Royal College of Nursing

Safe and Effective Staffing: the Real Picture

UK POLICY REPORT

Acknowledgements

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1. Foreword

This report paints a picture of an NHS struggling without the nursing staff it knows it needs. Our research reveals the size of the hole in the NHS nursing workforce, explains what lies behind it and offers advice to policymakers on how the trend can be reversed.

Vacant nurse posts in hospitals and other parts of the NHS is sadly nothing new. But in England, the number has doubled in the last three years.

Despite the best efforts of nurses, patient care is suffering because of a potent cocktail of factors swirling around the NHS.

For a nurse, demand and pressure at work has spiralled upwards at the very moment that pay has gone the other way. Nurses are being asked to work longer and harder – staying on beyond their shifts, even when they've already worked 12 hours flat out to give patients the care they deserve, before going home exhausted and sometimes in tears.

For some, it is just too much. Four in five Directors and Deputy Directors of Nursing in all four UK countries state that their organisation relies on the goodwill of staff to keep services running (82%). That goodwill does not last indefinitely and too many now feel no alternative but to leave a profession they love.

But when a nurse leaves, who replaces them? There's no certainty about the next generation of UK nurses. Some are being deterred by low pay, some by the considerable pressure and others by the new costs of training to be a nurse. We desperately need to retain the experienced nurses we have currently got.

Too few are being trained domestically at the very moment we risk losing the international nurses we depend upon because of leaving the European Union.

This report provides conclusive proof that, faced with insufficient numbers of available registered nurses, hospitals and other health care settings are hiring increasing numbers of unregistered support staff.

Three-quarters (76%) of Directors of Nursing and Deputy Directors say they are concerned about ensuring safe staffing levels.

It is unfair on the health care support worker, unfair on the nurse who must supervise and not least, unfair on the patient. The evidence shows that patients do best when they are cared for by the right number of registered nurses.

Recent history shows us that when finances get tight, nursing budgets get raided – with the worst possible consequences for patients. Directors of Nursing should not have to fight to get appropriate funding. The existing guidance on safe staffing does not have the sharp teeth it needs and must be enshrined in legislation. For the first time, the RCN is calling for staffing levels in all health and care settings across the UK to be put on a legal footing.

Politicians have a choice on whether to give the NHS the money it needs to deliver safe care. With law in place, we can guarantee safe and effective nurse staffing, and only then will we begin to draw a line under this current false economy and ensure patients are safe.

Janet Davies, RCN Chief Executive and General Secretary

2. Executive Summary

This report is an important step on the journey toward securing guaranteed enforceable safe and effective nurse staffing levels in all health and care settings across the UK. The time has come for legislation in each country in the UK to ensure that patients always receive the safe care they deserve through genuinely enforceable safe nurse staffing levels. Wales has led the way in addressing the issue of safe and effective staffing through legislation. England and Northern Ireland now need to respond in kind. Scotland is developing a legislative approach, although the detail of any Bill is not yet available to evaluate.

Currently, the health care system is clearly relying on the goodwill of nursing staff. Financial and efficiency concerns are trumping safe staffing concerns.

This report shows that

- the skill mix is being diluted and substitution is occurring
- vacancy rates have increased across the UK, but doubled in England in the last three years
- retention is a significant issue.

Three-quarters (76%) of nurse leaders in the UK who participated in our research say they are concerned about ensuring safe staffing levels. 90% say they are concerned about recruiting new staff, whilst 84% are concerned about retaining current staff. Four in five (82%) nurse leaders in our research say that their organisations run on the goodwill of their staff to keep services running.

The UK's overreliance on nurses from the European Economic Area/European Union adds another dimension of complexity and risk as the UK prepares to leave the EU. A recently leaked Department of Health workforce model of the UK stated that in the worst-case scenario, the nursing supply could fall 42,000 by 2020. But our report shows that with vacancy rates increasing across the UK, in England alone there are 40,000 staff missing already.

Guaranteed enforceable safe and effective staffing levels in all health and care settings across the UK will ensure patient safety is protected. Compliance with statutory requirements is the first priority for organisations – legislation works in changing behaviour. Legislation should reinforce safe and effective care to corporate responsibility of any health care organisation, rather than leaving it at individual levels of management. In a quality health and care system, central critical aspects are legislated for in aid of public protection and to enable value for money: financial viability, quality and outcomes, commissioning and provision of services. But **legislation for the accountable provision of staffing levels should also be present**.

It is vital that in every country of the UK it is clear where accountability lies, what the existing and future workforce strategy is, what the planning model will look like, and what and where robust workforce intelligence data will be stored and used. We know that the right number of registered nurses caring for patients is linked to better outcomes for patients and safer care. It is crucial that Governments across the UK resolve the historical lack of workforce strategy through a planning and development model that determines and provides adequate supply for each health and care system. This must be underpinned by the development of education and training models that maintain an appropriate supply of appropriately educated, skilled, competent and motivated nurses to meet the needs of their population.

There is clear evidence that the right number of registered nurses leads to better outcomes and safer care. While there is no fixed nurse to patient ratio staffing levels need to change in response to the severity of a patient's illness – enforceable safe staffing levels in every health and care setting must be in place to ensure that people using services are safe, wherever they are.

3. Introduction

This report provides an important contribution to the conversation on nurse staffing levels and to patient safety in health care. It contains two new datasets: assessments by Directors of Nursing of the state of the UK's health systems and its workforce, and data on nurse staff vacancies in Trusts in England specifically. This is presented, alongside evidence from frontline nursing staff, in the context of evidence, policy and implementation for safe and effective staffing across the UK. We provide constructive solutions to the problems identified and explain some of what the Royal College of Nursing is going to do next.

The provision of health and social care across the UK is extremely complex. Throughout this report we present workforce data from across the UK where it is available, and compare like for like where it is feasible. Comparing data across the four countries is difficult due to reporting differences and gaps. Accounting for the health and care across the NHS and outside the NHS including local government, independent and voluntary sectors is also difficult due to a lack of data. In some countries there is partial data collection on the social care workforce; however, due to differences and gaps, data from outside the NHS has not been included.

While this report is focussed on the NHS workforce in terms of its data presentation, the issues described apply to the wider health and care sector. It is for Governments across the UK, working with the Royal College of Nursing and others, to ensure that this data gap is filled, and to future proof our workforce through robust and credible workforce strategy, intelligence, planning and modelling. The evidence base is clear that degree-educated nurses have a positive impact on reducing mortality rates. Safe and effective care depends on having a well-staffed, highly qualified workforce. Without experienced staff who can provide complex care, the risk to outcomes and patient safety is too great.

4. Background: Nursing in the UK

The NHS and the wider UK health and care systems are under immense pressure as people struggle to cope with unprecedented demand and diminishing resource. Medical advances mean that people are living longer, but often in poor health with multiple chronic physical and mental health conditions. The contribution of registered nurses and health care support workers in assessing needs, providing holistic care, and supporting people's quality of life needs is crucial for UK health and care systems to be able to respond appropriately to rising demand and financial pressures. However without sufficient numbers and quality of nurse staffing to meet need, patients are at risk and Governments cannot guarantee a primary and fundamental cornerstone of health systems – the provision of safe and effective care.

Nursing is a highly skilled and educated profession and nurses are active everywhere that care is provided across the UK. Wherever people live and need health care, nurses are designing and leading the way - from children's wards, to adult and acute services, from primary and community settings, mental health and learning disability services, to schools, hospices, and prisons. Nursing is the most trusted profession in the UK with 93% of the public saying that nurses tell the truth.[1]

90% of Directors of Nursing and Deputy Directors are concerned about recruiting new staff, whilst **84%** are concerned about retaining current staff.

Over the last decade changes to nurse education, training and nursing innovations have resulted in improvements in the care that nursing provides to patients. Many nurses now operate at a level of specialism which means they are responsible for complete episodes of care including diagnosing and the prescribing of treatment. Nurses are now trained to deliver diagnostic care such as endoscopies. Nurses run a range of nurse-led services such as walk-in centres, primary care practices, travel clinics and mobile treatment centres for people living homeless. Advanced nurse practitioners provide clinical care in a range of settings, such as in dermatology where they detect cancer, diagnose malignant melanomas, perform surgery and provide follow-up treatment. Many aspects of care that were historically the reserve of medical colleagues are now fundamentally delivered by nurses.

Northern Ireland first made the move to nursing becoming a degree-level profession in 2000, followed by Scotland and Wales, with England joining in 2012. To become a registered nurse, a person must undertake at least three years of university study alongside clinical practice in a variety of care settings. Since 2016, registered nurses as regulated professionals, like doctors, undergo revalidation every three years. Due to the increase in complex care required to meet the needs of our population, the skills, knowledge and education of the nursing workforce must continue to progress. This will ensure that nurses continue to work positively with medical colleagues and the wider multidisciplinary team. This is why the Royal College of Nursing will continue to advocate for degree-trained graduate nurses. It is crucial to sustain this level of education in the wake of advancements in medical practice and clinical technologies.

How many nurses are there, where are they from and where are they working?

Across the UK, at the end of March 2017 there were 656,219 nurses on the Nursing and Midwifery Council (NMC) register.[2] Registered nurses are responsible for the delegation of nursing care to and supervision of health care support workers, who are currently unregulated. Health and care services across the UK have increasingly relied on international recruitment, due to a shortage of UK-trained nurses. Based on where they trained, 552,581 (84.2%) of those currently on the register are from the UK, 36,615 (5.5%) from the European Union (EU)/ European Economic Area (EEA) and 67,023 (10.2%) from outside the EU/EEA. Whilst the majority of the workforce is educated in the UK, a substantial number are not. Currently, there are two routes of supply of internationally recruited nurses: from within the EU, due to the free movement of people, and outside the EU through specific visas.

The policy of recruiting from outside of the UK is not a result of inadequate numbers of UK citizens applying for pre-registration nursing places. Many people want to become nurses with applications for nursing courses outstripping the number of places available.[3]

The importance of international supply comes into sharp focus following the latest annual NMC figures showing new additions to the register. For 1 April 2016 – 31st March 2017, 6,382 EEA nurses joined the register compared to 9,117 new registrations in the previous twelve months. This represents a drop of over 30% in just one year. While we do not know the full picture for why this fall has happened, we believe that uncertainty about the future status of EEA nationals is a significant factor for the nursing community. There have been suggestions that the drop in EEA registrations is a consequence of tougher language-testing requirements and that further research is needed.

The countries from which international nurses coming to the UK has changed significantly over the last fifteen years. In 2002 over 80% of nurses came from countries outside of the European Union (EU). Today, this ratio has reversed, with EU countries providing the vast majority of overseas nurses. This is largely a result of increasing recruitment from within the EU/EEA after 2010, and changes to immigration policy reducing the supply from outside the EU/EEA.

