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Executive summary

The RCN launched its Frontline First campaign in July of 2010 to monitor the impact of £20billion of efficiency savings on clinical staff and clinical services. At the time, the Government claimed that it would be possible to make efficiency savings without cutting frontline staff. However, the RCN campaign identified NHS trusts earmarking nursing posts to be lost and deliberately holding posts vacant as a fundamental part of the strategy to make these financial savings. In many trusts the nursing workforce has been cut to the bone.

The Francis Report and subsequent high profile reports including those produced by Professor Don Berwick and Professor Sir Bruce Keogh, have clearly linked nurse staffing levels to patient safety and quality of care. Concerns about the safety of staffing levels are widespread among the nursing profession, with a majority fearing similar issues of poor care occurring in their own workplace. Research also suggests that 43 per cent of hospital wards are regularly operating on more than eight patients per nurse, a level which the Safe Staffing Alliance has determined to be definitely unsafe. Following the publication of these reports and the clear focus on the evidence between patient safety and nurse staffing levels, there are now indications to show trusts are attempting to unfreeze vacancies, increase their nursing establishment and recruit actively, including going overseas. However, with evidence of England heading towards a serious nursing shortage, trusts are now encountering serious difficulties recruiting to these vacancies.

Official statistics identify 3,859 full time equivalent nursing, midwifery and health visiting posts have been lost since May 2010, an equivalent of 6,468 individuals (HSCIC, 2013a). The RCN does not believe this is actually the true extent of the current shortage once other factors are taken in to account. Vacancy rates are a key indicator that show the distance between the number of staff actually in post and the number needed to ensure patient safety and quality of care. The Government stopped collecting data on vacancies in 2011 and prior to this, the last available data suggested that the vacancies for nursing posts were 2.5 per cent (HSCIC, 2010). New research from the RCN into this issue, through a freedom of information request of NHS trusts, showed an average six per cent (ranging up to 16 per cent) vacancy rate in nursing posts. Replicated across the NHS this would amount to nearly 20,000 full time equivalent nursing, midwifery and health visiting nursing vacancies, or up to 34,000 individuals.

We also know that a nursing shortage is creating serious difficulties in recruiting to these vacancies. Evidence gathered by the RCN shows that 22 per cent of trusts are having to recruit from abroad and a further nine per cent are actively considering the possibility of doing so to plug these gaps over the coming year.

Government-commissioned work suggests that the impending crisis in the supply of registered nurses will result in a likely shortage of 47,545 registered nurses by 2016 (CfWI, 2013). The situation as a whole has been compounded by an almost 15 per cent cut in the number of nursing student places commissioned since 2009/2010. Despite numerous calls to action, there has been little progress so far on the scale required to stem the impending shortage. With rising demand for health care services, workforce shortages will have serious implications for staffing levels and the ability for providers to deliver safe, good quality care for patients. Achieving safe nurse staffing levels in NHS services is already a significant challenge for many providers in England, and as the full effects of a crisis in workforce supply begin to be felt, the situation has the potential to deteriorate rapidly. Urgent
action must be taken now to ensure NHS services have the right tools and resources in place to determine safe levels of nursing staff, within a robust national framework that ensures providers meet their obligation to care for patients in a safe environment. Ensuring the nation has enough nurses to meet these requirements in the future will require serious investment, not only in a new generation of nursing students, but also in those staff already in the service, who will continue to form the bulk of the workforce for many years to come.

Over the last year, the Francis, Keogh and Berwick reports have all made a number of practical recommendations on safe staffing levels. The RCN is now calling for action to match the rhetoric, with five urgent priorities for achieving safe staffing in NHS services today, and long-term planning to secure a workforce fit for the needs of tomorrow:

**Recommendations**

1. **A mandatory legislated requirement for safe staffing**
   There should be a mandatory legislated requirement for health care providers and commissioners to ensure staffing levels and skill mix never fall below levels determined to be safe. Determining safe staffing must take place within national frameworks of evidence-based, best practice standards and guidance, developed in conjunction with leading nurses, academics and institutions. This must include flexibility that enables nurses to exercise professional judgement in adjusting local staffing in response to changing patient needs. This should be inspected against by national health care regulators.

2. **The mandatory use of validated workforce planning tools**
   Safe staffing should be determined through the mandatory use of evidence-based, nationally-validated workforce planning tools. Tools should be developed and validated through extensive consultation, co-ordinated by an organisation such as the National Institute for Health and Care Excellence (NICE).

3. **Robust systems of review, supported by reliable workforce data**
   Safe staffing levels should be supported by workforce reviews and robust inspection regimes with the findings presented at board level on a monthly basis. This should be based on reliable, relevant, transparent and publicly available workforce and care quality data. Provider boards must be responsible and accountable for assuring the safety of staffing levels through the monitoring of a range of indicators.

