Patient and nursing care at breaking point

a UNISON survey into staff/patient ratios 2013
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For the second year running UNISON has conducted a staffing levels survey. We are alarmed to hear that nurses and midwives continue to be placed in situations where their professional views and concerns are not heard. UNISON and front line nurses and midwives believe that national minimum nurse/midwife-to-patient ratios should be set. They believe it will improve patient care and outcomes and that it will enable them to deliver the level of care which is needed.

We repeated the survey on a normal day – 5 March 2013. Like last year there were no major adverse problems on that day and it was not a Monday where the service was still trying to manage the weekend’s emergency admissions. Despite this only 31% of nurses working that day told us that they had sufficient numbers of staff to deliver dignified, compassionate care. The overwhelming majority who said this also told us that patients went without the fundamentals of care due to inadequate staffing levels. This wasn’t because staff didn’t care or try hard enough – they were simply understaffed and unable to provide the level of care needed. Nurses and midwives worked countless amounts of unpaid overtime on this day as well as working through their breaks - and it still wasn’t enough. 62% of respondents said that they didn’t have enough time with patients. The nursing profession has recently been heavily criticised in the press and while UNISON does not condone bad practise, we do have to look at the culture of the services, which is currently prioritising finance and targets over caring for the most vulnerable in our society.

Still staff feel unable to raise their concerns or when they do they are ignored one respondent said “When I reported an unsafe situation to a manager, the manager told me I was ‘too patient safety orientated.’”

By far the most worrying finding was that almost 20% of respondents described care failings in their organisations as on a par with Mid Staffordshire Foundation Trust. In the wake of the publication of the public inquiry led by Robert Francis this is simply unacceptable. Government, politicians and leaders need to listen to staff and act on staff concerns. The growing international evidence on minimum nurse-to-patient ratios can no longer be ignored. We owe it to the families of loved ones who died as a result of care failings at Mid Staffordshire.

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

Gail Adams  Ann Moses
Head of Nursing UNISON  Chair of UNISON’s Nursing and Midwifery Committee
Introduction

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

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

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

From statistical and anecdotal evidence we know that nurses feel very strongly about minimum staffing ratios, which they believe to be fundamental to patient safety and quality of care. In his Inquiry into the care failings at Mid Staffordshire Foundation Trust¹, Robert Francis QC identified the link between appropriate staffing levels and safe, compassionate care. UNISON wants to ensure that nurses are given the opportunity to perform their caring role to the best of their ability and that their contribution to care provision is recognised and valued.

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

This type of survey is unlike any other. In 2012 it was the first of its kind to ‘spot test’ a single, normal 24 hour period for staff across the country, and now it’s running in its second year. From Brighton to Lerwick it asks what work was like on this day, Tuesday 5 March 2013, and what can we learn from the circumstances that nursing staff are facing across the country. Several alarming similarities between working conditions nationally have arisen from this research.

Summary of main points and recommendations

“I want someone from Whitehall to come and work with me for one week: To not be able to go to the loo because you’re simply too busy; to hit the ground running every day; to not stop from 8am to 3.30pm. My hospital hired an outside company to see if they could find ways to make us work ‘smarter’. After three months they concluded that the staff could not work any harder or faster.”

Over 85% of nurses and healthcare assistants (HCAs) responding supported set minimum nurse-to-patient ratios.

Almost 90% of respondents supported legislation mandating minimum nurse-to-patient ratios.

Over 85% of HCA respondents supported minimum healthcare assistant-to-nurse ratios.

One in five respondents (19.7%) reported care failings in their organisations on the level of those at Mid Staffordshire Foundation Trust.

Staff overwhelmingly felt that understaffing affects their ability to do their job. Almost two-thirds of respondents (62.9%) said that they did not have enough time with each patient, and more than half (57.9%) reported that there was not enough staff to deliver safe, dignified and compassionate care.

Three quarters (76.6%) of staff who did not have enough time with patients were not able to give the care they wanted.

Respondents felt they had all the responsibility for any errors caused by dangerously low levels of staffing, but no control to fix the situation. Many reported bullying tactics as a means to keep staff from reporting understaffing.

Voluntary minimum staffing levels are ineffectual. Only 11% of respondents whose team or ward had a minimum nurse-to-patient ratio said it was always achieved. Minimum staffing levels need to be enforced by legislation to be effective.

Set minimum staffing levels work when organisations stick to them. Organisations that always achieve their own minimum staffing levels are several times more likely to have staff who report a better quality of patient care and a comfortable work/life balance.

More than half of respondents (55.7%) worked overtime and three out of five (59.8%) skipped breaks. These percentages increase for respondents working as nurses.

Many organisations are using bank and agency staff to fill long-term vacancies, which means a lack of continuity of care for patients. 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.

A gulf is emerging between the views of frontline nurses and midwives – whose everyday experience tells them that minimum nurse-to-patient ratios are a must – and the views of other senior nurse leaders who argue ratios are a ceiling.
Recommendations

➢ UNISON will work with other organisations, including patient bodies, to identify a UK model of nurse-to-patient ratios for different specialties. We will aim to use international evidence as a benchmark.

➢ UNISON will campaign for national legislation to enshrine minimum nurse-to-patient ratios in all healthcare settings. We will be discussing this with MPs to encourage them to support our position and to make sure that they are helping their local NHS staff achieve staffing levels that enable them to deliver safe, compassionate and dignified care to their constituents.

➢ UNISON will encourage, support and enable staff to raise concerns locally when they do not believe that staffing levels are adequate to deliver safe, compassionate and dignified care.

➢ UNISON produced a Be Safe pack based on the results of the 2012 survey and is now developing a Train the Trainers programme to be delivered by activists to enable staff to raise concerns.

➢ UNISON will develop national guidance for branches on how to raise concerns.

➢ UNISON will be speaking with the Care Quality Commission (CQC) to determine how they can incorporate evidence from trade unions at a local level into their inspection routines.

➢ UNISON branches and regions will use the findings in the survey to have discussions with employers at local, regional and national level about how staff can be helped to raise their concerns.

➢ UNISON will continue to work with stakeholders, including the Safe Staffing Alliance, to raise awareness and campaign for set nurse-to-patient ratios.

➢ UNISON will review its advice and guidance following the Mid Staffordshire Public Inquiry to ensure that it is updated and fit for purpose.

➢ The UNISON Health Group will continue to tackle down-banding and will assess how widespread the practice of using unqualified staff to perform certain tasks is, and whether workplaces are lacking primarily nurses or an even distribution of healthcare staff.
Survey background

"When we're short of staff we often have to deal with situations regardless. Nurses stay late, miss breaks and patient care is compromised."