Figure 1: NMC register broken down by country of training 31 March 2017

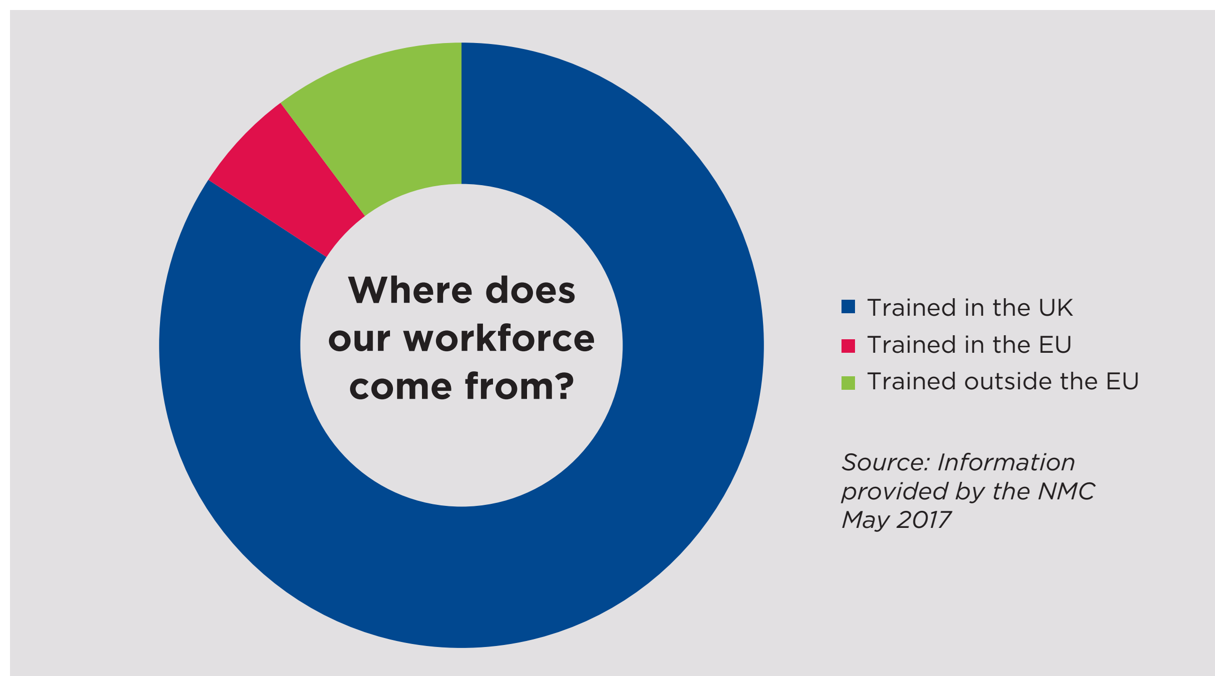
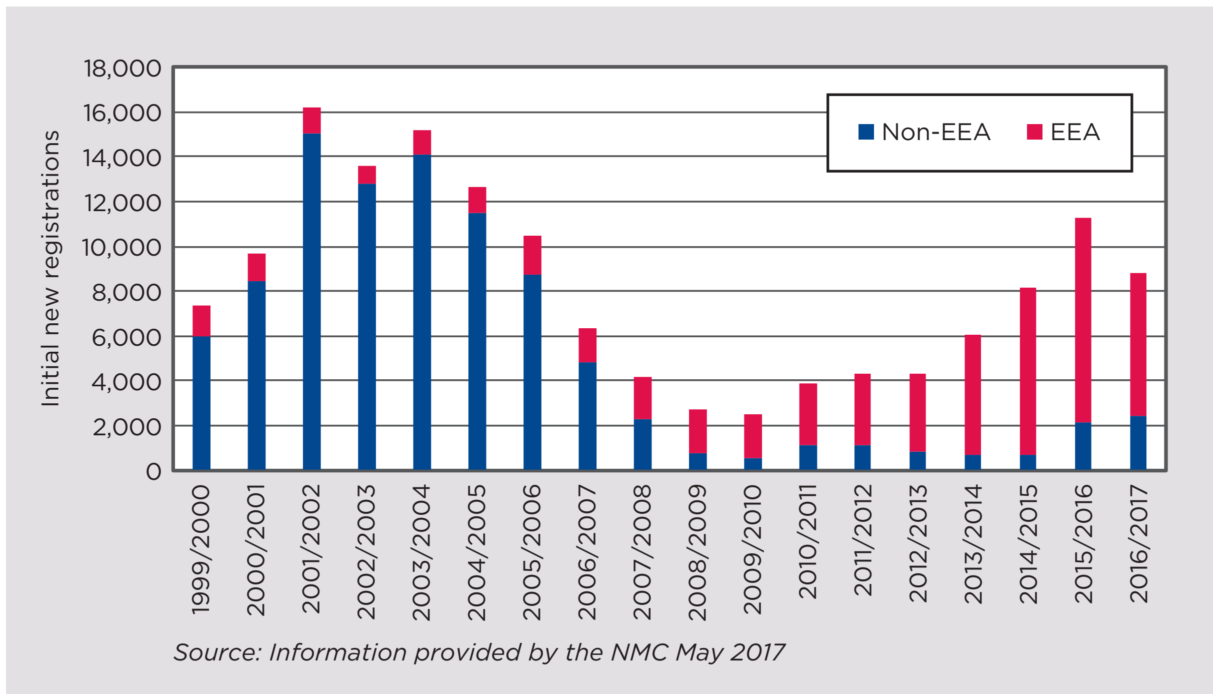


Figure 2: NMC register broken down by EEA (excluding UK) and non EEA 1999-2017



Source: Information provided by the NMC May 2017

In October 2015, to help with the UK-wide recruitment and retention challenges in both the NHS and independent sector, the Home Office added nursing to the Shortage Occupation List.[4] Inclusion means it is easier for providers to obtain visas for those nurses coming to work in the UK from outside the EU/EEA. However, this is not a long-term solution and these arrangements end in 2019. The ability to rely on current and future supply from the EU is uncertain. With nearly 37,000 EU nurses currently working in the UK, leaving the EU presents a major challenge for the UK health and care systems that needs to be considered in the context of safe and effective staffing.

The proportion of nurses to population in the UK was 8.3 per 1,000 population in 2013. This is below the Organisation for Economic Co-operation and Development (OECD) average and lower than countries in Scandinavia, Canada, Australia, the United States and New Zealand.[5]

Nurse staffing levels in the NHS – what we have found

Of the nearly 660,000 nurses on the NMC register in the UK, around 60% work in the NHS.[6] The remainder work across a range of health and care services provided by the independent and voluntary sectors, local government and in the education sector. As outlined above, data outside the NHS is poor and intelligence is limited to only being able to account for the registered workforce in the NHS.

Nurses and midwives are the largest section of the NHS workforce, accounting for nearly a third across the UK, with registered nurses comprising between 27–31% of the workforce in each country. As the biggest element of the workforce, they are also the most vulnerable when thinking about making efficiency savings by reducing headcount and the pay bill.

Table 1 shows a growth of the nursing and midwifery workforce between 1.2% and 8% across the four countries in the last six years. This slight growth in the nursing workforce needs to be considered in the context of an expanding, ageing population that is living longer with more complex needs.

Table 1: Regulated workforce numbers across the UK, 2010-16

Nursing, health visiting and midwifery - registered staff (FTE)	2010	2011	2012	2013	2014	2015	2016	Difference from 2010 to 2016	% change from 2010–2016
England	299,370	296,925	291,620	295,163	299,819	302,408	305,326	5,956	2.0%
Northern Ireland	13,899	13,649	14,039	14,295	14,546	14,840	15,075	1,176	8.5%
Scotland	42,513	41,495	41,159	41,869	42,616	43,085	43,025	512	1.2%
Wales	21,783	21,686	21,755	21,923	21,987	22,146	22,436	653	3.0%
UK	377,565	373,755	368,573	373,250	378,968	382,479	385,862	8,297	2.2%

Note: For consistency in reporting nurses, health visitors and midwives have been added in England.
The data point in each year is September for England, Scotland and Wales.
The data point in Northern Ireland data refers to December of the years 2012 to 2016 and March of the years 2009 to 2011.[7]

Despite slight growth in the workforce, patient demand on health and care services has also increased, alongside improvements in treatments available. By how much, and how this demand translates into forecasting supply is widely acknowledged to be difficult, mainly due to lack of clear and consistent measures of demand.[8] It is also important that this small increase in nursing workforce is considered in the context of the wider multidisciplinary team, what this means for the role of a nurse and the implications for safe staffing.

Table 2: Unregulated health care support workforce numbers across the UK, 2010-16

Nursing, health visiting and midwifery - health care support workers (FTE)	2010	2011	2012	2013	2014	2015	2016	Difference from 2010 to 2016	% change from 2010 to 2016
England	134,195	131,054	128,633	132,084	136,398	141,497	145,248	11,052	8.2%
Northern Ireland	3,999	3,867	3,962	3,998	3,993	4,047	4,150	151	3.8%
Scotland	15,322	14,724	14,712	15,141	15,575	15,732	16,051	729	4.8%
Wales	9,601	9,303	9,367	9,281	9,247	9,319	9,534	-68	-0.7%
UK	163,118	158,947	156,674	160,504	165,212	170,595	174,982	11,864	7.3%

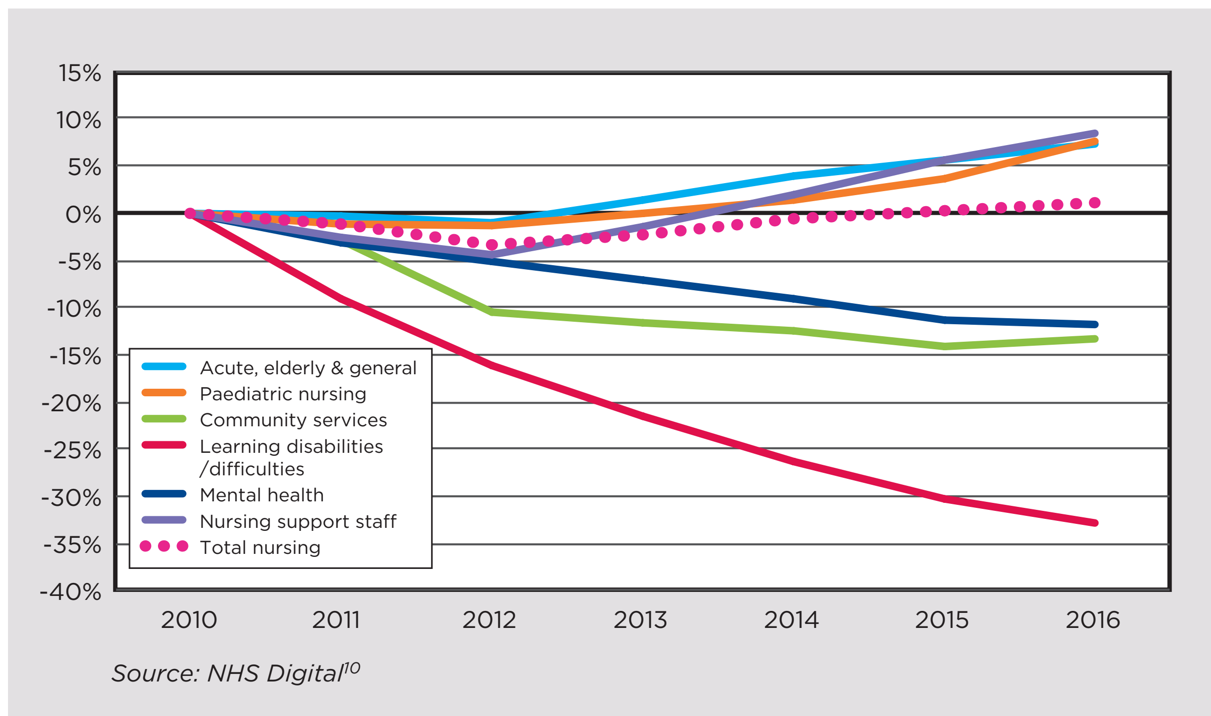
Note: For consistency in reporting nurses, health visitors and midwives have been added in England.
The data point in each year is September for England, Scotland and Wales.
The data point in Northern Ireland data refers to December of the years 2012 to 2016 and March of the years 2009 to 2011.[9]

Table 2 shows that there has been significant growth in the health care support workforce across the UK, with the exception of Wales. As nurses delegate nursing care to and supervise health care support workers, they are accountable for the care that they delegate. Any expansion to health care support workers has a direct impact on the capacity of nurses, and a knock on effect, diluting the skill mix and limiting the health and care systems ability to ensure safe and effective staffing levels.