4. **An end to boom and bust nursing workforce planning**
   There must be national, long-term and consistent co-ordination of workforce planning that is closely aligned to service planning and balanced with the needs of regional and local providers. Health Education England (HEE) must take urgent action to address an impending nursing shortage and ensure that the necessary investment in the nursing workforce takes place in order to secure the right number of nurses with the right skills to meet current and future health care demands.

5. **Investment in the current nursing workforce**
   The Government and employers must ensure that the necessary investment in the education and working conditions of the current nursing workforce takes place, both to ensure the skills of all nurses reflect the changing health care environment, and ensure the health service retains the staff it urgently needs to meet coming health care challenges.
1. The importance of safe staffing levels

A comprehensive and growing body of research indicates that nurse staffing levels have a significant impact in terms of patient outcomes, the recruitment and retention of nursing staff, and economic benefits to employers and communities. The overview presented here is indicative of a much wider body of evidence.

1.1 Patient outcomes

There is a strong correlation between nurse staffing levels, the quality of nursing care, and patient outcomes. This includes measures such as patient length of stay, complication rates, failure to rescue and mortality rates. Settings with fewer patients per nurse are strongly associated with improved patient outcomes. For example, one international meta-study, with data from hundreds of thousands of patients, estimated that each additional full time nurse per patient day saved five lives per 1,000 medical patients, and six per 1,000 surgical patients (Kane et al, 2007).

The impact of inadequate nurse staffing on patient care can be seen in the increasing likelihood of important nursing tasks being left undone. The National Nursing Research Unit’s (NNRU) RN4CAST survey found that 86 per cent of nurses thought “at least one necessary activity was left undone on their last shift due to lack of time” (NNRU, 2012). It found that the types of activities most frequently left undone included comforting and talking with patients (66 per cent), educating patients and family (52 per cent), developing and updating nursing care plans or pathways (46 per cent), and adequate patient surveillance (34 per cent). A UNISON survey similarly noted that other tasks “commonly forgone included giving patients food and drink, taking patients to the toilet or helping them to move, and writing up full and accurate records” (UNISON, 2013).

As the need for nursing care depends on a wide variety of factors, it is difficult to determine an optimal level of staffing necessary to deliver good quality care which can be applied generically. However, work undertaken by the Safe Staffing Alliance identifies that, in hospitals, there is a clear zone where the risk to patient care becomes unacceptably high. This alliance of senior nursing leaders, organisations and academics concludes that:

*Under no circumstances is it safe to care for patients in need of hospital treatment with a ratio of more than eight patients per registered nurse during the day time on general acute wards, including those specialising in care for older people (Safe Staffing Alliance, 2013).*

Evidence suggests that when ratios exceed eight patients per nurse, the risks to patient safety increase significantly. For example, surgical patients in English hospitals exceeding this ratio experienced a 20 per cent or more increase in the odds of death (Rafferty et al, 2007). This is also supported by research into patient satisfaction levels, with one Finnish study observing a significant decline in patient satisfaction beyond the eight patients per nurse level (Tervo-Heikkinen et al, 2008).

While the conclusions of the Safe Staffing Alliance definitively show that more than eight patients per registered nurse is an unacceptable risk, this does not imply that a ratio of fewer than eight patients per nurse can be considered safe. Any such assessment will have to take into account a number of factors, such as setting, geography, the acuity/dependency of patients, and the skills and experience of staff. Indeed, depending on the context, the actual safe ratio of patients per nurse is likely to be significantly lower than eight. A number of health systems around the world have introduced mandatory minimum staffing ratios with far fewer patients per nurse on medical/surgical wards, such as a minimum of one nurse to five patients in California, and at least five nurses per twenty patients in Victoria, Australia (RCN, 2010a).
1.2 Recruitment and retention of nursing staff

Inadequate staffing is also associated with negative nursing staff outcomes, including lower morale, higher stress levels, sickness and burnout. This has been supported by numerous research findings, including evidence from the United States that suggests nurses in hospitals with the lowest nurse-to-patient ratios are twice as likely to suffer job related burn out and twice as likely to be dissatisfied with their role (Aiken et al, 2002).

As lower staffing levels lead to increased stress and lower morale, it can result in increased sickness, absence and turnover, leading to a vicious cycle of deterioration as hospitals struggle to recruit to vacant posts and secure cover for unplanned absence. This was highlighted in the recent Keogh Review, which found serious issues around recruitment and retention in a number of hospitals in England, with actual staffing levels often much lower than planned establishments due to absence and unfilled vacancies (Keogh B, 2013a). This resulted in high usage of bank and agency staff, with subsequent implications for workforce efficiency and cost-effectiveness.

While temporary staff may provide much-needed flexibility in addressing short-term staffing issues, there are significant disadvantages to long-term reliance on agency and temporary staff. These include higher ongoing costs, and the fact that these staff may be unfamiliar with the ward environment, its patients and its permanent members of staff.

