last year’s survey where 70% of all respondents reported not being able to take all or some of their breaks. 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.

“...The area I work in have the attitude that if a nurse is experienced she can cope. That’s not the case. I intend to leave the NHS because of pressure, lack of support and too much paperwork. That takes away valuable care for patients but I am at breaking point” – Clinical nurse specialist / Nurse practitioner.

“We care for 21 young residents over two units, at times it is just one nurse and four carers. It’s difficult to try and meet all their needs. There are times when we have to compromise on this like ensuring the residents attend appointments, and nurses are running between meetings without a break. Often no support is offered and carers are administering medication to residents, which the home manager states is perfectly safe. This is most concerning to the nurses and is clearly not safe practice”. – Nurse manager.

When we looked at staff roles that did not have time to take any breaks on 9 February 2016, 17.8% of general
nurses and 17.3% of HCAs/APs/HSWs identified being in this category. The highest percentages by role were health visitors (50.0%), nurse managers (43.8%), mental health nurses (42.7%) and matrons (40.0%) (table 39).

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

Over two-thirds (69.8%) of respondents that said there were elements of care they could not provide because they did not have time. They did not take some or all of their breaks, and almost half (49.9%) worked over their contracted hours. Four in 10 (42.3%) 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. The impact of years of pay being frozen and subsequent insulting 1% pay offers have had a major effect on staff morale and motivation. The government is now abusing the good will of nursing staff. All of this runs contrary to their cultural aspirations for the NHS.

“All our staff are either on sick leave, returning from sick leave or leaving”.
– Staff nurse (general).

Furthermore, any individual who feels unsupported, unrecognised and un cared 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.

“Almost every shift I work we are short staffed and despite the efforts made by management to improve the situation it has not only got worse but far more dangerous for patients and staff”.
– Ward sister / Charge nurse.

“Always short staffed and moving staff nurses from our ward to work on others”.
– Staff nurse (general).

“Annual leave cannot be facilitated when needed due to staff shortages. Rotas are very short notice and do not meet family friendly policies”.
– Staff nurse (mental health).

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. However, there is now a clear reliance on agency staff being used to plug gaps in safe staffing levels longer term.

42 The Effectiveness of Health Care Teams in the National Health Service – Aston University
homepages.inf.ed.ac.uk/jeanc/DOH-final-report.pdf

39
Six in 10 (60.2%) 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 (39.8%) said they worked overtime. Almost one-third (32.7%) 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 8, 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. 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 9 February 2016 was a typical day in their workplace/organisation and a vast majority of respondents said it was.

“Capping agency nurse rates has not made nurses return to the NHS, it has just made matters worse as now they would rather work in the private sector. We are now expected to do the job of two nurses. The NHS needs to look at why nurses are leaving and on long term sick; they are burnt out. Morale is low on wards and the patient is the one stuck in the middle of it all”. – Staff nurse (general).

Bank and agency staff

“I find it very scary to be in charge at the weekend when you have unsafe staff ratios but you are unable to get bank or agency staff as only the managers can now book these, but they are not working at weekends and there is nobody to help you. They go off duty well aware of bad numbers but hope we manage.” – Staff nurse (general)

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.

However, UNISON does not 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 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 (28.8%)
- Chronic short staffing problems (37.9%)
- Permanent colleagues on frequent or long term illness/disability/maternity leave (22.6%).

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. In this group, a majority of respondents indicated all of the reasons listed above. Respondents were allowed to choose from multiple answers.
Table 40: Do your shifts frequently make use of bank or agency staff?

Nearly a quarter (21.6%) of respondents reported that they worked with one bank and/or agency staff member and 21.5% of respondents indicated that they worked with between two and five bank and/or agency members of staff (table 41).

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

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 (80.0%) or adequate numbers to deliver safe, dignified and compassionate care (76.2%) than those who did not work with multiple bank/agency staff on their shift (67.1% and 63.9% respectively) (tables 42 and 43). Many respondents explained that the reason for this was because of 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.
Pushing the call button on unsafe staffing: who will come to our aid?