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

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

The survey asked respondents to record details about their shift during a particular 24 hour period. This type of ‘spot test’ survey, performed across the country on the same day, was the first of its kind in 2012. What it unearthed was that nursing staff everywhere are feeling the pressure of service cuts, making care delivery more difficult.

The survey was chosen to run a second time in the same format one year later on Tuesday 5 March 2013. Much like the first survey (6 March 2012), the 2013 survey asked respondents to record details about their shift during the chosen 24 hour period.

UNISON provided a worksheet with a list of the information they would need to record, and then asked them to enter this data into an online survey.

The survey contained 42 questions, including five that asked for details about the respondent such as their gender. Most of the questions were multiple choice and centred around three primary topics:

- **Their workplace** – the region, field in which they worked, whether the organisation already had minimum staffing levels, etc
- **Their shift on 5 March 2013** – 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 over 2,000 responses to the survey, of which 1,533 were analysed in detail as a statistically valid sample. A copy of the survey questionnaire is available in Appendix One of this report.

The survey and data collection were advertised through a variety of mediums. For weeks before 5 March 2013 participation was advertised on the following UNISON channels: UNISON’s healthcare social media such as Facebook and Twitter, in UNISON weekly Health
circulars, and two personalised mass emails to all members working in the nursing family. Information was also posted on many UNISON branch webpages across the country and disseminated through the regional and specialist channels available to members of the UNISON Nursing and Midwifery Committee.

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

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

The UNISON health group receives regular reports from activists and members about their frustrations with the inadequate ratio of nurses to patients in their workplaces across the country, and the effect they believe that this has on patient care. UNISON champions quality patient care as well as the fair treatment of staff. Set staffing levels have proven to have positive effects in both these areas internationally.

The Nursing Times staffing levels survey

In early February 2013 the Nursing Times published the results of their survey about the effects of the Francis Report on the nursing profession. Almost 600 nurses responded, answering questions about the nursing profession as a whole as well as their individual workplaces.

One key finding in this report was that 56.8% of respondents classified their workplace as sometimes or always dangerously understaffed. This finding echoes responses to this survey, where 57.9% of staff felt that on 5 March 2013 there were not enough staff present to provide safe, compassionate and dignified care.

The Nursing Times survey also asked respondents whether they thought that there were more situations ‘like Mid Staffs out there.’ Less than one percent (0.9%) of respondents thought that Mid Staffs was a ‘one-off’ occurrence. The survey also asked respondents how they compared the care failings at Mid Staffs to their own organisation. UNISON repeated this question this survey with similar results that can be found on page 23.

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2 The Nursing Times, 5 February 2013, Full Survey Results: how will the Francis report affect nursing: http://www.nursingtimes.net/home/francis-report/full-survey-results-how-will-the-francis-report-affect-nursing/5054518.article
The results from the Nursing Times question are in Figure 1 below:

**Figure 1: How confident are you that a similar situation to the care failings at Mid Staffs could never happen at your trust?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident, a situation similar to Mid Staffs could never happen at my trust</td>
<td>6.5%</td>
</tr>
<tr>
<td>Fairly confident, a situation similar to Mid Staffs is unlikely to happen at my trust</td>
<td>30.4%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>28.0%</td>
</tr>
<tr>
<td>Not very, we are at risk of a situation similar to Mid Staffs developing</td>
<td>23.2%</td>
</tr>
<tr>
<td>Not at all, it’s already happening in isolated parts of the organisation</td>
<td>7.7%</td>
</tr>
<tr>
<td>Not at all, it’s already happening across the organisation</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

The Francis Report

Our survey follows on from the publication of the Francis Report into poor care being delivered at Mid Staffordshire NHS Foundation Trust. Over the course of several years, the quality of care delivered in this trust took secondary priority to achieving targets such as financial savings and gaining foundation trust status. As a result, the trust failed in its duty of care to hundreds of patients and families. Patients died needlessly and loved ones were left in the dark without adequate answers or explanations.

In the report Francis identifies that the year on year financial savings which the trust made had a cumulative impact on patient care. In recommendation 23 the report calls for staffing levels to be set, and he recommends that the National Institute for Clinical Excellence, working with key organisations, should be tasked with developing standards for these levels to be identified. Francis fell short of calling for national minimum standards, which UNISON believes is unfortunate.

Minimum staffing levels around the world

Before beginning this research, UNISON investigated the impact of set nurse-to-patient ratios in existing academic and professional studies. Certain states in Australia and the United States have used legislation to address the issue of safe levels of staffing. This legislation was implemented in both countries after long periods of hard campaigning by unions, nurses, charities and patient groups.

In both countries the campaigns focused primarily on the issue of improving patient care by making workloads manageable and providing adequate numbers of nurses to patients. Public support was enlisted by appealing first and foremost to the interests of patients. After legislation was implemented, the quality of healthcare was improved along with job satisfaction and staff welfare.

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 died where there were 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.3

Studies, including the 2009 Boorman Review into NHS Health and Wellbeing4, establish solid links between understaffing, stress, job satisfaction and patient care. Workplaces that report understaffing are likely to have high levels of stress and low levels of job satisfaction. In turn, workplaces with high stress and low job satisfaction are likely to have more patient safety incidents and higher rates of patient mortality.

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

With NHS organisations facing increasing cuts there is a real danger that healthcare providers will reduce staff as a means to achieving their proposed financial targets. This has already begun in several areas around the country with waiting times skyrocketing5 and services closing6.

Furthermore, a skills gap in the nursing profession seems likely to occur in the next several years. The number of nurses lost to austerity cuts since 2010 was almost 5,0007 in mid 2012, and the number estimated to be lost by 2015 is over 12,000.8 Combined with this are the tightening of immigration restrictions which will mean fewer nurses from overseas – applicants now need to make over £35,000pa to be able to apply for permanent residency – and a reduction in the number of total places offered across all nursing university courses in the country. In addition, the nursing profession is comprised of an ageing workforce; in 2008 over 60% of nurses were over the age of 40.9 If the

nursing workforce continues to decrease, this will no doubt have consequences for both employers and the healthcare profession as a whole and will cause further impairment to the delivery of quality care.

**NHS Staff Survey in England 2012**

The concerns and feelings voiced by respondents in UNISON’s survey echoed concerns in the recent NHS Staff Survey. The NHS Staff Survey is an annual survey of the 259 NHS organisations in England. Full and part time staff directly employed by an NHS organisation on 1 September 2012 could participate and the survey received a response rate of 50%.