Securing the right staffing levels is therefore crucial, not only from the staff and patient safety point of view but also from the staff recruitment and retention point of view. An employer’s approach to staffing levels will ultimately impact on the effectiveness and efficiency of workforce expenditure.

1.3 Economic benefits to employers and communities

While achieving the right staffing levels may require significant investment in the nursing workforce, evidence shows that such investment can result in reduced inpatient stays, better health outcomes and improved patient experience, all contributing to improved efficiency and productivity of workforce expenditure. Researchers have attempted to quantify the economic value of the care that registered nurses provide, with a United States study estimating the value of each additional full time nurse at nearly US$60,000, due to avoided medical costs and improved national productivity (Dall et al, 2009).

Investing in skill mix may also contribute to the cost-effectiveness of nursing care, for example, through the employment of specialist nurses. The RCN's review of specialist nurse roles suggests they can add significant value to patient care, while generating efficiencies for organisations through new and innovative ways of working. Cost benefits may be found in reduced waiting times, avoidance of unnecessary hospital admissions, reduction in post-operative hospital stay times, and the freeing up of consultant appointments for other patients. For example, the British Heart Foundation found the monitoring of patient symptoms by nurse heart specialists reduced readmission rates by 35 per cent, saving primary care trusts £1,826 per patient, and the Multiple Sclerosis Society found that its funded nurse multiple sclerosis (MS) specialists saved NHS trusts £60,000 per year by treating MS relapse symptoms at home (RCN, 2010b).

Furthermore, while most research so far has concentrated on the measurable direct costs relating to care, investment in the nursing workforce may also result in a whole range of additional, less tangible socioeconomic benefits, through the improvement of local employment conditions and local community health and culture (RCN, 2009a).

The costs of investing in the nursing workforce and skill mix may therefore be mitigated by a number of socioeconomic benefits. Similarly, reductions to the nursing workforce may be somewhat
counterproductive if additional costs are incurred as a result of lapses in patient safety and reliance on temporary staff. As one study notes, “as nurses are assigned additional patients, the associated savings in labour cost per patient declines, while the probability of a fatal error occurring increases, making higher ratios increasingly unattractive” (Rothberg et al, 2005).

Financial challenges may continue to exert downward pressure on investment in the nursing workforce due to the immediate costs incurred, but it is crucial that such decisions are made with a long term, whole-system view. Ultimately, as one researcher notes, the willingness to meet the cost of getting staffing levels right “depends on the value patients and payers assign to avoidable deaths and complications” (Needleman et al, 2006).
2. Update on the current nursing workforce

2.1 The NHS workforce

From the late 1990s and throughout the first decade of the 21st century, the NHS workforce saw significant expansion. Table 1 shows that over the last ten years, the total NHS workforce has grown by nearly 200,000 full time roles, a 40 per cent increase. While expansion took place across the majority of different staff groups, different professions grew at different rates; while the nursing and medical workforces have each grown by around 39,500 FTE (full time equivalent) roles over the period, this was a much larger proportional increase (40 per cent) for doctors than it was for nurses (14 per cent). As the nursing workforce has grown at a slower rate than the total NHS workforce, nursing as a proportion of the total workforce has been diluted from 29.3 per cent in 2002, to 27.7 per cent in 2012.

Table 1: FTE change for selected staff groups, NHS hospital, community and general practice services, 2002 – 2012 (HSCIC, 2013b)

<table>
<thead>
<tr>
<th>Staff group</th>
<th>FTE change 2002-2012</th>
<th>% change 2002-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>All doctors</td>
<td>+39,355</td>
<td>+40.4%</td>
</tr>
<tr>
<td>Qualified scientific, therapeutic and technical staff</td>
<td>+34,472</td>
<td>+35.0%</td>
</tr>
<tr>
<td>Total NHS staff</td>
<td>+197,489</td>
<td>+20.7%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>+28,182</td>
<td>+17.8%</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>+39,543</td>
<td>+14.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>+20,562</td>
<td>+10.0%</td>
</tr>
</tbody>
</table>

Figure 1: Percentage FTE change for selected staff groups, NHS hospital, community and general practice services, 2002–2012
Figure 1 shows that since 2010, the total NHS workforce, and a number of staff groups, have experienced stagnating or declining numbers. Again, this has not occurred evenly across all sectors – the medical and qualified scientific, therapeutic and technical workforces have seen continued growth, whereas nursing, infrastructure support and clinical support have seen a decline.

Concerns in 2010 that health care service reconfigurations and a drive for efficiency savings would have a serious impact on the frontline nursing workforce led to the launch of the RCN’s *Frontline First* campaign. For the last three years, the RCN has worked to monitor cuts to jobs and services, identify waste in the NHS, and develop and share innovations and nursing solutions.