From these results it continues to be the case that the addition of bank and/or agency staff does not necessarily solve the problem of understaffing. What is clear is that employers need to look at other ways of addressing understaffing than regularly using temporary staff that are unfamiliar with the workplace.

“Bank staff and agency staff make up the majority of the shift. Sometimes it means the numbers are made up to adequate staffing, but if the male to female ratio is not met or the training needs haven’t been met then the extra staffing has been pointless in provision as they are of no value.” – HCA/AP/SW.

“Last week I was on night duty with 19 patients holding the stroke bleep to go to ED for all stroke admissions and potential thrombolysis patients and I was left with one trained agency nurse and two bank auxiliaries. I expressed safety concerns to the duty manager, but I was told I would have to manage.” – Ward Sister / Charge Nurse.

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 and risk patient safety. We also believe safe staffing levels could be a positive contribution to reducing the incidents of ‘never events (serious incidents that are wholly preventable)’, 306 of which occurred between 1st April 2014 and 31st March 2015.

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 NHS Improvement, £3.3 billion was spent on temporary staff in 2014/15. 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. However, we are yet to see an increase in substantive posts following his announcement.

In an attempt to reduce the amount NHS trusts were spending on agency staff, the government introduced an agency spend cap in England in November 2015. The new rules will see:

- An annual ceiling for total agency spend for each trust between 2015/16 and 2018/19. Trusts are being sent individual ceilings and will have the opportunity to apply for exceptions if there are specific local needs;
- Mandatory use of frameworks for procuring agency staff;
- Limits on the amount individual agency staff can be paid per shift, which will be implemented later in the year after further work by the two organisations.

However, the cap was introduced at a time when the supply of nurses has not kept up with demand. Health Education England (HEE) data shows that NHS trusts had 15,489 FTE vacancies for adult nurses in April 2014, equivalent to a 6.5% vacancy rate. Therefore, it’s not surprising that over one-third (39.3%) of respondents strongly agreed or agreed that the introduction of the agency spend cap in England last year affected their organisation’s staffing levels (table 43A). The government needs to take steps to increase the supply of nurses before introducing any agency spend caps which have a detrimental impact on staffing levels and, consequently, patient safety.

Almost half (44.7%) of respondents stated that their ward/setting spent up to £10,000 in December 2015 on agency staff compared with over one-third (35.3%) of respondents in November 2015. Worryingly, 7.3% of respondents said that their ward/setting spent over £50,000 on agency staff in November 2015 and 8.4% of respondents in December 2015 (table 43B).
Raising concerns

While off duty, my ward was left with only two staff nurses and one HCA on duty on an afternoon shift for 24 patients. We should’ve had six staff members. No help was sent and no concerns regarding patient and staff safety were taken seriously” – Deputy ward manager.

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 over half (52.3%) of respondents 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 fifth 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.

"In the majority of cases when we are working short staffed, management have attempted to fill the shift, but the nurse bank are unable to fill it. Then the upper management are not prepared to pay out for agency". – Staff nurse (general).

"The staffing levels have remained critical for about the last three years, but it is the hiring of unsafe agency or bank nurses with no critical care or little experience to cover the numbers that puts patients lives most at risk." – Staff nurse (general).

"It doesn’t matter how many times you call clinical nurse managers with concerns over your staffing levels, our area never gets help. But we help many other wards on a daily basis which leaves our ward constantly short staffed. They rob Peter to pay Paul!" – Staff nurse (general)

"I feel under constant threat of being moved to other areas due to staffing being so bad. Wards are dangerously understaffed or covered by agency staff who are unfamiliar with the wards and require additional support from any regular staff on duty. I do not feel it is safe to work in these areas and am not listened to when I raise concerns with management about this". – Staff nurse (general)

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.