The NHS Staff Survey uncovered a trend in falling satisfaction with working for the NHS, compared to previous years. Among the highlights relevant to this survey, the NHS Staff Survey found that:

- 40% were satisfied that their trust values their work
- 69% of staff attended work when they felt too ill to attend
- 32% of staff witnessed potentially harmful errors, near misses or incidents in the last month
- 24% of staff experienced harassment, bullying or abuse from other staff in the last year.

Unfortunately the NHS Staff Survey chose not to repeat particular questions from 2011 that probed the nature of work pressures – working unpaid hours, having enough time to carry out all work, having enough staff in their organisation to do their job properly. In 2011, specific questions about work pressures found that:

- 53% of staff regularly worked unpaid hours
- 46% felt they do not have enough time to carry out all their work
- 42% felt they cannot meet all the conflicting demands on their time at work
- 30% said there was enough staff in their organisation for them to do their job properly

Respondents to UNISON’s survey echoed the feelings in the NHS Staff Survey by and large; it would appear across the health service staff are feeling overworked and undervalued.

NHS organisations need to carefully consider the results of the NHS Staff Survey, as it has served as an indicator of the quality of care delivered in the past. In 2007, only 50% of staff working for Mid Staffordshire Foundation Trust reported that they would recommend their workplace as a place to receive treatment. NHS organisations with a low level of staff satisfaction coming out of the 2012 survey are strongly encouraged to take this evidence into consideration when assessing the quality of care they deliver.

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My shifts are always ‘full on’ as I have too many clients on my caseload and not enough time to do all the paperwork etc. Feel like I am running to stand still quite often.

The majority of questions in this survey originated from the 2012 survey. While from the perspective of statistical analysis it would have been preferable to exactly replicate the previous survey, several of the questions from last year proved to be confusing for respondents and needed simplification. Furthermore, it was deemed appropriate to add some new questions due to the publication of the Francis Inquiry. Before going ‘live’, the survey questions were given to UNISON’s National Nursing and Midwifery Committee for review and comment.

The 1,533 analysed responses came from healthcare staff distributed fairly evenly across regions and shifts worked, while other factors such as gender reflected the percentage of that characteristic in the workforce.

**Regions**

Geographically, the largest percentage of respondents identified themselves to be from the South East (14.9%), the North West (13.7%), Yorkshire and Humberside (13.4%) and Scotland (12.9%). The region with the fewest respondents was Northern Ireland, which made up 1.9% of the responses. All regions responded to the survey.

These percentages roughly reflect the distribution of regional responses when this survey was run in 2012. The largest increase in number of respondents came from Yorkshire and Humberside, which nearly doubled its total number of responses.

*Figure 2: What region is your organisation in?*
Workplaces

“We have a huge patient intake and no spaces to offload ambulance patients into our department nor beds available on the wards. The hospital is full to bursting, but we never close to admissions. Instead we let patients sit on trolleys in the corridor with the paramedics doing basic observations. This is becoming a daily event.”

More than half of the respondents worked in an acute setting, which was further broken down as either a foundation trust (20.8%) or an NHS trust (34.1%). The next largest grouping was mental health, where a quarter of total respondents worked in either a foundation trust (14.4%) or an NHS trust (11.5%). The remaining fifth of respondents came from a mix of workplaces that included GP surgeries, community services, learning disabilities and care homes. Only 2.6% of respondents identified themselves as working in the private sector.

Echoing the results of the 2012 survey, over 70% of respondents worked for a large organisation with more than 2,000 employees.

The areas of care in which respondents worked on 5 March were hugely varied and spread across the full spectrum of healthcare. This included: accident and emergency, paediatrics, care of the elderly, community, community mental health, critical care, general practice, learning disabilities, medical, mental health (inpatient as well as secure unit), obs and gynae, surgical, rehabilitation and theatre. A fifth of respondents chose ‘other’ and wrote in a response.

The greatest number of respondents for any area of care was care of the elderly at 166 (12.4%), followed by mental health inpatient (12%) and medical including orthopaedic (11.7%).
This is one reason – the vast dispersal of care areas and limited number of respondents in each – that this report does not make numerical recommendations on staffing levels for each of these areas. The determination of minimum staffing levels is an intricate process, requiring many variables that were outside the scope of this survey. UNISON supports the work done by NHS Scotland in conjunction with trade unions such as UNISON to develop a workable staffing levels matrix.

**Shifts**

The dispersal of shifts was roughly even, as shown in Figure 4 below.

**Figure 4: On 5 March 2013, which shift did you work?**

More than a third (38.8%) of respondents worked a shift that was contracted to last for more than 10 hours, including 16.1% whose shifts were intended to last more than 12 hours. It’s worth noting that these figures are only for the shift’s contracted length. With more than half (55.7%) of respondents reporting that they worked overtime on 5 March, and only a third (38.7%) reporting that they took all their allotted breaks, the length of these shifts becomes treacherously long. Please refer to the section overtime and breaks later in this report for further analysis.

**Figure 5: How many hours is that shift contracted to be?**

Respondents

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 in Figure 6.

As the survey was advertised primarily through UNISON’s own channels, the vast majority of respondents (92.3%) were UNISON members. The remainder belonged to another union (6%) or no union (1.6%).

The majority of respondents identified as women (79.2%), which is representative of the gender make-up in the NHS workforce and in UNISON’s membership (Figure 7).

Almost one in 12 respondents (7.9%) noted that their gender identity is different than the sex they were assigned at birth (Figure 8).
A large majority (87.1%) 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 across the UK and UNISON health care membership.

One in 17 respondents (5.7%) described themselves as having a disability (Figure 9).

Half (49.8%) of respondents identified themselves as between the ages of 35 and 50, with a further third (33.3%) as over the age of 50. Only 6% of respondents were age 27 or younger (Figure 10).

![Figure 10: How old are you?](image)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 27</td>
<td>6%</td>
</tr>
<tr>
<td>28-35</td>
<td>11%</td>
</tr>
<tr>
<td>36-50</td>
<td>49.8%</td>
</tr>
<tr>
<td>51-66</td>
<td>33.1%</td>
</tr>
<tr>
<td>Over 67</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

![Figure 11: How do you describe yourself?](image)

<table>
<thead>
<tr>
<th>Ethnicity Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British / English / Scottish / Welsh / Northern Irish</td>
<td>82.5%</td>
</tr>
<tr>
<td>White Irish</td>
<td>2.2%</td>
</tr>
<tr>
<td>White Other</td>
<td>2.4%</td>
</tr>
<tr>
<td>Black British / English / Scottish / Welsh / Northern Irish</td>
<td>2.2%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1.1%</td>
</tr>
<tr>
<td>Black African</td>
<td>2.8%</td>
</tr>
<tr>
<td>Black Other</td>
<td>0.1%</td>
</tr>
<tr>
<td>Mixed or multiple ethnic groups</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian British / English / Scottish / Welsh / Northern Irish</td>
<td>1.4%</td>
</tr>
<tr>
<td>Indian</td>
<td>0.4%</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.2%</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.2%</td>
</tr>
<tr>
<td>Filipino</td>
<td>1.7%</td>
</tr>
<tr>
<td>Asian Other</td>
<td>0.6%</td>
</tr>
<tr>
<td>Arab</td>
<td>0.0%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1.2%</td>
</tr>
<tr>
<td>Any other background</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
The impact of staffing levels on care quality

“There is no time for compassionate care. The other nurse I was working alongside had to look after 10 patients with complex needs. One died while on shift and there was no time allocated to provide support for the family - she had to break bad news, liaise with doctors and attempt to look after nine other patients. This means the nurse ended up working with no break, over her shift time. She had one support worker to help care for the other patients. The ward is usually like this.”