The NHS workforce works across different settings (such as acute adult, children's, mental health, learning disabilities). The figures in Table 1 represent all settings but a growth can mask reduction in individual settings. The workforce is fluid, as the labour market also is; and changes across settings can occur in relation to increase in patient demand, changes in the flow of funding, or often in response to national policy or local priorities.

The workforce trends highlighted in Figure 1 illustrate how stark the variation is in England.

Figure 3: Register nurse numbers by setting in England since 2010 (FTE)



Source: NHS Digital[10]

Four in five (82%) Directors of Nursing and Deputy Directors say that their organisations run on the goodwill of their staff to keep services running.

The registered nursing workforce in England has grown by 2% but the majority of this growth has been in acute, elderly and general hospitals since 2013. From May 2010 to September 2016 there were nearly 12,000 more nurses employed in acute hospitals. This was a direct response to the public inquiry led by Sir Robert Francis[11] that cited poor nurse staffing as a large contributing factor to the failings at Mid-Staffordshire NHS Foundation Trust. The UK Government regularly quotes this growth in English hospitals.[12]

This figure is technically accurate but also only part of the story. Because at the same time, over the same period, the nursing workforce in community services has shrunk by 14% (5,709 FTE posts). Similarly, mental health and learning disabilities services have seen reductions in nursing posts of 13% (5,142) and 36% (1,926) respectively. These trends are at odds with the overarching policy intention to move care closer to home and the UK Government's priority to equally value people's mental health on a par with physical health.

In Scotland, due to issues with data quality, community nursing workforce data was reviewed and in 2014/15 an NHS Scotland-wide project was carried out to improve the accuracy of recording and reporting. Longer term trend data is not available as data prior to the completion of the review is not comparable. The emerging National Health and Social Care Workforce Plan in Scotland is likely to include ambitions for the quality and availability of workforce data across all sectors.

In Wales, there are particular concerns about the shortages in district nurses and children's nurses, with only 412 district nurses recorded working in community services in 2015. There are also historically low numbers of children's nurses, and we are concerned that current workforce planning for children's nursing does not take into account the number of potential registrants due to retire or the reconfiguration of services. The shortage of children's nurses is particularly damaging in neonatal nursing and in the community, with neonatal units unable to meet national standards for safe, high-quality care.[13]

There is a lack of workforce data in Northern Ireland broken down by setting. The numbers of district nurses in Northern Ireland has also decreased, with only 390 working in community nursing services.

Nursing is on the Shortage Occupation List and analysis of the macro NHS workforce figures provides us with a broad understanding of the shortage and shows variation across countries in the UK and across different clinical settings. What is evident is that even before actual safe and effective staffing levels are considered, there is already a lack of qualified substantive staff to currently guarantee patient safety in taxpayer funded health and care services across the UK. Crucially, as many others have done, the Migration Advisory Committee also highlights inconsistent workforce data collection and intelligence, significantly hampering the ability to set meaningful workforce strategy across health and care, whoever is providing it. But lack of data should never be justification or rationale for lack of a credible workforce strategy.

5. The issue: What is safe and effective staffing and why is it important?

Appropriate nurse staffing levels mean safe and effective care

Despite the lack of an agreed definition of 'safe and effective staffing' in NHS and wider UK health and care services, the pressures on the nursing workforce due to vacancies and other key factors give rise to significant concerns for the provision of safe and effective care because of a lack of experienced staff required to deliver care that is needed by patients. The public need to be assured that there are sufficient registered nurses, with the right skills, in the right place, at the right time. This is critical as safe and effective care depends on having a well-staffed, highly qualified workforce.

How to define what ensures that staffing is safe and effective is complex and depends on the constantly changing nature of how people are diagnosed and treated when they access any type of health and care service. When we refer to 'safe and effective staffing' in this report, we mean that the health and care services are able to have:

- the right nurses,
- with the right skills,
- are in the right place
- at the right time.

Having the right number of nurse staffing, with the right level of education, qualification and experience protects the public and nursing alike. So to ensure safe, effective and efficient service provision, employers of health care workforce must consider the right mix of staff and the skills they require. The latter is referred to as the 'skill mix' - the various skills of health staff - usually defined by their level of education, experience, role and pay-banding. In this report, when we refer to the 'skill mix', we mean the skills, competence and experience across registered nurses and health care support workers in the team.

Nurse staffing levels are critical to the delivery of safe and effective care. The Francis Inquiry cited poor nurse staffing levels as one of the primary failings at Mid Staffordshire NHS Foundation Trust. A subsequent study by Sir Bruce Keogh[14] into mortality rates at 14 failing Trusts in England found inadequate numbers of nursing staff in a number of ward areas, particularly out of normal working hours - at night and at the weekend. This was compounded by an over-reliance on unregistered support staff and temporary staff.[15] The findings of Francis and Keogh are underpinned by a growing body of evidence, proving a strong correlation between the number of registered nurses and mortality rates and a causal relationship between registered nurse numbers, the amount of care that is left undone, and mortality rates.[16]

A range of studies clearly warn that diluting the nursing skill mix has potentially life threatening consequences for patients.[17] Consequently, the merits of increasing the proportion of registered nurses should be a big part of the conversation about what safe and effective staffing actually is – more registered and experienced staff educated to a degree level are better equipped to deal with complex conditions, apply sound clinical judgement on care needs and act appropriately to provide high-quality safe and effective care.

It is also clear that when focussing on the effectiveness of care, sufficient numbers of nurses have been proven to increase productivity of the wider workforce.[18] Out of all the factors explored, evidence shows that the number of registered nurses was the most significant factor in increasing the productivity of medical consultants.

The evidence is clear: sufficient numbers of registered nurses lead to improved patient outcomes, reduced mortality rates and increased productivity. It is critical that health and care services have enough available nurses to staff services safely and effectively.

The policy context and implementation of safe and effective staffing across the UK...

As health is devolved to UK countries, the policies governing safe and effective staffing across the UK vary considerably. In Wales the Nurse Staffing Levels (Wales) Act 2016[19] provides firstly a general duty on all Health Boards to, when planning the provision of nursing care, have regard to providing sufficient nurses, to allow the nurses time to care for patients sensitively, and also when securing the provision of such services. The second important clause allows for the Act to cover the provision of NHS nursing care in the independent sector. It also gives Health Boards a specific duty to calculate and provide appropriate nurse staffing levels on acute medical and surgical wards.

This legislation was the first in the UK and consultation on implementation guidance closed in April 2017. At present, the NHS in Wales is guided by the existing 2012 Chief Nursing Officer principles, which refer to a number of factors in determining an appropriate nurse staffing level including ward layout, patient dependency and a general principle of one registered nurse to seven patients during the day in acute hospitals. In October 2016, the Welsh Government announced their commitment to extend this Act to other areas of care during this Assembly term (before 2020). Whilst these areas are not specified, community, inpatient mental health, maternity and acute paediatric care have all been discussed.

In Northern Ireland, nurse staffing is outlined by the Northern Irish Department of Health in the Delivering Care framework. This supports senior nurses and managers in presenting the need for investment in nurse staffing. To date it has been implemented in acute, medical and surgical wards and does not prescribe the staff numbers that should be on any ward at any time. Instead, a range has been agreed for general medicine and general surgery which goes from 1.4-1.8 registered nurses per bed (expressed as nurse to bed ratio). Work is currently underway to agree implementation in emergency departments, community nursing and health visiting, with mental health, learning disability and neonatology being potential areas for later extension.

In Scotland, Nursing and Midwifery Workload and Workforce Planning tools are mandated by the Scottish Government and cover 98% of clinical areas. They are differentiated to each clinical area and take a triangulated approach to workload measurement, incorporating professional judgement and quality measures. The tools are mandated to Boards by the Scottish Government and need to be referenced in each year's Board workforce plan before being signed off. In June 2016 the Scottish Government announced that these tools are to be enshrined in law and it is currently consulting on the legislation.

In England, nurse staffing levels are set locally by providers in negotiation with commissioners. Resources and guidance are used to support local decision making. There are no mandated tools, legislation or any form of standardised approach for setting nurse staffing levels or clearly identifying accountability. Following a recommendation by the Francis Inquiry in 2013, the Department of Health commissioned the National Institute for Health and Care Excellence (NICE) to undertake a programme of work which was subsequently suspended in June 2015.[20] The work was handed to the finance and improvement regulator, NHS Improvement, who are currently in the process of developing safe and sustainable staffing improvement resources across different clinical settings. We are deeply concerned that this approach lacks enforceability.

'The NHS in England's approach to nurse staffing has been relatively slow to evolve since the Mid Staffs Inquiry report in 2013, in comparison to the other three UK countries. This leaves it open to criticism that the current guideline-based approach does not, as yet, cover important areas. It does not favour the mandatory, legal-based, or standardised systems being advocated in the other UK countries. It can 'look' relatively weak and incomplete in comparison.'[21]

What this means and what we have done

It is fundamentally clear that sufficient levels of registered nurses to health care support workers are required within nursing team for safe care. While legislation alone won't secure the extent of the changes that the public and health care workers need, it is a critical mechanism to embed patient safety requirements, standards, clarify accountability within a system and to improve patient outcomes. Each country in the UK is at a different point in this journey, including some developing statutory means of securing and implementing safe and effective staffing levels. To help build the case for change, and in support of our call for safe and effective staffing legislation that is genuinely enforceable across each country in the UK, we have done three things so far:

1. Analysed publicly available macro level workforce data for the UK nursing workforce.

2. Commissioned ComRes to carry out research with 90 Directors of Nursing and Deputy Directors (referred to here as nurse leaders) in the NHS across the UK, to provide a richer picture that explores issues such as safe staffing, finance and retention and recruitment.[22] Detail is in Appendix 1.

3. Conducted a freedom of information exercise asking NHS Trusts across England for data on nurse staffing, to start filling the evidence gap. 76% of Trusts in England responded to our request and detail is in Appendix 1.

This report shows, to the best available information, how many nursing staff there are in the NHS, where they are from in the world and where they are currently working. We assess the impact that current nurse staffing trends are having on people using the NHS and nursing, as well as considering why this is happening and what answers can address this. We explore vacancy rates[23] as a useful indicator in helping us to know if the NHS, and the wider system, is able to provide care which is safe.[24]

Nearly three in five (57%)
Directors of Nursing and Deputy Directors say that staff wellbeing has become worse over the past two years.

6. Our findings

Vacancy rates across the UK

Workforce data presented so far shows numbers of staff on the NMC register and employed in the NHS to provide care. What it does not show is the numbers needed to meet actual demand for care. As acknowledged, determining patient demand and setting staffing levels that can flexibly respond to changes in demand is complicated. Using vacancy data can be of significant value as it can provide an indication of precisely this insight.

Our research highlights that 87% of nurse leaders across the UK are concerned about overall vacancy rates in their organisation.

Vacancy rate data across the UK is incomplete so direct comparisons should not be drawn. However, trends do show similarities across three of the four countries. Due to lack of available data conclusions could not be drawn for Wales.

At the end of December 2016, 4.1% (2,526) of nursing and midwifery full-time equivalent (FTE) posts were vacant in the NHS in Scotland. This compares to 3.6% at 31 December 2015.[25] In Northern Ireland the last available data are from March 2015 showed a vacancy rate of 5.1% for nursing, midwifery and health visiting staff.[26] This equates to 736 FTE posts and is an increase from 2.3% in March 2014.[27]

In England, central collection of nursing vacancy data stopped in 2010 and we have routinely called for the Department of Health to re-commission this data to underpin workforce planning. In August 2016 NHS Digital begun publishing NHS vacancy statistics but not on the same basis as previously provided, instead looking at job adverts listed on the NHS jobs website.[28] Although helpful and indicative recruitment information, this does not provide the number of vacant posts in the NHS which is critical for workforce intelligence as well as general monitoring.