"Table 43B: How much did your ward/setting spend on agency staff in November and December 2015?"
and are still aware that their employers would not be held to account for any mistakes contributed to by unreasonable workloads or lack of staff.

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

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 that their concerns will be listened to and acted on.

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

"I work in older people services mental health and very often there is 1 registered nurse for 20 patients. I have expressed my concerns for patient safety to the manager but nothing is done". – Staff nurse (mental health).

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

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

Blame culture

"I have been moved to wards where I feel my skill mix and lack of acute ward experience is unsafe. When I have raised my fears I have felt belittled or not welcome". – Staff nurse (general)

"I feel that staff should be listened to by the management without fear".
– Midwife.

"Even when you raise concerns... no one bothers".
– Staff nurse (general).

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.

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45 Nursing and Midwifery Council, 2015, The Code

Pushing the call button on unsafe staffing: who will come to our aid?

The effect of government policy on safe staffing levels

“Staff to client/patient ratios have been declining for decades. The government failed to address this and prioritises cost over care every time.” – Staff nurse (mental health).

“I fear for the safety of patients and staff in the current climate, the ever growing pressure at work, driven by government goals and statistics. Patient care and safety must be the priority.” – Staff nurse (general).

When asked whether they thought that staffing levels have got worse, better or stayed the same since May 2015, two-thirds (66.6%) of respondents believed that they have got worse. This compares with only 4.5% 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, including:

- The government’s decision to cut nursing places across England between 2010/11 and 2012/13 resulting in nursing training places falling by 12.7%.

- Public service cuts resulting in many nurses being made redundant.

- The introduction of the agency spend cap in England at a time when the supply of nurses has failed to keep up with demand.

- Changing immigration rules to make it difficult or impossible for organisations to recruit from outside the European Economic Area (EEA) resulting in the number of nurses from outside the EEA falling by over 95% from its peak of more than 15,000 in the early 2000s.

The supply of nurses could reduce even further if the government does nothing to ensure safe staffing levels. When asked whether they’d considered leaving the organisation they work for over the last 12 months, over two-thirds (68.7%) of respondents said yes. The percentage of respondents who said yes was similar regardless of the respondents age (table 44). This implies that it is not because they are close to retiring that they wish to leave their organisation, it is due to unsafe staffing levels.

In its response to the NHS Pay Review Body’s call for evidence in 2014, the government expressed its intention to cut unsocial hours payments severely. It argued that this is necessary to deliver the seven-day services vision. 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.

The government could do well to learn from the Australian experience where new improved nurse-to-patient ratios...
Over the last three years, the number of respondents contracted to work 12 or more hours on their shift has increased significantly. In addition, over two-thirds (60.5%) of respondents are not taking some or all of their breaks and over one-third (36.2%) of respondents 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. Workforce plans must have in place sufficient coverage to allow for all breaks.

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

Over one-third (35.8%) of respondents felt their shift had the right skill mix, although not in the correct numbers. 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 (89.2%) 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 there should be a level of staffing below which standards do not fall. However, these will have little effect in ensuring safe staffing levels unless they are mandatory and legally enforceable because even where guidance has been developed we have seen that it is not used by many organisations. For example, only 17.7% of respondents said that their organisation continues to use the NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England. In the absence of legally enforceable standards the default position should be a legal minimum.

Almost one-third (32.9%) 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,

\[\text{“Staffing can be very poor and extremely stressful. I cannot give all the care I want because of this.” – Staff nurse (general).}\]

The survey results show a continued systemic 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 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 over half (55.6%) of 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 we need greater transparency surrounding the impact of staffing levels on patient care and their outcomes.

We believe organisations should be required to report, collate and review the following:

1. Any in patient shift where a nurse is looking after eight or more patients
2. Any incident where care is left undone or delayed
3. Where staff are put in a position where they have to decide how to ration care.

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.

Conclusions

“Staffing can be very poor and extremely stressful. I cannot give all the care I want because of this”. – Staff nurse (general).