Respondents overwhelmingly felt that staffing levels in their workplaces were not sufficient to deliver the quality of patient care required. Across all respondent groups – including regions, job roles, shifts, and workplace – the majority felt that the inadequate number of staff present in their workplace on 5 March 2013 resulted in the delivery of a lower standard of care.

Respondents were asked: “Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?” Only three in 10 (31%) answered yes. This percentage remained roughly constant across all staff groups, with some deviation from staff nurses who felt even less confident that quality care was being delivered. This result, although still unacceptably low, is a slight increase on the figure the survey received in 2012. In last year’s survey, only 19.6% reported that on their shift on 6 March 2012 they felt there were adequate staff numbers to deliver safe, compassionate and dignified care (Figure 12).

“Often due to staffing levels aspects of care would be missed, people would be left soiled in urine or faeces for long periods of time, a large workload would be left for on-coming staff, unsafe short cuts would be taken to speed up your work (for example bad manual handling or quick medicine checks including control drugs).”
When asked “Did you feel that you had an adequate amount of time to spend with each patient?” again only three in 10 (30.1%) respondents answered yes. When cross-analysed, it was confirmed that the majority (85.3%) of respondents who felt that care had been comprised also did not have enough time with each patient. Clearly there exists a strong link between staff availability and the level of care that a patient receives (Figure 12).

Much like the question regarding safe care, the percentage of respondents who felt they did not have enough time with each patient increased slightly on last year’s survey. In 2012, only 19% felt that they had enough time with each patient. Although it is important to acknowledge these increases, it is still not acceptable when only three in 10 respondents report having had enough time with each patient. Organisations need to re-examine the workloads that their nursing staff have.

Respondents who said that no they did not have enough time with patients, were then asked “Were there elements of care that you could not provide because you didn’t have time?” More than three quarters (76.6%) answered that because they did not have enough time, there were aspects of care they did not deliver.

When asked what care was left undelivered, the survey received a heartbreaking list of 477 examples. By far the most common type of care left ungiven was simple one-to-one communication, such as reassuring fears, explaining treatments and diagnoses and providing basic compassionate support. Several respondents wrote that they were unable to spend time with dying patients. Other types of care that were commonly forgone included giving patients food and drink, taking patients to the toilet or helping them to move, and writing up full and accurate records. It is unacceptable to UNISON that nurses and care workers were put in this position; even working through their breaks and working unpaid overtime they could not deliver the care required.

“ It is getting worse. ”

“ There is a haemorrhage of experienced staff. ”
Students are being put in areas of responsibility where they should not be, and are not properly supervised.

Every shift, I think my registration is on the line.

There but for the grace of God it wasn’t me today that was picked on by management for not doing something... when I did not have the time.

I am fed up with working every shift without a break, not even time to go to the toilet. Donkeys have better working conditions.

Nurse respondents were more likely to say they did not have enough time with each patient than healthcare assistants or assistant practitioners (HCAs/APs). 57.9% of HCA/AP respondents said they did not have enough time, whereas 71.7% of nurses said the same. This is extremely worrying as nurses and midwives are professionally accountable for their actions to the Nursing and Midwifery Council, while HCAs/APs are not. Regulated nurses are accountable for the supervision of HCAs/APs as well as ensuring that patients in their care receive safe, compassionate and dignified care (Figure 14).

The UNISON health group has received a lot of anecdotal evidence that some employers have down-banded their workforce numbers with lower graded staff as a cost saving measure. Given how many more nurses than HCAs/APs reported insufficient time with patients in this survey, UNISON needs to assess just how widespread this form of down-banding is and whether workplaces are lacking primarily nurses or an even distribution of healthcare staff.
Trained nursing staff are now undertaking doctors’ tasks, which means health care assistants take on trained nurses’ duties. None of these staff are paid for the extra duties involved. HCAs are delegated duties from trained nurses to allow the nurses to complete other tasks. HCAs are expected to complete these tasks along with their normal duties. Our responsibilities and workload grow but our pay bands and staffing levels remain the same.

Correspondingly, more nurse respondents reported that there were more elements of care they were unable to give than HCA/AP respondents. 73.9% of nurse respondents felt that they could have given more or better care with more time, compared to 58.9% of HCA/AP respondents.

Respondents were also asked if they felt that their shift had “an adequate skill mix.” Almost 50% of respondents felt their shift’s skill mix was inadequate for the care they needed to deliver (Figure 15).

Workforce wellbeing

Many respondents reported suffering numerous symptoms of stress due to their unreasonable workloads. Low morale was attributed to an uncaring attitude from managers, an over-burdensome workload, bullying and the effect of having to deliver care that a staff member knows is beneath them and inadequate.

I felt patients were neglected and always feel like this lately. Staff on the ward are stressed and getting more emotional over the lack of care we are providing, and no support is offered.

I was asked to take two patients due to lack of staff. One patient was sedated and intubated, the other was a tracheotomy patient. I had to refuse as I felt the patients would not be safe. My clinical area regularly pressurises staff to do this sort of thing. Our staff morale is zero because of this and we all want to leave.
I felt I didn’t deliver care adequately which made me feel inadequate; physically and mentally drained when I finished.

Staff were stressed due to both a lack of staff and trying to arrange for staff to take over from others in A&E. Staff felt guilty about the whole situation. Staff also were angry that if they complained they would be victimised and it would be insinuated they were not up to the job. There is no support as clinical supervision is discouraged although it is supposed to be compulsory.

We really did struggle. At this rate, we cannot really please all the patients. Staff are tired from these low staffing levels. When I first started I was so dedicated to my work. But now, more often than not I dread coming to work.