The NHS Digital data and the data published in Northern Ireland does not include posts that are being held open under scrutiny arrangements and recruitment freezes, which we understand to be widespread.

The Welsh Government does not publish national figures on nursing. The Welsh NHS 'sustains' vacancies by holding or suspending the existence of posts once the post holder has retired or moved to another post. It is difficult to penetrate the bureaucratic labyrinth that allows brisk movement of nurses around the NHS, obscuring the need for additional nursing staff. While vacancy rates are not obtainable in the same fashion as England, it is possible to demonstrate the need for additional nurses in Wales by looking at the overreliance on agency spend. In 2015/6 the cost of agency nursing in Wales to the NHS was £48,278,757. This cost is the equivalent value of an extra 2,182 newly qualified nurses. In short the Welsh NHS is scrambling in an inefficient and costly way to make up a shortfall of nearly 3,000 extra nurses required to complete the work already allocated.

England vacancy findings

Our findings show that as of December 2016:

- there are approximately 40,000 registered nurse vacancies in England
- the vacancy rate for registered nurses in England has nearly doubled in the last three years from 20,000 to 40,000 nursing posts; a rise from 6% in 2013 to 11.1% in December 2016[29]
- there are approximately 12,000 vacancies in the health care support worker workforce
- nearly a quarter of NHS Trusts reported a registered nurse vacancy rate of over 15%, with the highest vacancy rate at 37%
- there are approximately 28,000 vacancies of Band 5 nurses, with an average vacancy rate of 16%
- over a third of trusts reported a Band 5 vacancy rate of over 20%, the highest being 39%
- seven out of the top 10 highest reported vacancy rates for registered nurses are in Mental Health Trusts.
- 65% of Trusts who responded employed a higher proportion of health care support workers than registered nurses in their 2016 funded establishment, compared to 2015
- 16% (27) of the Trusts who responded decreased their registered nursing establishment while also increasing their unregistered nursing support workforce.

A leaked Department of Health workforce model states the nursing supply in the worst-case scenario could fall by **42,000**

Currently, for every nine funded posts, just over one remains unfilled with a permanent appointment. This is exaggerated at Band 5 (the band at which a newly qualified registered nurse usually begins their career). While we would expect the total number of vacancies to be higher overall in Band 5 as this represents a higher proportion of the overall registered workforce, this shows that the demand for newly qualified registered nurses cannot be met. This fact is of particular relevance in the context of new roles introduced into the workforce in England and wider workforce strategy and policy. This will be discussed in more detail in the next section.

These findings are reinforced by external analysis of fill rates data (that shows whether Trusts have the staff they planned against what actually happened). In one example, on a specific day in October 2016, 96% of acute hospitals in the NHS in England failed to meet their own planned level for registered nurses working during that day, with 85% also missing their target for nurses working on night shifts in the same month.[30]

When analysing vacancy rates and changes to the funded nursing establishments from 2015 to 2016 by type of Trust, it is clear that nursing posts have been cut from nearly 60% of all Community Trusts and Mental Health Trusts, in comparison to a reduction in 30% of Acute Trusts. This is a major issue which negatively affects the possibility of achieving safe and effective staffing, as well as addressing unmet levels of patient demand and their needs.

Our findings show that there are 12,000 health care support worker vacancies. It is important to recognise that the introduction of new roles such as the Nursing Associate is intended to develop and upskill existing health care support workers. This means that these posts are generally drawing on people already working in the NHS. Therefore, expansion of this role is not the solution to meeting gaps in the nursing workforce as it will not increase supply overall.

So overall, despite 2% overall growth in the UK NHS nursing workforce, when set against the increasing vacancy rates across the UK it is clear that the pool of nurses in health systems is insufficient. To fill gaps in shift rotas with existing registered nurses the NHS is attempting to access nursing staff from a diminishing supply which has not been sufficient to meet demand and need in the first place. The costs of failing to fill these posts is greater than simply doing so – an expensive agency staff bill and costs incurred through poor quality service lacking in consistency and continuity.

There are simply not enough nurses and health care support workers currently in the system to provide the care that patients need. Importantly, there are not enough for what the NHS already has funding for.

7. The Impact: What this means for people using and working in the NHS

Why does any of this matter for the public and for nursing staff? As explained above vacancy data is one very useful indicator of the pressures facing the NHS, and there is a requirement for robust long-term workforce strategy and planning. Employers use a variety of methods to provide staffing cover for vacant posts:

1. Deployment of nurses via a nurse bank;
2. Buy in temporary staff through an agency (many of whom are nurses that are employed substantively elsewhere in the NHS, but seek additional work);
3. Existing staff who have worked 37.5 hours in any week doing overtime.

All three avenues fundamentally reach into the same pool of workers. Health and care organisations' ability to use temporary bank and agency nursing staff as mitigation measures to help enable safe care is increasingly restricted, given that the pool of registered nurses is not big enough to meet current demand or need, let alone fill a growing vacancy gap. Cost saving measures restrict nurses on permanent contracts. They are denied overtime and deployed via nurse banks. These employment practices mask nursing workforce demand, nursing vacancies and adversely impact workforce planning.

As described in Section 2, on a daily basis the NHS is responsible for providing safe and effective care to patients. Increasing vacancy rates across the UK show that the NHS is increasingly unable to recruit the nursing staff they require. The gap between the numbers that health and care organisations have set as their need, and what they actually have, is growing at an alarming rate.

This situation contradicts repeated pledges to the public that care provided by the NHS should be the best in the world.[31] Based on our findings, on what our members tell us, and what regulators across the UK find in many inspections, despite the best efforts of some, the care being provided in many NHS services is not always able to be safe or effective.[32]

Increasingly limited mitigation strategies lead to…

As noted above, when it is not possible to fill shifts on a nursing rota with substantively employed staff. It is the option of filling shifts via external agency staffing that is particularly difficult because of its impact on NHS funding and finances. This also means that many nurses are currently working extensive hours to deliver needed care to patients, often at the expense of their own health, to increase their basic wage to meet the cost of living.

Pay is a critical factor in retaining and recruiting skilled health care staff. Nurses and midwives deserve fair pay for the work they do, and nursing pay is low compared with other similarly qualified professions and in relation to living costs. More nursing staff than ever before are leaving the profession, piling the pressure on people who are already overstretched. This, coupled with increasing workloads, is affecting quality of patient care. The 2017 decision to continue the 1% pay cap for NHS staff in England, Wales and Scotland represents the continuation of restrictions and another real-terms cut to pay. This means the gap between nurses' pay and the cost of living is getting even bigger. Nurses in Northern Ireland are the lowest paid in the UK. Because of the current absence of a Northern Ireland Executive, no pay award for 2017/18 has been made.

Agency work has increased in appeal to nurses because it allows individuals to increase their earnings to close gaps between rises in the cost of living and the depression of their wages over years of Government pay restraint. Agency work also allows nurses to adopt more flexible working patterns which are often not available to them as employees in NHS organisations. Doctors do exactly the same thing through locum roles at much higher rates. However, the problem with this practice is that it increases expenditure of the NHS, and thereby taxpayers' money, unnecessarily and reaches into the existing pool of workers to fill demand for care. The NHS should not need to rely on agencies so heavily to make the system work.

With so many unfilled posts, the UK health and care system's reliance on agency staff is far from likely to change without substantive intervention from policymakers. The actual availability of nurses through agencies is diminishing as the pool of registered staff is insufficient to meet demand. There is a major recruitment issue, but also a significant retention issue as registered staff move to take on permanent agency work.

With nearly **37,000** EU nurses currently working in the UK, leaving the EU presents a major challenge for retaining existing staff.

Agency spend in the NHS is not a new controversy, and yet use of agency and bank staff is increasing across the UK. The solutions nurse leaders say they have taken to fill staffing gaps include increasing use of bank staff (83%), offering overtime hours (82%) and recruiting agency staff (71%). Whilst there will always be a need for flexibility within the system, push and pull-factors are compounding one another and policy interventions are sometimes provided to address individual issues, while what is really needed is meaningful problem solving within context and at root cause.

In 2016 in England, to try to reduce how much the NHS spends on agency nurses, NHS Improvement introduced a suite of measures including price caps, maximum wage rates and required use of approved agreements.[33] Latest forecasts indicate a reduction in spend from £3.7bn in 2015/16 to around £3bn in 2016/17.[34] NHS Improvement recently attempted to restrict the ability of a nurse to generate additional income by working across Trusts and also for an agency, whilst also choking the pipeline of staff availability with NHS services. This ban has since been suspended but the issues that it sought to resolve remain fundamentally unaddressed.

Use of agency nursing and midwifery staff in NHS Scotland has increased each year over the last four financial years, with particularly notable increases since 2013/14. Agency cover was equivalent to 276.7 WTE in 2015/16, a 44.9% increase from 191 WTE in 2014/15. The cost of agency nursing and midwifery use in NHS Scotland has subsequently risen from £16m in 2014/15 to just under £23.5m in 2015/16.[35]

In 2015/6 the cost of agency nursing in Wales to the NHS was £48,278,757. This cost is the equivalent value of an extra 2,182 newly qualified nurses. We recommend that spend on agency nursing in the NHS in Wales is published annually by the Welsh Government. Apart from the financial implications, in the absence of more effective data, expenditure and usage rates for bank and agency nursing represent a useful proxy measure of additional nursing need.

In Northern Ireland agency costs have nearly doubled from being £8.56m in 2011/12 to £15.08m in 2015/16.[36] Over the same time the cost of employing bank staff has risen from £35.66m to £64.1m.[37] This shows a UK-wide pattern of rising costs.

There will always be a need for a flexible nursing workforce able to take on temporary roles. Sickness, maternity, paternity and annual leave alongside sudden variations in patient numbers and dependency ensure this. However, a systemic reliance on temporary nursing staff is not desirable. Nursing staff unfamiliar with the patient caseload, ward layout or equipment, or inexperienced with the particular patients, will need more support than NHS directly employed colleagues who can deliver consistency of care. Extra time also has to be allocated for supervision. There will always be times when some investment in agency nursing will be needed to ensure safe patient care, however the increasing use of agency nurses is just not sustainable. This results in a lack of continuity of care for patients, puts increasing pressure on existing nursing staff and affects their morale.

It is not a financially effective strategy and the resulting instability in staffing levels and subsequent stress of nurse team leaders is not conducive to best patient care. What is needed is to get the workforce strategy and cycle of workforce planning right – from the number of nurses being trained in our universities right through to filling nursing vacancies when they arise, rather than employers not recruiting to try and save money. This only leads to short-termism and expensive increases in agency spend.

… a reliance on less experienced staff to provide complex care…

Skill mix is an important measure of safe and effective staffing. It is a key indicator of ensuring that the right number of staff with the right skills and qualifications needed to carry out safe and effective patient care is on duty for each shift. Nearly half (47%) of nurse leaders in our research are concerned about dilution of the skill mix, such as by employing more health care support workers and/or reducing the number of registered nurses. 41% are concerned about the delegation of nursing care to unregistered roles.

When the numbers of registered nurses with the appropriate knowledge, skills and experience are insufficient to provide care required by patients there are two major consequences: less qualified staff are employed and/or deployed to fill these gaps and existing staff have increased workload. The former is called 'diluting the skill mix' or 'substitution'. In practice, dilution and substitution can occur at the same time as the number of registered nurses increases or appears stable. If growth in the nursing workforce is outpaced by rising patient demand then the registered workforce will still find itself increasingly stretched in spite of more numbers.