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Almost one-third (32.9%) 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.

Over two-thirds (69.7%) of respondents reported not having an adequate amount of time to spend with patients. The main activity that was necessary but was left undone because they lacked time was comforting and talking to patients.

Over half (52.3%) of respondents felt that they were not at all confident, not very confident or only somewhat confident about raising concerns at work, which in a post Francis era is deeply worrying.

Despite the National Quality Board’s guidance, just over one-quarter (27.7%) 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 two years, 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 nearly a third of respondents (32.0%) reported their organisations were at risk of a serious care failing developing in their organisation, and 15.3% of respondents indicated that care failings similar to Mid Staffs were happening in isolated parts of, or across, the organisation.

The supply of nurses has failed to keep up with demand since 2010. The supply has been affected by various policies that the government has implemented, including cutting nursing training places, public sector cuts, and restricting the recruitment of overseas nurses. If the government wants to increase the supply of nurses, it could do well to learn from the Australian experience where new improved nurse-to-patient ratios saw 20,000 nurses come back into the profession. A similar approach here could work wonders for the NHS.
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 tells us that the ratio of nurses to patients is going to have an effect on patient care.

This is our fifth year running this type of 'spot test'. In 2015, the Department of Health and NHS England asked NICE to suspend its work to determine safe staffing levels across the NHS. This year, we require evidence to assess what impact this decision has had on safe staffing levels in your workplace, and whether the situation is getting better, worse, or staying the same, and whether the acute and maternity guidance published by NICE before its work was suspended remains in force.

Thanks for taking the time to record your organisation’s nurse-to-patient ratio on 9 February 2016 and filling in this survey.

Please note that this survey is about your experience on 9 February 2016.

The survey will take about 15 minutes to complete. It's not mandatory to fill in every question, but it will really help us if you do! Our reports are ground breaking and your evidence helps to show the true work and pressure you are under.

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?
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 tells us that the ratio of nurses to patients is going to have an effect on patient care.

This is our fifth year running this type of 'spot test'. In 2015, the Department of Health and NHS England asked NICE to suspend its work to determine safe staffing levels across the NHS. This year, we require evidence to assess what impact this decision has had on safe staffing levels in your workplace, and whether the situation is getting better, worse, or staying the same, and whether the acute and maternity guidance published by NICE before its work was suspended remains in force.

Thanks for taking the time to record your organisation's nurse-to-patient ratio on 9 February 2016 and filling in this survey.

Please note that this survey is about your experience on 9 February 2016.

The survey will take about 15 minutes to complete. It's not mandatory to fill in every question, but it will really help us if you do! Our reports are ground breaking and your evidence helps to show the true work and pressure you are under.

Nurse to patient ratios on 9 February 2016 survey

UNISON's Staffing Levels Survey 2016

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.

About your organisation

1. What is the name of the organisation that you work for?

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

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

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

3. What region is your organisation in?

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

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

5. Are you a UNISON member?

- Yes
- Yes and I’m also a workplace representative or activist
- No and I belong to another union
- No and I don’t belong to any union
If on 9 February you worked in a new or different workplace or role, you should fill out this survey based on your experience on the 9th only.

UNISON's Staffing Levels Survey 2016

Your shift on 9 February 2016

The following questions will help us get an accurate picture of how your ward/unit/department was staffed on 9 February 2016. 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 9th. For example, if you work from 22:00 on the 8th until 06:00 on the 9th, then you should record the whole shift because the majority of hours fell on the 9th.

Did you work a night shift on both 8 and 9 February? Choose one of the two shifts to report about.
Pushing the call button on unsafe staffing:
who will come to our aid?

1. What type of ward/field were you working in on 9 February 2016? 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 9 February 2016, 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

UNISON's Staffing Levels Survey 2016

1. How many additional hours did you work?

- Up to 1 hour
- Up to 2 hours
- More than 2 hours

2. Was this additional time paid?

- Yes
- No
Pushing the call button on unsafe staffing: who will come to our aid?