The links between stress, job satisfaction and productivity are measurable. Academic and professional studies, including Boorman\textsuperscript{11}, confirm the impact of sickness is not just on the individual but is also a quantifiable, financial cost to the service. The following points are fundamental:

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

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

Mid Staffordshire Trust

“I have for months been raising concerns about urgent referrals to the service and their safety but have been ignored by management. I have been asked to stop putting incident forms in and been told by the complaints department to be ‘corporate’. This is the backdrop to my working day: Isolated, unsupported by management and concerned for service delivery.”

Respondents were asked to evaluate their organisation against the care failings at Mid Staffordshire Foundation Trust, and specifically whether they thought that a similar situation could happen where they work. Shockingly only one out of 15 respondents (6.2%) felt very confident that a similar situation would never happen at their organisation. And appallingly, one fifth of respondents (19.7%) felt that a similar situation is already happening either across or in isolated parts of their organisation.

“My ward will end up killing someone. That’s how bad it is and how unsafe.”

These figures varied by only a few percentage points when broken down by type of organisation, with slightly more respondents from acute trusts reporting that care failings were already happening.

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

The regions with the highest percentages of reported care failings were Northern Ireland (28%), Yorkshire and Humberside (25.6%) and the South West (23.1%). It is worth noting that there were a limited number of respondents from Northern Ireland and that 28% represents seven responses. Figure 17 (overleaf) depicts the percentage of respondents in each region who categorised their workplace as having situation(s) similar to the care failings at Mid Staffordshire either in isolated parts or across their organisation.

Figure 16: How confident are you that a similar situation as the care failings at Mid Staffs could never happen at your trust?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very confident, a situation similar to Mid Staffs could never happen at my trust</td>
<td>6.2%</td>
</tr>
<tr>
<td>Fairly confident, a situation similar to Mid Staffs is unlikely to happen at my trust</td>
<td>29.5%</td>
</tr>
<tr>
<td>Not very, we are at risk of a situation similar to Mid Staffs developing</td>
<td>29.6%</td>
</tr>
<tr>
<td>Not at all, it’s already happening in isolated parts of the organisation</td>
<td>9.9%</td>
</tr>
<tr>
<td>Not at all, it’s already happening across the organisation</td>
<td>9.8%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>14.9%</td>
</tr>
</tbody>
</table>
Figure 17: Percentage who felt that their organisations had situation(s) similar to the care failings at Mid Staffordshire either in isolated parts or across their organisation.

The largest percentage of respondents answered this question by selecting the response “Not very [confident], we are at risk of a situation similar to Mid Staffs developing.” In total, almost a third (29.6%) of respondents selected this answer. This means that half (49.3%) of respondents reported that a situation similar to that at Mid Staffs could happen or is already happening in their organisation. See Figure 18 for how these figures played out in each region.

One of the answer choices to this question was “Don’t know.” 14.9% of respondents chose this option, and it is reflected in the percentages above as they are calculated from a total that includes ‘Don’t know’ responses. If the ‘Don’t know’ answers are ignored and only the responses that made a judgment are counted, these percentages increase. Now the total percentage of organisations with possible or actual care failings is 58%. This percentage is more accurate because it...
only counts the responses of individuals who understand the situation enough to make a judgement.

Thus, ignoring all ‘Don’t know’ answers, the percentage per region of respondents who reported that a situation similar to Mid Staffs could happen or is already happening at their organisation is reflected in Figure 19.

**Figure 19: Not including those who answered ‘Don’t know’: Percentage who felt that their organisations had situation(s) similar to the care failings Mid Staffordshire either in isolated parts or across their organisation**

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**Steps UNISON has taken**

Where UNISON has been able to identify the organisation, the relevant region has been asked to work with the local UNISON branch to raise these concerns formerly with the trust. They have also been asked to look in detail at the core questions outlined in the NHS Staff Satisfaction Survey.

All members were emailed with a reminder of the importance of raising concerns to protect those in their care, themselves and their colleagues.

UNISON also shared with the Care Quality Commission an advance copy of the survey, requesting they ask inspectors to routinely meet with local UNISON representatives as part of their inspection processes.
Support for safe staffing levels

“Short staffing is the norm, not the exception.”

Respondents were asked to weigh in on their opinions for or against set minimum nurse-to-patient ratios. When asked “Do you think there should be a set national minimum nurses to patients ratio?” the overwhelming majority (85.4%) responded yes. 9.2% were unsure. When the respondents were broken down into groups by their job, there was little difference between the groups. After being broken into job groups, the percentage in favour of set national minimum nurse-to-patient ratios ranged from 82%-100% – a clear majority in every group (Figure 20).

Respondents were then asked what sort of effect – positive, negative or neutral – set nurse-to-patient ratios would have on patient care and safety. 87.5% responded that it would be a positive effect and 7.3% were unsure.

To further explore this topic, respondents were asked if they thought that there should be legislation requiring organisations to adhere to minimum nurse-to-patient ratios. The answer was an overwhelming yes (88.1%) (Figure 21).

High levels of support (80.5%) were also present for minimum healthcare assistant to nurse ratios. Although percentages were roughly the same across job roles, the highest level of support (85.4%) came from healthcare assistants, assistant practitioners and healthcare support workers (Figure 22).
Concerns articulated against set minimum ratios came from the fear that if an organisation were required to increase its numbers of frontline workers, the money to employ the new staff would come from existing staff resources.

“If minimum ratios come in we’ll just lose out in other ways, like flexible working or training.”

This fear is a fair one – attacks on pay, terms and conditions are increasing in number and in scope all over the country. Undoubtedly if set minimum staffing ratios were imposed at a national level, a few unscrupulous employers might try to recover the cost of new staff in other areas. But it’s not as easy as it sounds. Employers who are signed up to Agenda for Change face an uphill battle to change terms and conditions. UNISON has successfully fought proposed local terms and conditions across the country, setting precedents in the courts that dictate how organisations need to behave in the future.

UNISON activists can also take advantage of UNISON’s campaigning against the cuts training and resource pack, as well as the Defending Agenda for Change training course.

Other respondents voiced concern that if minimum nurse-to-patient ratios were implemented, the minimum number would become the ceiling rather than the floor. This point is also argued by other senior nurse leaders.

“The difficulty of setting minimum ratios is that quite often this would be adhered to – minimum doesn’t mean optimum.”

Some employers may see the implementation of a minimum nurse-to-patient ratio as a target box they can tick by sticking to it at all times irrespective of patient dependency.

However UNISON has already witnessed that enforced minimum safe staffing levels cause employers to act and add staff to their rota. On 30 November 2011 UNISON took national industrial action over NHS pensions. As part of the plan to ensure emergency cover, discussions took place at a local level to agree which services would be provided and what service would be needed in the different wards, units and departments in addition to what care needed to be maintained in patients’ homes.