To keep up, health and social care organisations often employ and/or deploy unregistered health care support workers who may end up working outside the scope of their role or without the adequate supervision of registered nurses. This is a public protection issue. Likewise, Band 5 registered nurses may be required to take on more complex Band 6 responsibilities and so on. In other cases, specialist and advanced nurses may have to cover Band 5 vacancies, leaving gaps in leadership, managerial roles and specialists. Both of these practices increase the possibility of adverse impact on patients and access to services.

Wherever substitution happens, there is a direct risk to patients. The evidence shows that patient outcomes benefit when the skills mix of nursing teams is enhanced – specifically through increasing the proportion of registered nurses.[38]

Increasing the proportion of health care support workers may occur when it is accompanied by an increase in the registered nurse workforce, and the skill mix remains stable. As all nursing care carried out by support staff is delegated by a registered nurse who is responsible and accountable for that delegation and for the supervision of the support worker providing nursing care within a delegation framework, increases in support staff directly impacts on the workload of nurses.

The dilution of the skill mix is likely to be a direct consequence of a lack of supply of registered nurses, and health and care organisations have started to recruit and employ more staff with lower qualifications and less experience than they originally planned, and received funding, to do.

Our new data shows that 65% of Trusts in England who responded have increased the proportion of unregistered nursing support staff. In 16% of Trusts (27) the health care support workers have increased while the registered nursing workforce has decreased. Given high vacancy rates at band 5, this suggests there is substitution of qualified nurses with less qualified support staff. In one Trust, funding for band 5 nurse vacancies is being transferred for the explicit purpose of using filling this gap in the registered nursing workforce with new Nursing Associate posts on the basis of availability – not because this is in line with evidence or what is needed for safe care.[39]

We call for an end to the practice of down-banding of registered nurses and substitution with less experienced staff. We know both down-banding and substitution are being used as a way of controlling costs. Our members tell us it is now commonplace for unregistered staff to undertake tasks that should be carried out by registered nurses. We support the development of health care support workers but it must not be allowed to substitute registered nurses with less experienced staff because they are cheaper or more readily available.

...and a burned out and demoralised existing workforce

The overreliance on existing staff to fill gaps in rotas is contributing to low morale, increased stress-related sickness absence and burnout, which ultimately translates into poor retention rates for both nurses and health care support workers. These impacts add considerably to the existing nurse staffing shortage. Unfortunately, retention and retirement rate data is not consistently reported across the UK and we have not been able to address this data gap. But we know from our members that working conditions are pushing people to leave the NHS. This is supported by our UK-wide research, with 84% of nurse leaders reporting they are concerned about retaining current staff.

While retention is a complex matter, there are key factors in the case of the nursing workforce: additional and unpaid hours, high workloads and pressures, stress and burnout and pay. All of these are, of course, interrelated and continued understaffing is part of the consequence of such impacts.

The latest NHS staff surveys within each country shows that nurses across the UK are concerned there are not enough staff to do their job properly (England (49%)[40], Wales (49%)[41], Northern Ireland (28%)[42] and Scotland (26%)[43]. The same surveys show that the majority of nurses work unpaid overtime, with 76% and 74% of nurses saying they work unpaid additional hours in Northern Ireland and England respectively.

Across the UK, the 2015 RCN Employment Survey[44] shows there has also been a rise in the proportion working more than eight unpaid hours a week over their contracted hours than in 2013 (14.7% compared with 12.7%) . By country, heavy unpaid overtime working seems most common in England, where 53% say they work in excess of contracted hours either several times a week or every shift. This compares with 50% in Wales, 49% in Northern Ireland and 48% in Scotland.

The survey also found that 72% of respondents had worked at least once in the previous 12 months despite not feeling well enough to do so, with 15% having done so on five or more occasions. The main reason for feeling unwell was work-related stress, reported by 46% of those who have worked when not well enough to do so. This is supported by four in five (82%) nurse leaders who say that their organisations runs on the goodwill of their staff to keep services running.[45]

Stress is the single biggest cause of sickness absence in the UK and its prevalence is particularly high among nursing staff. Nurses are at greater risk of work-related stress, anxiety, and depression than other occupational groups.[46] The UK has one of the highest rates of nurses reporting burnout across Europe. In a European nursing workforce study, the highest report of burnout was reported in the UK – 42% as compared to the European average of 28%.[47]

Long shifts, overtime (more likely unpaid than paid), weekends, nights, holidays and weekend overtime have been found to be predictors of turnover. Extended shifts and overtime subject nurses to high physical and emotional demands, leaving them fatigued, and unable to cope with stress effectively.[48] This is an issue for staff and for patients, with a clear relationship between staff wellbeing and patient care performance.[49] Seeking to systematically enhance staff wellbeing is important in its own right and can also improve the quality of patient experience.[50]

Nearly three in five (57%) UK nurse leaders responding to our research said that staff wellbeing has become worse over the past two years.

Pay is also a factor exacerbating low retention rates. Although each UK country has differing NHS pay rates, the maintenance of a fair pay system through the Agenda for Change system acts as a national benchmark for pay, terms and conditions for all health care staff. However there has been a real-terms drop in earnings of up to 14% for nursing staff since 2010. This loss of earnings has severely impacted on nursing staff's quality of life; our members repeatedly tell us that they are struggling to pay the rent or mortgage and bills and there are examples of nurses using foodbanks. 30% had struggled to pay gas and electricity bills, 14% missed meals because of financial difficulties, 53% had been compelled to work extra hours to increase earnings and 32% were working extra night/ weekend shifts to help pay bills. The latter points are particularly relevant in relation to agency

and banks shifts: they illustrate how low pay forces nursing staff to work additional bank and agency shifts, thereby increasing NHS spend and working existing staff to the core.

It is profoundly concerning that recent studies on suicide prevalence in England[51] found that the risk of suicide among female nurses is 23% above the national average, while the whole health and care workforce is at higher risk than the general population.

When health and care organisations are faced with shortages in essential nurse staffing, and are under immense pressure to balance the books through short-term efficiencies, it may be tempting to allocate resources to less expensive, less qualified staff and work existing staff through agency and bank shifts. But a sustained reliance on this puts both patients and nurses at risk.

We need a strategic approach to safe and effective staffing levels and statutory mechanisms that are responsive to the evidence base. These must guarantee Governments are accountable for enforceable nurse staffing levels, which local organisations are supported to implement. This must include clarity of role responsibility and accountability for workforce planning, commissioning of pre-registration nurse education and post-registration professional development, and preparation for specialist and advanced practice.

8. The causes: Why is this happening?

Why is the UK in a situation where the NHS, and the wider health and social care sector, do not have enough staff to provide the care that the population needs? A large part of the cause has already been set out: we are in a downward spiral where the existing, already too small nursing workforce is working in conditions that lead to it diminishing even further. Three factors are crucial: lack of health and social care funding, lack of workforce intelligence and a lack of robust workforce strategy with accountability, which would help address both the number of posts and supply into them.

Lack of funding in the NHS and poor retention

Funding is a core issue across the UK. Two in three nurse leaders in the UK say that, compared with two years ago, finances have become worse (64%) with half of them agreeing that financial pressures mean they can't always make the best decisions for patients in their care (49%). Three in five nurse leaders in the UK disagree that their organisation has the financial resources it needs to deliver the high-quality nursing care that patients expect (58%). This is supported by the financial measures being introduced across the UK.

It is the lack of NHS funding that has led to efficiency pressures in the system and despite the findings of the Mid-Staffordshire public enquiry, lessons have not truly been learned. Over the last decade efficiency savings and finance have been consistently prioritised over safe and effective staffing. Short-sighted cost-saving measures implemented in the absence of proper engagement with the profession or risk assessment have resulted in a shortage of nurses. This has not delivered anticipated cost savings and has proven costly due to patients, the health and wellbeing of nurses and the public purse in terms of increasing financial cost. Pay restraint and a deterioration in working conditions is contributing to agency spend, bank use and poor retention rates.

In England, in the 2014 the Five Year Forward View, Chief Executive Simon Stevens explained that by 2020/21 there would be a £30bn funding gap between demand and what the NHS would have.[52]

To meet this funding gap, the UK Government would provide £8bn, but the remaining £22bn must be found by efficiency savings.[53] In July 2016, NHS Improvement put five Trusts and nine Clinical Commissioning Groups into financial special measures and named 63 Trusts that had significant pay bill growth in excess of inflation and pension effects from 2014/15 to 2016/17. NHS Improvement provided clear instruction to Trusts that they needed to both reduce the NHS deficit and reduce their pay bill. Pressure is being put on providers to reduce their pay bill, but also to ensure safe staffing levels. It is a conflict of interest that in practice operational responsibility for staffing has been transferred to the financial regulator.

The pressure to reduce the pay bill and the deficit in funding for the NHS must not replicate the pattern previously observed when Trusts in England were pushed to achieve Foundation Trust status. A focus on finance and not patient safety is widely understood as one of the contributing factors to the failings at Mid-Staffordshire.[54]

In her most recent overview of the NHS in Scotland,[55] the Auditor General noted that Scottish NHS boards had to make "unprecedented levels of savings" during 2016/17, risking some boards not breaking even. In total, health boards planned a 65% real-terms increase in planned savings between 2015/16 and 2016/17. NHS boards were classifying more savings as high risk, did not know how they were going to make all their savings at the start of last year and intended to make nearly a third of their savings through one-off, unsustainable options to save money. With £6.2bn of the NHS budget spent on staff costs in 2015/16, savings targets are putting significant pressure on the Scottish health care workforce.

Because of the current political situation, there is no Northern Ireland Executive budget for 2017/18 and potential requirements for cost/efficiency savings are unknown. If no Government is in place by 29 June 2017, the Secretary of State has indicated a possible 3% increase in cash for health and will intervene to effectively set the budget for the rest of the financial year.[56]

In Wales, 2016 estimates suggested that the NHS could face a £700m hole in finances by 2019/20 – a shortfall equivalent to more than 10% of what NHS Wales currently spends in an entire year. There are warning signs that the costs of social care might nearly double by 2030/31.[57]

Lack of workforce strategy and planning

It is important to understand that there is a historic lack of robust workforce strategy and planning across the NHS and the wider health and care sector, and this is directly connected to lack of clarity in some countries around responsibility and accountability for workforce policy and planning, cost saving measures and problems in determining demand across NHS and wider health care settings. The Health Foundation comments that "the lack of policy coherence across the funding-staffing connection [is] a recurring theme. The combined effect has been to undermine any long-term consistency in approach to workforce policy and planning, and this has been compounded by changes in funding arrangements, and limitations in workforce data availability and configuration."[58]

In Scotland, Government intends to publish a National Health and Social Care Workforce Plan in 2017.[59] We responded,[60] outlining that Scotland needs to adopt a multidisciplinary, multi-agency workforce plan with the ability to deliver the workforce necessary to ensure that people across Scotland's communities have the health and social care interventions they need. Ultimately, a refreshed, joined-up approach to workforce planning should deliver better outcomes for people. The model set out by Scottish Government includes national, regional and local workforce planning. We have raised three areas of concern which related to demand: the new integrated health and social care landscapes; the importance of voices from each health and social care sector being equal; and all sectors having sufficient, detailed input that reflects their practical position and recognises the constraints they are under because of external factors. We've also noted the importance of having feedback mechanisms within and between national, regional and local structures. This will allow the Scottish Government to anticipate and plan the funding needed for Scotland's future workforce, which is crucial to delivering any workforce plan. If constraints on the amount of funding continue at the current levels, it will be incredibly challenging to deliver a workforce plan which matches current and adapts to future need.

The Welsh Government currently commissions nursing student numbers nationally based on a yearly cycle. In 2017 a new arms-length commissioning body will be established. There is a consultation on this workforce planning process with key stakeholders including the RCN. Each Health Board submits an Integrated Medium Term Plan, which includes a workforce plan for approval by the Government. These plans should account for NHS but also nursing needs in the independent sector (predominately care homes). The Government then uses these plans to set student commission numbers across Wales.