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

- The ward would have been left unsafe
- Unable to complete documentation
- 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)

UNISON's Staffing Levels Survey 2016

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

UNISON's Staffing Levels Survey 2016

Nurse to patient ratios on your shift

* 1. Did you work on a ward on 9 February 2016?

- Yes
- No

UNISON's Staffing Levels Survey 2016
1. Did you or a colleague count and record the exact registered nurse to patient ratio on your shift on 9 February 2016?
   - 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 registered nurse to patient ratio on your shift on 9 February 2016? This means that for every 1 registered nurse, how many patients were they taking care of? (For example, if on your shift there were 2 registered nurses and 12 patients, the ratio would be 1:6).
   - The ratio was 1:1
   - The ratio was 1:2
   - The ratio was 1:3
   - The ratio was 1:4
   - The ratio was 1:5
   - The ratio was 1:6
   - The ratio was 1:7
   - The ratio was 1:8
   - The ratio was 1:9
   - The ratio was 1:10
   - The ratio was 1:11
   - The ratio was 1:12
   - The ratio was 1:13
   - The ratio was 1:14
   - The ratio was 1:15
   - The ratio was 1:16
   - The ratio was 1:17
   - The ratio was 1:18
   - The ratio was 1:19
   - The ratio was 1:20
   - The ratio was more than 1:20
Pushing the call button on unsafe staffing: who will come to our aid?

3. Suppressed NICE safe staffing guidance for hospital emergency departments called for the NHS to implement minimum registered nurse ratios. If you worked in A&E on 9 February 2016, please answer the questions below about your shift.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Don't know</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>My shift had at least 1 registered nurse to 1 cubicle in triage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 4 cubicles in majors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 2 cubicles in resuscitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least 2 registered nurses to 1 trauma patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 1 cardiac arrest patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least 1 registered nurse to 1 priority ambulance patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least 1 band 7 registered nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My shift had at least one children’s registered nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* 4. Were 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

UNISON's Staffing Levels Survey 2016
1. What was your caseload (i.e. the number of patients you’re expected to see in a non-ward setting) on 9 February 2016? 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. How has the agency spend cap, which was introduced in England last year, affected your organisation’s staffing levels?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Don’t know</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing levels are worse because my organisation is using fewer agency staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. How much did your ward/setting spend on agency staff in November and December 2015? Your ward manager will have this information.

<table>
<thead>
<tr>
<th>November 2015</th>
<th>December 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £10,000</td>
<td></td>
</tr>
<tr>
<td>Up to £20,000</td>
<td></td>
</tr>
<tr>
<td>Up to £30,000</td>
<td></td>
</tr>
<tr>
<td>Up to £40,000</td>
<td></td>
</tr>
<tr>
<td>Up to £50,000</td>
<td></td>
</tr>
<tr>
<td>Over £50,000</td>
<td></td>
</tr>
</tbody>
</table>

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

☐ Yes
☐ No
☐ I’m not sure
1. On 9 February, which of the following activities were necessary but left undone because you lacked the time to complete them? Please tick all that apply.

- [ ] Adequate patient surveillance
- [ ] Adequate documentation of nursing care
- [ ] Administering medication on time
- [ ] Comfort/talk with patients
- [ ] Develop or update nursing care plans/care pathways
- [ ] Educating patients and/or family
- [ ] Frequent changing of patient’s position
- [ ] Oral hygiene
- [ ] Pain management
- [ ] Planning care
- [ ] Preparing patients and families for discharge
- [ ] Skin care
- [ ] Undertaking treatments/procedures
- [ ] Other (please specify)

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

- [ ] Yes
- [ ] No
- [ ] I’m not sure
3. What was the skill mix on this shift?