As a result, a number of employers sought to ensure higher levels of cover on 30 November than they would on any other normal day when activity is typically higher. While this did not happen everywhere the effect was that, in some understaffed workplaces, staffing levels were temporarily improved.

As one respondent stated, “There is some concern that [with set ratios] there would be a ‘race to the minimum.’ However we are now working well below the safe staffing levels so a minimum would help us!”

Several respondents made note of the complicated factors that would need to be carefully considered if minimum nurse-to-
Patient and nursing care at breaking point – a UNISON survey into staff/patient ratios on our wards

Patient ratios were set nationally. These include patient dependency and acuity, the area of care, type of workplace, and the team’s skill mix and level of experience.

UNISON supports a considered approach to staffing levels rather than a ‘one size fits all’ approach. Clearly what is appropriate and safe for a city centre A&E will be different from a low secure mental health ward. And even within different areas of care, requirements are going to change from day to day in unpredictable ways as new patients arrive, the health of existing patients improves or deteriorates and the projected number of discharges changes.

Many policy makers, including the current government’s health team, have argued that because one ratio is not applicable to every field, then it isn’t possible or reasonable to put into place any minimum ratios that do not already exist.

One need only look at the multitude of examples of wards, units and departments that are routinely appropriately staffed – both in the UK and abroad – to see that this is not the case. If it were indeed impossible to estimate or plan for the events during a shift, it would be a miracle when any shift had the right balance of staff.

Furthermore, UNISON does not believe that just because something requires planning and thought that it should be abandoned. It’s true that it took Australia and the USA a lot of work to get the formulas right which indicate what an appropriate nurse-to-patient ratio should be in a particular area of care. It required the input of many experts from many fields and the process wasn’t finished in an afternoon.

Fortunately, the NHS has the benefit of being able to evaluate how other countries have set and implemented staffing ratios. NHS Scotland has begun development of its staffing levels matrix, which will be 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 entirety of the UK.

A gulf is emerging between the views of frontline nurses and midwives – whose everyday experience tells them that minimum nurse-to-patient ratios are a must – and the views of some senior leaders who argue ratios are a ceiling.

Nurses and midwives are at a breaking point on a daily basis. They feel that they are failing patients as they cannot give the level of care which they believe patients should receive. UNISON believes that we as a society are failing nurses and patients if we continue to ignore the importance of nurse-to-patient ratios.

**Do voluntary minimum staffing levels work?**

"Even if there was a set ratio of nurses to patients and care assistants to trained staff - if they are not there what are you going to do about it? Management care more about their targets than staff and patients, and they would need a map to find the wards as they never get that far, hence the Staffordshire problem."

Many of the respondents (42%) worked in a ward or team that has already set a minimum nurse-to-patient ratio. The majority of these respondents felt that the existing ratio was appropriate. The regions with the highest percentage of respondents working in wards or teams with set ratios were the West Midlands (51.8%) and Eastern (51.7%). The region with the lowest percentage of respondents was Cymru/Wales (29.8%) (Figure 23).

Unfortunately, only half (51.4%) of respondents with a set minimum nurse-to-patient ratio reported that their workplace achieves their own ratio either most or all of the time.

"Every hospital I've worked in has set their own staffing levels seemingly according to what they can get away with rather than what's safe."

A comparison between organisations who regularly achieve their own ratios and those who do not shows two very different working experiences. Staff who work in wards, units or departments that always achieve their set minimum nurse-to-patient ratios are more likely to leave work on time, take breaks, be satisfied with the skill mix on their shift, and report that their patients received more of their time and better care.

By comparison, almost every respondent who worked on a ward or team that rarely or never achieved their minimum nurse-to-patient ratio reported that the quality of care delivered suffered. Furthermore, although the staff in these organisations report not having enough time with patients, they also reported working more overtime and missing their breaks.

"When we're fully staffed the ratio works well and is usually sufficient."
To answer the question of whether voluntary minimum staffing levels work, the answer is that minimum nurse-to-patient ratios work, but voluntary implementation does not. As clearly shown in Figure 24 respondents report better patient care and a better working experience in wards, units and departments that stick to their minimum ratios.

Protocols for understaffing

“Staffing ratios will only work if they are adhered to, and unfortunately most trusts will ‘borrow’ staff from other wards who do not plan ahead - thus leaving the lender short.”

One third (35.9%) 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. This percentage is alarmingly high and 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 (Figure 25).
The respondents who reported that their workplace had a protocol or policy to address short staffing were asked if they had ever had to use it. Three quarters (76.9%) answered that they had. Respondents were then asked how they viewed the outcome of using this protocol or policy. Less than two out of five respondents (38.4%) felt that their concerns were listened to and acted upon swiftly.

This percentage has improved since the 2012 survey ran. In 2012 only 28.9% of respondents who had used a protocol or policy to address understaffing felt that their concerns had been listened to and acted upon swiftly. In the past year this percentage has clearly risen, which may be a result of campaign work and media activity around the issue of safe staffing levels. Although this increase is clearly an improvement, it’s important however to remember that when more than six out of 10 staff don’t feel they’re being listened to about patient safety issues, there is still a lot of work to be done. This reinforces the points and recommendations which Francis made regarding the culture of the NHS.

Comparison to the 2012 survey

“When I first qualified the staff nurses had a team of six patients each. Now it is often one nurse to 16 patients. With six patients you could provide the care you wanted to provide, instead of feeling that your best is never enough.”

When this survey ran in 2012 it received an outpouring of feedback about voluntary minimum staffing levels. Specifically, the survey received many examples of the creative ways in which wards, units and departments achieved their minimum staffing levels – such as counting students as nursing staff, altering the dependency of patients on shift records, and “forgetting” to deduct absent staff or unfilled vacancies from the count.

When the survey ran this year in 2013, it again received examples of how workplaces were achieving their ratios without having the necessary staff present. This year the focus of such stories was primarily on the use of unqualified staff working in roles above what they were trained for – specifically healthcare assistants working in nurse roles.

Many respondents also reported that staff would be ‘borrowed’ from one ward (or unit or department) to the next to help the other area achieve its minimum ratio. Unfortunately this practice only rotated the problem as it tended to leave the first area understaffed.
I work on an emergency surgical admission unit. We aim for three trained nurses for every 13 beds. Often a member of staff is taken off us if management feel that we are ‘quiet.’ However situations constantly change on the unit as patient numbers increase, but staff never return so we run on low ratios.

Since the 2012 survey ran, the percentage of respondents aware of minimum nurse-to-patient ratios in their ward or team has increased by 10%. In 2012, almost one in three respondents (28.5%) were unsure whether their ward or team had a minimum nurse-to-patient ratio. In 2013, the percentage dropped to 18.9%.