In Northern Ireland, the Department of Health is responsible and accountable for workforce planning for the Health and Social Care Services. The Department is also responsible for the three-yearly cycle of commissioning pre and post-registration education programmes. The three-yearly planning cycle has been inadequate to date, primarily as it only accounts for NHS services.

In England, Health Education England provides oversight of the workforce strategy, but in reality this yearly workforce planning process is locally driven and fragmented.[61] The local driven numbers do not cover any provision outside the NHS, therefore previously set student commissions never considered the demand for nurses outside the NHS. Many of the challenges regarding the supply line of nursing staff are of the system's own making. While examining the approach to workforce strategy and planning in England, the National Audit Office substantively concluded that "current arrangements for managing the supply of NHS clinical staff do not represent value for money."[62]

Education and training

Historically, devolved administrations have controlled training of nurses through a student bursary and commissioning model.[63] This allowed the NHS to tell each Government how many new nurses they were likely to need every year, and the number of university places were then commissioned. Most importantly, it has meant that historically the NHS has told the Governments how many nurses it could afford to employ, rather than measuring patient need.

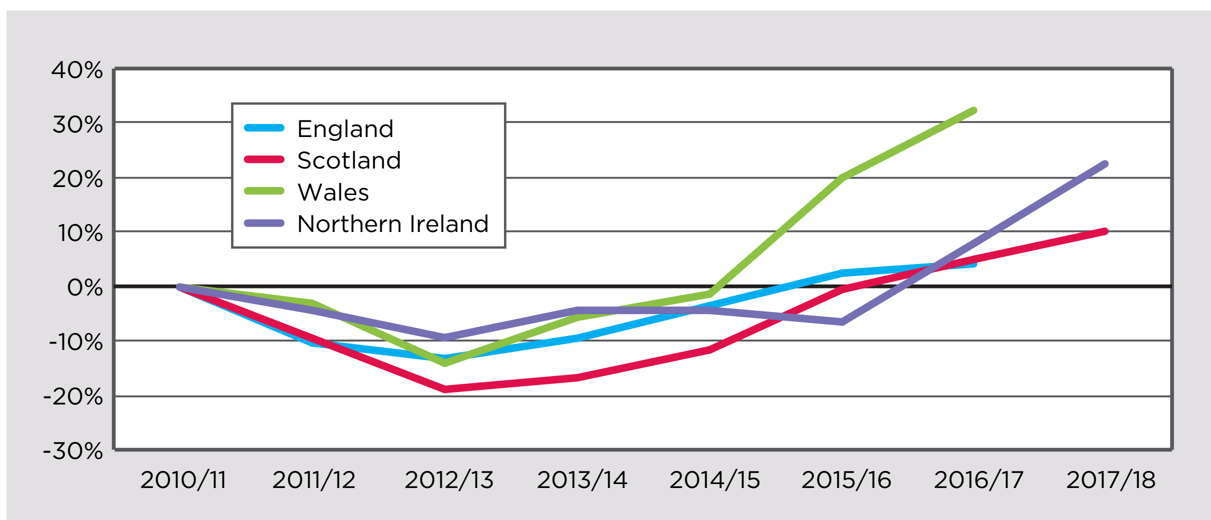
All countries across the UK cut nurse training places from 2010 to 2012/13: Scotland by 19%, Wales by 14%, England by 13%, and Northern Ireland by 9%. Wales have increased the number of pre-registration nurse places significantly since 2014/15, exceeding levels in 2010 by a third. This is partly in response to the ongoing recruitment challenges, but is also a direct result of the Nurse Staffing Levels (Wales) Act 2016. It was acknowledged early on that should the legislation be ratified and have the chance of being implemented properly, it needed to be underpinned by a workforce strategy that ensures growth in the domestic supply of nurses.

Table 3: Commissioned training places for pre-registration nursing 2010-2017

Pre-registration nurses	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
England	19,904	17,827	17,264	18,009	19,206	20,410	20,741	-
Scotland	2,878	2,600	2,330	2,390	2,538	2,865	3,027	3,169
Wales	1,070	1,035	919	1,011	1,053	1,283	1,418	-
Northern Ireland	690	660	625	660	660	645	745	845

Sources: Welsh Government, Scottish Government, Northern Ireland Department of Health, Health Education England, Commissioning and Investment Plan 2016/17.

Figure 4: Commissioned training places for pre-registration nursing 2010-2017



In Scotland, commissioning is still centrally controlled and funded by the Scottish Government, who allocated numbers to HEIs with performance monitoring via NHS Education for Scotland (NES). Following a number of years of cuts to student numbers, there is now a gradual increase which is slowly reversing the previous trend. But this is still not considered to be sufficient to meet patient population health demand. While there is also a Scottish Government commitment to retain the non-means tested non-repayable student bursary, this has not been uplifted for several years and the package of student support is currently under national review by the Chief Nursing Officer in Scotland. Scotland have increased commissions year on year since 2012/13, a cycle that is directly linked to a national process for determining numbers, which includes analysis of workforce data.

Because the staffing legislation in Wales is underpinned by a workforce plan that increases nurse training places, this will, in the long term, help overcome staffing shortages. In Northern Ireland there has been a commitment to increase student training places in response to rising demand across the health and care system; a 22% increase.

In England, in 2016 the supply side of nursing has recently undergone fundamental changes, without reasonable engagement or consultation with the nursing profession. Previously, the NHS advised the Government via Health Education England how many new nurses they were likely to need each year, and the number of university places were commissioned centrally. In 2016/17 Health Education England commissioned only 331 additional student places, when based on providers' forecasts they should have commissioned an extra 3,000.[64] Decisions made on the basis of finance resulted in numbers being restricted despite requests from NHS providers. This approach was abolished in 2016.

As of 1 August 2017, new nursing, midwifery and most allied health students in England will no longer receive NHS bursaries. Instead, they will have to access the same student loans system as other students. The UK Government's reported aim of this funding reform was to help to secure the health care workforce, by enabling universities to offer up to 10,000 extra training places on pre-registration health care programmes.[65] For 2017/18, this vision has not been realised and the number of nursing applicants has fallen by 23%, with a 28% reduction in the number of mature student applications.[66] As training places remain capped at 2016/17 levels for 2017/18 through the placement funding allocations and further arrangements have not been announced, it is as yet unclear what the scale of the impact of this reform will be.

Vacancy rates are increasing across the UK. There are approximately **40,000** registered nurse vacancies in England alone. This equates to an **11.9%** vacancy rate. The rate has doubled in the last three years from 20,000 to 40,000 nursing posts.

This move in England to a market-led, fees-based nurse education may grow the workforce over time, but there is currently no market intervention or regulation that ensures successful implementation of the reform on the supply side. No one in the system is currently accountable for ensuring the required number of nurses are trained, with the right skills, in the right locations. This approach stands at odds with the requirement to ensure that the health and social care sectors are equipped with the workforce that is necessary to deliver quality care and support. It is particularly concerning that, despite taxpayers' expectations that their

contributions will help secure access to health care services, the UK Government does not currently hold the means to actually generate and be assured that the health system has the nursing workforce that the NHS in England needs for patient safety. Safe staffing legislation in England is precisely the intervention that would help ensure adequate supply for safe and effective staffing. It would also act as a lever to achieve the Government's original ambition of creating 10,000 extra training places.

There is a clear opportunity for Governments to do something radical and constructive to tackle this problem. We call for guaranteed safe and effective staffing levels in all health and care settings in each country in the UK, underpinned by a long-term and robust approach to getting workforce planning right within each devolved setting. Now is the right time for the expansion and introduction of enforceable statutory mechanisms to guarantee patient safety by ensuring safe and effective nurse staffing levels.

Conclusion

It is vital that there is clarity in every country of the UK as to where accountability lies, what the existing and future workforce strategy is, what the planning model will look like, and what and where robust workforce intelligence data will be stored and used. We know there is clear evidence that the right number of registered nurses caring for patients is linked to better outcomes for patients and safer care.

Preparing to leave the EU adds another dimension of complexity and risk to this, with a historical overreliance on nurses from the EEA/EU. A leaked Department of Health workforce model states that the nurse staffing supply in the worst-case scenario could fall by 42,000.[67] But our new figures in England alone show that the health system is already nearly at this worst-case scenario.

In our research, 59% of nurse leaders in the UK responding say they have recruited non-UK EU nationals in order to fill staffing gaps and 47% say they have recruited outside the EU for the same reason. 86% of nurse leaders say that nurses recruited from the EU are essential for the proper functioning of NHS services across the UK. Brexit carries the risk of not only making the pool of registered nurses even smaller, it also puts at risk one of the system's primary means to fill supply gaps by securing nursing staff from Europe.

The pace of untested policy changes, including short-sighted financial cost savings measures; the debate over new roles such as the Nursing Associate; potential changes to the regulation framework; and the impact of Brexit, have extreme implications in practice and are putting the future supply of nurses at huge risk.

9. The answers: What needs doing and quickly

The Royal College of Nursing is committed to ensuring that safe and effective staffing levels are in place, for the benefit of patient safety, the public and for nursing staff. For our part, we will work with our members and lead the nursing community, partners across the system and the public to make our vision a reality for nurse staffing in each part of the UK. We are determined to work with Governments across the UK to provide solutions which enable the provision of safe and effective care, with exceptional nursing skills at its heart. As for Governments, clear and decisive action must be taken, and here we set out the next steps of this journey.

Workforce strategy, planning and development are intrinsic aspects of any health and care system, along with other aspects such as financial viability, quality and outcomes, commissioning and provision of services. Powers and duties for these aspects are clearly provided through legislation in some parts of the UK, including accountable bodies and means of regulation. Addressing staffing levels for patient safety, including through legislation, should be the rule and not the exception.

There are four key dimensions of nurse staffing levels for patient safety, which each country of the UK needs. Within the devolved nations, progress has been made on some aspects. We want to see each country in the UK having in place:

1. Legislation for the accountable provision of safe staffing levels;
2. Increased funding flows with political accountability for safe staffing;
3. Credible and robust workforce strategy;
4. Scrutiny, transparency, openness and accountability.

Legislation for the accountable provision of staffing levels

We need genuinely enforceable safe and effective nurse staffing levels. Wales has led the way in addressing the issue of safe and effective staffing through legislation. England and Northern Ireland now need to respond in kind. Scotland is developing a legislative approach, although the detail of any Bill is not yet available to evaluate.

While legislation alone won't guarantee patient safety, it is a critical building block in clarifying roles and responsibilities for the workforce, a crucial component of a health and care system. Each system needs clarity around named accountability and responsibility for workforce strategy, policy and planning. This must also include clarity around accountability for commissioning of pre-registration nursing places, post-registration professional development and preparation for specialist and advanced practice.

Increased funding flows with political accountability for safe staffing of health and care services

Short-sighted cost saving measures and lack of funding have been demonstrated to be a significant factor in the issues described – an increase in funding will grow both 'pools' of posts to meet actual demand and numbers of qualified staff needed. It will also lessen the pressures on the system so that patients can be put first again, with staff enabled to deliver high-quality care and maintain wellbeing, thereby improving retention rates and ultimately decreasing the cost of agency and bank spend.

It is critical that the responsibility for a workforce strategy lies at Ministerial level, to give patient safety the accountability and prominence it deserves.

Credible and robust workforce strategy

It is crucial that Governments across the UK resolve the historical lack of workforce strategy through a planning and development model that determines and provides adequate supply for each health and care system. This must be underpinned by the development of an education and training models that maintains an adequate supply of appropriately educated, skilled, competent and motivated nurses to meet the needs of their population.