<table>
<thead>
<tr>
<th></th>
<th>Number of Managers</th>
<th>Number of Registered Nurses</th>
<th>Number of Healthcare Assistants</th>
<th>Number of Administrators</th>
<th>Number of Allied Health Professionals</th>
<th>Number of Other Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Yes
- No
- I'm not sure

5. 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
6. 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:

7. Is there anything else you would like to add about the shift?


UNISON’s Staffing Levels Survey 2016

Your place of work (ward/unit/etc)

1. Does your clinical workplace openly display accurate 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 displays information about staff on duty, but it is not accurate.
- 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 registered nurse-to-patient ratio for your ward or team? (For example if there are 2 registered nurses for every 12 patients, the ratio would be 1:6).

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

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
Pushing the call button on unsafe staffing: who will come to our aid?

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

8. If you answered yes to the previous questions, were your concerns listened to, acted upon swiftly, and resulted in more staff?
   - 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. Please tick the statement that best reflects your feelings following the decision by NHS England and the Department of Health to suspend the work NICE were doing on safe staffing?

- I was worried that staffing levels would get worse and patient safety would suffer
- I wasn't worried because I don't think the guidance makes a difference
- I don't know
- Not relevant because I don't work in England

12. Do you think NICE should have been allowed to continue their work on safe staffing in accident and emergency, mental health and community settings?

- Yes
- Yes, because NICE are independent
- No
- I don't know
- Not relevant because I don't work in England

* 13. Following the decision to suspend the work NICE were doing on safe staffing, does your organisation continue to use the NICE guidance on safe staffing for nursing in adult inpatient wards in acute hospitals in England?

- Yes
- No
- I don't know
- Not relevant because I don't work on an adult inpatient ward in an acute hospital in England

UNISON's Staffing Levels Survey 2016

* 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. Are you still encouraged to record 'red flag events' by your employer?

- Yes
- No
- I don't know
UNISON's Staffing Levels Survey 2016

1. Did a nursing 'red flag event' occur on your ward on 9 February 2016?
   - Yes
   - No
   - I don't know

2. Did the occurrence of the nursing 'red flag event' prompt an immediate escalation response by the registered nurse in charge?
   - Yes
   - No
   - I don't know

3. In Scottish, Welsh and Northern Irish 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, Welsh or Northern Irish Hospital

4. In Wales, the Safe Nurse Staffing Levels (Wales) Bill will first apply to adult inpatient wards in acute hospitals. Do you think the Bill should be extended to cover other clinical areas?
   - Yes
   - No
   - I don't know
   - Not relevant because I do not work in Wales

UNISON's Staffing Levels Survey 2016

Staffing ratios - a good or a bad thing?
1. In your opinion, do you think that staffing levels have got worse, better or stayed the same since May 2015?
   - Better
   - Worse
   - Stayed the same
   - Don't know

2. Have you seriously considered leaving the organisation you work for over the last 12 months?
   - Yes, I have seriously considered leaving
   - Yes, I have considered leaving
   - Yes, I have considered leaving but not seriously
   - I am handing in my notice
   - I intend to leave when I can because I have had enough
   - No
   - Don't know

3. What is your main reason for seriously considering leaving nursing?
   - Unsafe staffing levels
   - Upcoming retirement
   - Overwork and pressure
   - Poor levels of pay
   - Introduction of revalidation
   - Too much paperwork
   - Poor media portrayal
   - Other (please specify)
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. UNISON believes that safe staffing levels should be applied to all health care staff. Do you agree with this position?

- Yes
- No
- I don't know

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

UNISON's Staffing Levels Survey 2016

About you

1. Do you identify as a...

- Woman
- Man
- In another way

2. Do you identify as Trans or have a Trans history?

- Yes
- No
- Prefer not to select
3. Do you identify as...
- Lesbian
- Bisexual
- Gay
- Heterosexual/straight
- Prefer not to select

4. Do you have a disability?
- Yes
- No
- Prefer not to select
5. 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

6. What is your age?

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

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

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.
Pushing the call button on unsafe staffing: who will come to our aid?