It is unclear whether this change signifies an increase of teams and wards with minimum ratios or merely an increase in staff awareness. Either way, it does demonstrate that this subject of nurse-to-patient ratios is gaining strength.
Overtime and skipping breaks

“We are used to making ends meet by starting early, finishing late and forgetting about breaks and this shift was no different.”

On 5 March 2013, more than half (55.7%) of the survey’s respondents worked overtime. Of those who worked beyond their contracted hours, almost one in five (18.1%) worked more than an hour extra (Figure 27).

The overwhelming majority of this time was unpaid. Only one in 10 respondents (10.9%) reported that they were paid for their overtime.

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 (63.5%) as healthcare assistants (36.5%).

Figure 28 shows the percentage of respondents in each role who reported working any overtime as well as the percentage who worked for more than an hour.

It should be noted that there were not many respondents for all of these roles.

These figures represent a small increase upon the responses to the survey in 2012, where 62.2% of respondents worked overtime and only one in 13 reported having been paid for it.
There were fewer than 10 respondents working as a matron or health visitor, each. The roles of nurse manager, midwife or student nurse each had fewer than 35 respondents.

The majority of respondents were also unable to take all of their breaks. Three out of five respondents (59.8%) skipped some or all of their breaks during their shift on 5 March 2013 (Figure 29).

When grouped by type of organisation, there were some small differences in the percentages of staff that worked overtime or missed their breaks. 8% more respondents who worked at a foundation trust skipped their breaks than those at NHS trusts.

Staff who were able to take all their breaks were also more likely to leave work on time, be paid for any overtime they did work, and report that they had enough time to spend with each patient. These figures show that the solution to understaffing isn’t just to put in a bit of extra effort because ‘We’re all in this together.’ In fact, where nursing staff are breaking their backs to deliver the best care they can – by working unpaid hours and skipping their rest and meal breaks – the quality of patient care is still lower than in workplaces where staff are able to maintain a more comfortable work/life balance (Figure 30).

Clearly something differentiates the workplaces that have a better work/life balance and a better standard of patient care from those with a poor work/life balance and poorer standard of patient care, because it isn’t how hard nursing staff are working. As shown earlier in this report in the chapter on voluntary minimum staffing ratios, respondents working in wards or teams that always achieve their set minimum ratios are more likely to go home on time, have all their breaks, and report higher levels of care quality.

“When we are left short staffed we just have to get on with it because we are expected to finish all paperwork so that we don’t fail the audits. Therefore we wait behind at the end of a shift and miss our breaks, even though we know this is breaking NMC guidelines.”
“I am the only qualified nurse on a 13 hour shift, so I don’t get a break during these shifts. You get tired. It’s unsafe.”

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

“No breaks. The nurse in charge wasn’t bothered to check if staff had breaks or not. By midday my brain was not functioning as I hadn’t eaten for six hours.”

It is of greatest concern to UNISON that healthcare staff are not able to take their breaks and are 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.

This type of voluntary overtime stems from nothing other than healthcare workers’ concern and care for their patients. In some
cases leaving on time means putting patient care at risk. Employers are aware of this necessity as well and some may refuse to pay overtime or reduce the workload because they know their staff will choose the patients over themselves. As this is such a commonplace and practical occurrence, refusing to build flexibility into the working agreement puts staff in a distinctly unfair position and takes advantage of workers’ good will.

It is dangerous to the health of employees to work extended periods of time without breaks. No one should be expected to work an eight, 10 or 12 hour shift with only the hope of a meal break. All workplaces need to be in line with the Working Time Regulations, both for the sake of the staff as well as the patients. It should be clear to anyone that a nurse who had several breaks and is leaving on time will be able to provide better care than a nurse who has not eaten in the last 10 hours.

Particularly in the current climate where the government is trying to weaken the Working Time Regulations, UNISON stresses the importance of these Regulations and calls for them to be strengthened. It is clear from these survey responses that the impact of skipping breaks and working unpaid overtime can often be dangerous for both staff and patients. If the Regulations were to be weakened, any unscrupulous employer could increase the risk to patients by forcing staff to work without breaks.

To rule out the possibility that these incidences of overtime and skipping were atypical, respondents were asked whether they considered their shift on 5 March 2013 to be representative of a typical shift.

Three quarters of respondents (72.8%) reported that it was indeed “typical or as busy as normal.” When this group of respondents was isolated, the percentage of this group reported the same percentages of overtime, missed breaks and level of care given to patients as the entire respondent pool did. For this reason it can be assumed that the responses provided to this survey are by and large representative of the everyday working experiences of the respondents.

“This was a typical shift – day and night – where patients’ needs/wants exceed the time available.”
The back-up plan: bank and agency staff

“"It is not just about numbers of staff but also the quality of staff. Having far too many agency nurses and only one senior nurse on shift is not safe.""

Use of bank and/or agency staff is a popular failsafe with organisations when too few permanent staff are available. This is a strategy that UNISON generally supports – when the unexpected happens and a shift is left with too few staff it can be both unfair and unsafe for both patients and staff, so it is important to have available staff that can provide cover.

UNISON does not however support the use of bank or agency staff as a regular replacement for vacancies or long-term absences/leave, which is a practice that many respondents reported happening in their organisation. More than half (58.1%) of respondents answered that their employer frequently makes use of short-term bank or agency staff for one or more of the following reasons:

- long-term unfilled vacancies
- chronic short staffing problems
- permanent colleagues on frequent or long-term illness/disability/maternity leave.

In situations such as these, continuity of care is disrupted by the use of short-term staff, despite the potential to engage staff on longer term temporary contracts.

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 Figure 31. In this group, one in seven respondents (13.8%) indicated all of the reasons listed above. Respondents were allowed to choose multiple answers.

When the respondents were split into two groups – those with bank/agency staff on their shift and those without – it was clear that there was a connection between the use of bank/agency staff and the respondents’ feelings about the level of care they were able to provide.

Figure 31: Reasons for use of agency staff

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term unfilled vacancies</td>
<td>30%</td>
</tr>
<tr>
<td>Chronic short staffing problems</td>
<td>50%</td>
</tr>
<tr>
<td>Permanent colleagues on frequent or long-term illness/disability/maternity leave</td>
<td>40%</td>
</tr>
<tr>
<td>All of the above</td>
<td>13.8%</td>
</tr>
</tbody>
</table>
Specifically, more respondents who worked with bank and/or agency staff reported feeling that they did not have enough time, that there were not enough staff to deliver compassionate care, and that the skill mix was not correct during their shift. See Figure 32 for a comparison.

Of respondents who worked with multiple bank/agency staff on their shift, an even higher percentage felt they did not have enough time with patients (77.3%) or adequate numbers to deliver safe, dignified, and compassionate care (72.6%).