Progress on developing workforce strategy has been made in Scotland and Wales. In Northern Ireland, responsibility for regional workforce planning for health and social care and commissioning of pre and post-registration education sits with the Department of Health in Northern Ireland.

In England, the Department of Health is ultimately accountable for securing value for money on training and employing nurses. While in principle Health Education England oversees national workforce strategy for health care, and this is a locally driven process, in light of the changes to student funding arrangements it is no longer clear which organisational body is responsible for addressing the national shortage of nursing. This must change.

Scrutiny, transparency, openness and accountability

Whilst legislative interventions help provide additional data, to be fully successful robust workforce data must be collected and published in each country and intelligence generated from it. This will help ensure that there is full accountability for the staffing of services serving our population and enable delivery of workforce strategy through providing a sound evidence base. Importantly, data collection must cover the entire health and care system irrespective of provider.

Call to action

Nurses tell us they are struggling to deliver the care that patients require every single day. 38% of nurse leaders in the UK responding in our research disagree with the statement that their organisation is in a better position to provide high-quality nursing care to patients than it was 12 months ago. Burnout is high, and morale is low. Many nurses tell us they will leave the NHS, and there is a real risk that nursing is becoming too unattractive a career, when the reality is that nursing provides radical opportunities to transform care in innovative and cost-efficient ways.

Governments within each country are ultimately accountable for resolving this crisis, and must lead the way in clarifying the specific accountabilities and responsibilities of Government, Ministers, Arms-Length Bodies, employers, providers and service designers to address the challenges in recruitment and retention at national policy level, and implement them locally with support, scrutiny and oversight.

Nurse-led services provide some of the most cost-effective, high-quality outcomes in the world. In the context of increased efficiency and productivity, and a shift towards providing care closer to home, nurses are uniquely placed to design and deliver integrated, holistic care to meet population health needs. But this cannot be done without significant Government-led action in each country of the UK in these four key dimensions. It is time to close the vacancy gap and grow the number of registered qualified nurses to provide safe and effective care and support for people, when they need it.

10. Appendix 1

Methodology for vacancy data in England

From December 2016 to January 2017 we conducted a Freedom of Information exercise, asking NHS Trusts across England for data on their staffing, covering acute, community and mental health services. The data we obtained includes the number of vacant nursing posts. This is the gap in the number of positions a Trust has allocated for the performance of certain duties that do not currently have an employee functioning in that role.

Vacancy data is no longer centrally collected or published. We have routinely called for the Department of Health to re-commission the collection of this data as part of workforce intelligence because it is so crucial in underpinning effective workforce planning and providing assurance about the availability and quality of workforce to provide NHS-funded services.

More than 76% of Trusts responded, sharing data on staff numbers and vacant posts at 1 December 2015 and 1 December 2016. We asked how many registered nurses and health care support staff Trusts had according to their Agenda for Change band. This covers bands 1 to 4 (health care support workers) and bands 5 to 8 (registered nurses). This distinction really matters because banding gives a strong indication of an individual's level of education, experience and skill. There is strong evidence showing that the more degree-educated nurses you have caring for patients (band 5 upwards), the better the outcomes for patients tend to be.

The questions we asked were:

1. What was your whole time equivalent nursing establishment for each AfC band 5 to 8, at i) 1 December 2016 ii) 1 December 2015?
2. How many whole time equivalent nursing vacancies did you have, for each AfC band 5 to 8, at i) 1 December 2016 ii) 1 December 2015?
3. What was your whole time equivalent nursing support staff establishment for each AfC band 1 to 4, at i) 1 December 2016 ii) 1 December 2015?
4. How many whole time equivalent nursing support staff vacancies did you have, for each AfC band 1 to 4, at i) 1 December 2016 ii) 1 December 2015?

Responses

174 of the 228 (76%) Trusts we wrote to provided us with answers to questions 1-4. 174 provided totals to each question providing totals for 1-4 and 5-8. 154 of the 174 Trusts provided the breakdown by individual Agenda for Change Band.

Results

One basic way to calculate the total number of vacancies across England is to use the whole figure from the 76% data return and, using the average, scale up from trusts who reported 30,224 registered nurse vacancies. This crude method provides a total of 39,603 nurse vacancies.

The total band 5-8 nursing funded establishment figure provided was 272,228 and the total band 5-8 vacancy figure was 30,224 giving vacancy rate of 11.1%. When the total funded establishment figure is scaled up based on the response rate, we estimate this to be approximately 337,500.

We also looked at two other approaches, scaling up the 76% data return to a whole figure by using the average based on Trust type. We also did this by Health Education England region. Details are provided in the two tables below. This provides a range from 38,901 to 40,958 registered nurse vacancies, respectively.

Based on the consistency of the results of the three different methodologies we are confident that as of 1 December 2016 there were approximately 40,000 vacancies of registered nurses in England.

Table 4: England registered nurse vacancies based on Trust type

Trust type	Total Trusts	Response rate	Vacancy rate	Number of vacancies reported	Approximate scaled total by Trust type
Acute	136	78%	10.5%	20,470	26,263
All (acute, community and mental health)	1	100%	12.3%	114	114
Community	17	65%	9.4%	996	1,539
Mental Health	51	80%	14.2%	7,448	9,265
Mental health and community	6	83%	10.5%	624	749
Specialist	17	59%	8.2%	571	971
Total	**228**	**76%**	**11.1%**	**30,224**	**38,901**

Table 5: England registered nurse vacancies based on region

HEE region	Total Trusts	Response rate	HEE regional vacancy rate	Number of vacancies reported	Approximate scaled total for region
East Midlands	15	67%	9.6%	1,754	2,630
Eastern	26	88%	13.1%	3,381	3,823
Kent, Surrey and Sussex	17	59%	12.5%	2,075	3,528
North Central and East London	15	53%	18.0%	3,673	6,886
North East	10	90%	5.6%	1,032	1,147
North West	40	68%	8.1%	3,030	4,489
North West London	10	70%	15.8%	1,816	2,595
South London	10	90%	15.0%	2,914	3,238
South West	19	84%	8.4%	1,866	2,216
Thames Valley	6	83%	12.6%	1,183	1,420
Wessex	11	91%	11.4%	1,613	1,774
West Midlands	28	86%	11.0%	3,515	4,101
Yorkshire and the Humber	21	76%	8.9%	2,371	3,112
Total	**228**	**76%**	**11.1%**	**30,224**	**40,958**

11. Appendix 2

Methodology for ComRes telephone survey with Directors of Nursing and Deputy Directors across the UK

ComRes interviewed 90 Directors and Deputy Directors of Nursing at NHS Trusts in the UK between 24 January and 13 March 2017. Full information tables are available at **www.comresglobal.com**

12. References

[1] Ipsos Mori, Veracity Index 2016 www.ipsos-mori.com/researchpublications/publications/1896/Enough-of-Experts-Ipsos-MORI-Veracity-Index-2016.aspx)

[2] NMC Freedom of Information request May 2017

[3] Royal College of Nursing (2015) Frontline First: The fragile frontline, London: RCN. Available from: royalnursing.3cdn.net/9808b89b8bfd137533_krm6b9wz7.pdf (accessed 11/05/17)

[4] May T (2015) Letter from the Home Office on nurse shortages. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468692/2015_10_15_HS_-_Prof_Sir_David_Metcalf_CBE__MAC_.pdf (accessed 10/05/17)

[5] Buchan J, Seccombe I and Charlesworth A (2016) Staffing matters; funding counts: Workforce profile and trends in the English NHS, London: The Health Foundation. Available from: www.health.org.uk/publication/staffing-matters-funding-counts (accessed 09/05/17)

[6] NMC Freedom of Information request May 2017

[7] NHS Digital (2017) NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – Provisional Statistics. Available from: http://content.digital.nhs.uk/catalogue/PUB23470/nhs-work-stat-dec-2016-area-levl.xlsx (accessed 09/05/17)

Stats Wales (2017) Non-medical NHS staff by grade and staff group. Available from: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/nonmedicalnhsstaff-bystaffgroup-grade-year (accessed 10/05/17)

Department of Health NI (2016) Northern Ireland health and social care (HSC) workforce census March 2016. Available from: www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-census-march-2016 (accessed 10/05/17)

Department of Health NI (2012) Northern Ireland health and social care (HSC) workforce census March 2012. Available from: www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscwc-march-2012.pdf (accessed 10/05/17)

Department of Health NI (2011) Northern Ireland health and social care (HSC) workforce census March 2011. Available from: www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscwc-march-2011.pdf (accessed 10/05/17)

Department of Health NI (2010) Northern Ireland health and social care (HSC) workforce census March 2010. Available from: www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscwc-march-2010.pdf (accessed 10/05/17)

[8] Buchan J, Seccombe I and Charlesworth A (2016) Staffing matters; funding counts: Workforce profile and trends in the English NHS, London: The Health Foundation. Available from: www.health.org.uk/publication/staffing-matters-funding-counts (accessed 09/05/17)

[9] NHS Digital (2017) NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – Provisional Statistics. Available from: http://content.digital.nhs.uk/catalogue/PUB23470/nhs-work-stat-dec-2016-area-levl.xlsx (accessed 09/05/17)

https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Staff/Non-Medical-Staff/nonmedicalnhsstaff-bystaffgroup-grade-year

https://www.health-ni.gov.uk/publications/northern-ireland-health-and-social-care-hsc-workforce-census-march-2016

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscwc-march-2012.pdf

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscwc-march-2011.pdf

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hscwc-march-2010.pdf

[10] NHS Digital (2017) NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – Provisional Statistics. Available from: http://content.digital.nhs.uk/catalogue/PUB23470/nhs-work-stat-dec-2016-area-levl.xlsx (accessed 09/05/17)

[11] The Mid Staffordshire NHS Foundation Trust (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, London: Stationery Office (Chairman: R Francis QC). Available from: www.midstaffspublicinquiry.com (accessed 08/05/17)

[12] Hunt J (2016) NHS Services: Winter, HC Deb, 20 December 2016, vol 618, c1303. Available from: https://hansard.parliament.uk/commons/2016-12-20/debates/C2B259E7-BB84-4D02-8321-0510BAA7CEFC/NHSServicesWinter (accessed 10/05/17)

"May I gently urge the hon. Gentleman to be careful with his rhetoric? We are not closing operating theatres for a month over Christmas. We need to be very careful what we say in this place, because people outside are listening. The answer is to ensure that we increase capacity in the NHS, and that is why we have 11,000 more doctors and **11,000 more hospital nurses than we had six years ago**. We are training 15,000 more doctors every year from 2018-19 to ensure that we can avoid these problems in the future."

[13] Cleland S (2016) Bliss baby report 2016: time for change, London: Bliss. Available from: www.bliss.org.uk/call-for-change-wales (accessed 10/05/17)

[14] Keogh B (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, NHS. Available from: www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf (accessed 08/05/17)

[15] Ibid.

[16] Aiken LH, Sloane D, Griffiths P and others (2016) Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care, BMJ Quality and Safety, Published online first: 15 November 2016. Available from: http://qualitysafety.bmj.com/content/early/2016/11/03/bmjqs-2016-005567 (accessed 10/05/17)

Griffiths P, Ball J, Murrells T, Jones S and Rafferty A (2016) Registered nurse, healthcare support worker, medical staffing levels and mortality in English hospital trusts: a cross-sectional study, BMJ Open, 6. Available from: http://bmjopen.bmj.com/content/6/2/e008751 (accessed 10/05/17)

Aiken LH, Sloane DM, Bruyneel L and others (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study, Lancet, 383 (9931), pp.1824-30.

Available from: http://thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/abstract (accessed 10/05/17)

Ball JE, Murrells T, Rafferty AM, Morrow E and Griffiths P (2014) Care left undone during nursing shifts: associations with workload and perceived quality of care, BMJ Quality and Safety, 23, pp.116-125.