There was a similar divide between respondents who reported never working with bank or agency staff and those who reported frequently having bank or agency staff on their shifts. Of those who never worked with bank or agency staff, less than a quarter felt that the skill mix on their shift was not adequate. In comparison, almost half of those who frequently work with bank or agency staff thought that the skill mix was inadequate on their shift. See figure 33.

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

Many respondents wrote in the free text boxes about problems they encountered with bank or agency staff. These problems centred primarily around the difficulty of being unfamiliar with a new workplace and the effect on efficiency. There were also reports that sometimes bank/agency staff do not fit into the team as well as staff would like; that they wait for their shifts to be over or don’t participate in as much patient care as permanent staff.
Even if you have the correct number of staff, if three out of four are agency or bank and I’m the only permanent staff member, things are just as bad for me as if I was the only one working. Patients only want to speak to staff they know.

Regular staff are important. Lots of bank staff can be unsafe because they are unsure of the procedures and patients on the case loads.

Other respondents wrote that their workplaces do not have access to any bank or agency staff at times when they are desperately understaffed, either because their managers won’t approve extra staff or because there are shortages of qualified staff available. This also proved problematic, with respondents reporting that they were unable to spend necessary time with patients or take their breaks.

[My employer doesn’t] use bank/agency staff due to ‘efficiency savings’. If staff are on annual leave or off sick there is no cover. If staff are on maternity leave we are unlikely to get cover unless there is more than one person off at the same time.

The overuse of bank and agency staff in any one area is a strong indication that the established staffing levels are insufficient. It would be better to increase staff numbers and decrease the use of bank and agency staff.

Clearly a review of the best use of bank and/or agency staff needs to be undertaken.
Responsibility and control

“I am a newly qualified nurse and have to work in these dangerous conditions daily. I fear for patients and for my own job – ie I fear I could be struck off or worse – for being unable to do things I simply do not have the time for.”

We were short staffed all day. A doctor wrote an incident form about one of the nurses due to an infusion not being given as quickly as he would have liked. This nurse had ordered it from pharmacy, but then had a discharge and an immediate admission who was agitated and aggressive. She didn’t have adequate time to deal with this patient and spend time on the phone to pharmacy chasing up the magnesium order.”

Many respondents wrote about the same depressing situation: when they speak up about unsafe staffing levels it is insinuated they can’t do their jobs, but if they keep quiet it’s their neck on the line if a mistake is made. Nursing staff are being left with all of the responsibility and none of the control.

The survey’s comments sections were filled with examples of target-driven cultures that manipulate numbers and turn a blind eye to risky practices. Stories included counting supernumerary staff in official staffing levels, achieving a particular minimum staff ratio with under-qualified or unfamiliar bank/agency staff, bullying whistleblowers until they stop raising concerns, and simply ignoring warning signs.

“When I reported an unsafe situation to a manager, the manager told me I was ‘too patient safety orientated.’”
UNISON condemns bullying, harassment and victimisation in the workplace, which can take many forms and may be quite subtle. All UNISON members are asked to report incidences of workplace bullying, harassment and victimisation to their local UNISON representative.

UNISON members and activists are encouraged to use the Be Safe pack in the event that they are put in an unsafe working condition. This pack provides guidance on where to go for help, how to report problems effectively and how to use the Nursing and Midwifery Code of Conduct\textsuperscript{13} to maintain professional responsibility. It can be accessed either from the local UNISON branch or on the website.

**Blame culture**

“We are being told that if we don’t like it then we should leave. Patients are being neglected. Patients are falling and are not fed properly. Our matron is only concerned about money and we are afraid to whistle blow because nothing is ever done.”

Respondents to the survey felt acutely aware that their employers would not be held to account for any mistakes contributed to by unreasonable workloads or lack of staff.

\textsuperscript{13} Nursing and Midwifery Council, 2010, \textit{The Code}
A blame culture continues to exist in the health service, hurting healthcare workers as demonstrated in the survey responses. Respondents felt they would be held completely accountable for all mistakes, regardless of any contributing circumstances. Working daily with that belief adds to stress, dissatisfaction and ultimately to worse patient care.

When things go wrong most NHS organisations investigate and manage the issue through a disciplinary procedure rather than reviewing it independently. The NHS could learn from the aviation industry how to manage risk more effectively and review incidents independently. The aviation industry’s model of incident review has led to fewer overall incidents and an improved system of staff management.

A ‘no blame’ culture does not mean that poor practitioners are not held to account. Instead it requires looking at all contributing factors, including the circumstances leading up to an event, before drawing any conclusions. No healthcare worker goes to work intent on giving poor care. However, poor care is sometimes the result of circumstances which are outside their control. UNISON is frequently given anecdotal evidence of how in the NHS today if a nurse and a doctor make the same type of drug error a nurse is more likely to be disciplined while the doctor would receive counselling.

It should be clear at this point that nursing staff – like all other human beings – have a finite capacity for what they can deliver.
Conclusions

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

Nurses are crying out for help. On a daily basis they are are prevented from delivering the care they want to, due to inadequate staffing levels. In a post-Francis era, we cannot – and should not – ignore these warnings.

The survey results show a problem with understaffing that 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. The concerns were evenly divided across all groups, regions, shifts, roles, organisational types, fields and so forth.

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

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

There is no ‘one size fits all’ nurse-to-patient ratio for every area of healthcare. Patient needs vary widely across the spectrum and nurse-to-patient ratios need to reflect this. Careful planning, examination and a review of what has worked in other countries is needed to determine appropriate and safe staffing ratios for individual units. UNISON has established policy calling for a minimum nurse-to-patient ratio of 1:4 in many areas of care. However it should be realised that this ratio cannot be applied everywhere, as some areas, such as ICU, will require more intense care and more nurses. International models have solved this problem with complex staffing equations that dictate how many nurses are required where.

There was overwhelming support for set minimum nurse-to-patient ratios in order to deliver good patient care. Almost 90% supported legislation mandating staffing levels. Additionally, the majority (80.5%) of respondents were in favour of a minimum healthcare assistants to nurses ratio as well.

Organisations with voluntary minimum ratios are ineffectual. Where the organisation chooses to adhere to their own ratios, staff report better patient care and a better work/life balance. Unfortunately there is no penalty for not achieving these ratios – except for the penalties suffered by patients and staff if an error is made.

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

Respondents were acutely aware that they would bear the responsibility for any errors made due to understaffing or unmanageable workloads. Concerns were also raised about the internal repercussions of raising concerns and whistleblowing. Some respondents expected bullying or the loss of their job if they reported a problem.
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