Available from: http://qualitysafety.bmj.com/content/23/2/116 (accessed 10/05/17)

Needleman J, Buerhaus P, Pankratz VS and others (2011) Nurse staffing and inpatient hospital mortality, New England Journal of Medicine, 364 (11), pp.1037-1045. Available from: http://www.nejm.org/doi/full/10.1056/NEJMsa1001025#t=article (accessed 10/05/17)

Kane RL, Shamliyan TA, Mueller C and others (2007) The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis, Medical Care, 45 (12), pp.1195-1204.

[Reference only, full text not available online]

Rafferty AM, Clarke SP, Coles J and others (2007) Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records, International Journal of Nursing Studies, 44 (2), pp.175-182.

[Reference only, full text not available online]

Aiken LH, Clarke SP, Sloane DM and others (2002) Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction, JAMA, 288 (16) pp.1987-1993. Available from: **http://jamanetwork.com/journals/jama/fullarticle/195438** (accessed 10/05/17)

[17] Note: On a large scale, the RN4CAST study, for example, looked at the impact of nursing skills mix on patient mortality in nine European countries, including England. It found that every 10% increase in the number of degree-educated nurses decreased the likelihood of a patient dying by 7%. The implication is that hospitals where at least 60% of nurses are degree educated and with no more than six patients per nurse would have a 30% lower mortality risk compared to hospitals with a 30% degree educated workforce and a nurse-to-patient ratio of one nurse for eight patients

[18] Lafond S, Charlesworth A, and Roberts A (2017) A year of plenty? An analysis of NHS finances and consultant productivity, London: The Health Foundation. Available at: **www.health.org.uk/sites/health/files/YearOfPlenty.pdf** (accessed 08/05/17)

[19] National Assembly for Wales (2016) Nurse Staffing Levels (Wales) Act 2016. Available from: **www.legislation.gov.uk/anaw/2016/5/contents/enacted** (accessed 10/05/17)

[20] NICE (2015) NHS England asks NICE to suspend safe staffing programme. Available from: **www.nice.org.uk/news/article/nhs-england-asks-nice-to-suspend-safe-staffing-programme** (accessed 09/05/17)

[21] The Health Foundation (2017) In short supply: pay policy and nurse numbers – Nurse staffing, London: The Health Foundation. Available from: **www.health.org.uk/file/workforce-pressure-points-2017nurse-supplement-finalpdf-0** (accessed 09/05/17)

[22] Note: Data from Scotland is limited as from a small number of Directors of Nursing

[23] Note: The vacancy rate is generally understood as the number of positions a health or care organisation has allocated for the performance of certain duties that do not currently have an employee functioning in that role.

[24] Note: Vacancy data is a critical tool for national workforce strategies, accountability and transparency.

[25] NHS Scotland (2017) NHS Scotland Workforce Information – Quarter ending 31 December 2016. Available from: **www.isdscotland.org/Health-Topics/Workforce/Publications/2017-03-07/2017-03-07-Workforce-Summary.pdf?88602846861** (accessed 09/05/17)

[26] HSC Vacancy Survey, collated by the Department of Health in Northern Ireland

[27] NI Department of Health (2015) Northern Ireland Health and Social Care Workforce Vacancies as at 31 March 2015. Available from: **https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-vacancies-march-2015.pdf** (accessed 11/05/17)

[28] NHS Digital (2017) NHS Vacancy Statistics: England – February 2015 to September 2016. Available from: **http://content.digital.nhs.uk/catalogue/PUB23154/nhs-vac-stats-feb15-sep16-eng-tables.xlsx** (accessed 09/05/17)

[29] RCN (2013), Running the Red Light, Available at: **https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2013/november/pub-004529.pdf**

[30] Lintern S (2017) Revealed: The hospitals with the worst nurse staffing, Health Service Journal, 19 January. Available from: **www.hsj.co.uk/7014906.article** (accessed 09/05/17)

[31] Theresa May, Party conference speech, Wednesday 5 October 2017: “Like the NHS – “one of the finest health care systems anywhere in the world, and a vital national institution”: **http://www.telegraph.co.uk/news/2016/10/05/theresa-mays-conference-speech-in-full/**

[32] Care Quality Commission (2017) The state of care in NHS acute hospitals: 2014 to 2016. Available from: **www.cqc.org.uk/sites/default/files/20170302b_stateofhospitals_web.pdf** (accessed 09/05/17) inspection reports of Brighton and Sussex University Hospital NHS Trust/ CQC report *state of care in NHS acute hospitals: 2014 to 2016*

[33] NHS Improvement (2016) Reducing expenditure on NHS agency staff: rules and price caps. Available from: https://improvement.nhs.uk/resources/reducing-expenditure-on-nhs-agency-staff-rules-and-price-caps/ (accessed 09/05/17)

[34] Letter to all NHS providers from NHS Improvement on 28 February 2017

[35] NHS Scotland (2016) NHS Scotland Workforce Information: Quarterly update of Staff in Post, Vacancies and Turnover at 31 March 2016. Available from: https://isdscotland.scot.nhs.uk/Health-Topics/Workforce/Publications/index.asp#1662 (accessed 11/05/17)

[36] Northern Ireland Assembly (2016) AQW 7968/16-21, Nursing and Midwifery Agency Expenditure. Available from: http://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=283695 (accessed 11/05/17)

[37] Northern Ireland Assembly (2016) AQW 53169/11-16, Expenditure by HSC Trusts on locum, agency and bank staff. Available from: http://aims.niassembly.gov.uk/questions/printquestionsummary.aspx?docid=255950 (accessed 11/05/17)

[38] Aiken, L; Sloane D; Griffiths P; Rafferty A-M. (2014). Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. Philadelphia: Published by the University of Pennsylvania School of Nursing. Available at: http://thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/abstract [accessed March 2017]

[39] Nursing Times March 2017 Nurse vacancies converted into associate posts at acute trust. Available at: https://www.nursingtimes.net/news/workforce/nurse-vacancies-converted-into-associate-posts-at-acute-trust/7016340.article

[40] Picker Institute Europe and NHS (2017) NHS Staff Survey – 2016 Results. Available from: www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/ (accessed 09/05/17)

[41] Welsh Government (2016) NHS Wales Staff Survey 2016: National Report. Available from: http://gov.wales/docs/dhss/publications/161208nhs-survey-en.pdf (accessed 10/05/17)

[42] Northern Ireland NHS Staff Survey

[43] NHS Scotland Staff Survey www.shb.scot.nhs.uk/board/foi/2016/09/2016-370.pdf

[44] Dayan M and Thorlby R (2015) Health leaders' panel survey six: footprints, financing and staff morale, London: Nuffield Trust. Available at: www.nuffieldtrust.org.uk/resource/health-leaders-panel-survey-six-footprints-financing-and-staff-morale (accessed 09/05/17)

[45] RCN Employment Survey (2015) Available at: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2015/september/005350.pdf

[46] Health and Safety Executive. Work-Related Stress, Anxiety and Depression Statistics in Great Britain, 2016. Available at: http://www.hse.gov.uk/statistics/causdis/stress/

[47] Heinen M M. et al (2012) 'Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries' Available at: http://www.journalofnursingstudies.com/article/S0020-7489(12)00330-6/fulltext#sec0070

[48] Heinen M M. et al (2012) 'Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries' Available at: http://www.journalofnursingstudies.com/article/S0020-7489(12)00330-6/fulltext#sec0070

[49] National Nursing Research Unit (2013) Does NHS staff wellbeing affect patient experience of care?, Policy+, 39, May 2013. Available from: www.kcl.ac.uk/nursing/research/nnru/policy/Currentissue/Policy-Plus--Issue-39.pdf (accessed 11/05/17)

[50] National Nursing Research Unit (2013) Does NHS staff wellbeing affect patient experience of care?, Policy+, 39, May 2013. Available from: www.kcl.ac.uk/nursing/research/nnru/policy/Currentissue/Policy-Plus--Issue-39.pdf (accessed 11/05/17)

Maben J, Peccei R, Adams M, Robert G, Richardson A, Murrells T and Morrow E (2012) Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. NIHR Service Delivery and Organisation programme. Available from: www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1819-213_V01.pdf (accessed 11/05/17)

[51] Office for National Statistics (2017) Suicide by occupation, England: 2011 to 2015. Available from: www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015 (accessed 10/05/17)

[52] NHS England (2014) Five Year Forward View. Available from: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (accessed 11/05/17)

[53] NHS Improvement (2016) Strengthening financial performance and accountability in 2016/17. Available from: https://improvement.nhs.uk/uploads/documents/Strengthening_financial_performance_and_accountability_in_2016-17_-_Final_2.pdf (accessed 10/05/17)

[54] The Mid Staffordshire NHS Foundation Trust (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, London: Stationery Office (Chairman: R Francis QC). Available from: www.midstaffspublicinquiry.com (accessed 08/05/17)

[55] Audit Scotland (2016) NHS in Scotland 2016. Available from: www.audit-scotland.gov.uk/uploads/docs/report/2016/nr_161027_nhs_overview.pdf (accessed 10/05/17)

[56] The Belfast Telegraph (2017) Cut to education but increase in health budget if Stormont parties fail to reach agreement, 24 April 2017. Available from: www.belfasttelegraph.co.uk/news/politics/cut-to-education-but-increase-in-health-budget-if-stormont-parties-fail-to-reach-agreement-35649019.html (accessed 11/05/17)

[57] Watt T and Roberts A (2016) The path to sustainability: Funding projections for the NHS in Wales to 2019/20 and 2030/31, London: The Health Foundation. Available from: www.health.org.uk/news/nhs-wales-facing-urgent-funding-pressures-long-term-sustainability-possible (accessed 10/05/17)

[58] Buchan J, Seccombe I and Charlesworth A (2016) Staffing matters; funding counts: Workforce profile and trends in the English NHS, London: The Health Foundation. Available from: www.health.org.uk/publication/staffing-matters-funding-counts (accessed 09/05/17)

[59] Scottish Government (2017) National Health and Social Care Workforce Planning: Discussion Document. Available from: http://www.gov.scot/Publications/2017/02/6174 (accessed 11/05/17)

[60] Royal College of Nursing (2017) Workforce Planning Consultation. Available from: www.rcn.org.uk/about-us/policy-briefings/sco-parl-workforce-planning-consultation-response (accessed 10/05/17)

[61] National Audit Office (2016) Managing the supply of NHS clinical staff in England, HC 736, Session 2015-16, 5 February 2016. Available from: www.nao.org.uk/wp-content/uploads/2016/02/Managing-the-supply-of-NHS-clinical-staff-in-England.pdf (accessed 11/05/17)

[62] Ibid.

[63] Note: Higher education, like health, is a devolved matter.

[64] Health Education England (2015) HEE commissioning and investment plan - 2016/17. Available from: https://hee.nhs.uk/sites/default/files/documents/HEE%20commissioning%20and%20investment%20plan.pdf (accessed 11/05/17)

[65] Department of Health, Bursary reform, **https://www.gov.uk/government/publications/nhs-bursary-reform/nhs-bursary-reform**

[66] UCAS (2017) Application rates by the March 2017 deadline. Available from: **https://ucascomsb6.ucasenvironments.com/corporate/data-and-analysis/ucas-undergraduate-releases/2017-cycle-applicant-figures-march-deadline** (accessed 11/05/17)

[67] Lintern S (2017) Exclusive: Leak reveals worst case scenario for nursing after Brexit, Health Service Journal, 6 April 2017. Available from: **www.hsj.co.uk/topics/workforce/exclusive-leak-reveals-worst-case-scenario-for-nursing-after-brexit/7017082.article** (accessed 10/05/17)

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