As part of the *Frontline First* campaign, the RCN uses national data, collected and published by the Health and Social Care Information Centre (HSCIC), to monitor the size and shape of the nursing workforce. The monitoring of this data has raised serious concerns about lost posts, devaluation of roles, and dilution of skill mix.

As table 2 shows, according to the most recent data, **the total NHS workforce has lost 22,428 FTE roles (an equivalent of 33,903 headcount) since May 2010, a decrease of 2.1 per cent.** The impact on different staff groups has varied greatly, with NHS infrastructure support (including managerial, administrative and maintenance roles) experiencing the heaviest loss in posts, with 22,845 fewer full time roles, a decrease of 11.2 per cent. In contrast, doctors and qualified scientific, therapeutic and technical staff have seen year on year increases in workforce numbers. But while these clinical professions are being protected from workforce cuts, the same protection has not been extended to the nursing workforce.

**Table 2: FTE change for selected staff groups, NHS hospital and community services, May 2010 – July 2013**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May-10</th>
<th>Jul-13</th>
<th>Change</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>95,421</td>
<td>101,003</td>
<td>+5,582</td>
<td>+5.8%</td>
</tr>
<tr>
<td>(not including others in training)</td>
<td>81,518</td>
<td>85,324</td>
<td>+3,806</td>
<td>+4.7%</td>
</tr>
<tr>
<td>Qualified scientific, therapeutic and technical staff</td>
<td>129,700</td>
<td>132,377</td>
<td>+2,677</td>
<td>+2.1%</td>
</tr>
<tr>
<td>Qualified nursing, midwifery and health visiting staff</td>
<td>310,793</td>
<td>306,935</td>
<td>-3,859</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Qualified midwives</td>
<td>20,132</td>
<td>21,443</td>
<td>+1,311</td>
<td>+6.5%</td>
</tr>
<tr>
<td>Qualified health visitors</td>
<td>8,092</td>
<td>8,792</td>
<td>+700</td>
<td>+8.7%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>282,569</td>
<td>276,699</td>
<td>-5,870</td>
<td>-2.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>230,917</td>
<td>228,199</td>
<td>-2,719</td>
<td>-1.2%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>204,695</td>
<td>181,850</td>
<td>-22,845</td>
<td>-11.2%</td>
</tr>
<tr>
<td>Total NHS staff</td>
<td>1,056,652</td>
<td>1,034,223</td>
<td>-22,428</td>
<td>-2.1%</td>
</tr>
</tbody>
</table>
2.2 The nursing workforce

Since May 2010, the qualified nursing, midwifery and health visiting workforce has lost 3,859 FTE roles (6,468 headcount), a decrease of 1.2 per cent. Support to doctors and nursing staff, including roles such as health care assistants and assistant practitioners, has also decreased by a similar proportion, with 2,719 full time posts lost (7,058 headcount). Figure 2 illustrates the varying experience of different staff groups more clearly:

Although the aggregated qualified nursing, midwifery and health visiting workforce has decreased over the last three years, the picture is more complex than this. As figure 3 shows, workforce numbers for both qualified midwives and qualified health visitors have actually increased. The midwifery workforce has increased by 1,311 FTE roles since May 2010, and the health visiting workforce has increased by 700 FTE roles. If these figures are removed from the aggregated data, it indicates a true fall of 5,870 FTE nurse roles (or 7,578 headcount) since May 2010.

In recent years, a soaring birth rate and critical decline in the health visiting workforce have resulted in maternity and early years care being seen as a specific service priority. There is explicit reference in the Department of Health (DH) mandate to Health Education England (HEE) to “maintain midwifery-training numbers at a sufficient level to meet service demand” and a national plan to increase “the health visitor workforce by 4,200 FTE by April 2015” (Department of Health, 2013a). This goes some way to explaining the recent growth in the midwifery and health visiting workforces, but the RCN is concerned that these efforts must not come at the expense of securing a registered nursing workforce with the right numbers and skills to meet demands. Recent experience shows that there are a number of services where investment in the registered nursing workforce is long overdue, with a number of key priority areas.

Figure 2: Percentage FTE change for selected staff groups, NHS hospital and community services, May 2010 – July 2013
2.3 The nursing workforce by service type

While the nursing workforce has decreased overall, posts have been lost from different services at varying rates. Table 3, based on annual NHS non-medical workforce census, shows that the only service to see real expansion in the workforce since 2010 has been the maternity/neonatal workforce, which might be expected given the rising birth rate and increase in midwife numbers. In contrast, the majority of other services have lost nursing staff, with relatively higher losses in mental health, learning disability, and community nursing.

Table 3: FTE change in nursing, midwifery and health visiting staff by service type, NHS hospital and community services, 2002–2012 (HSCIC, 2013d)

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</thead>
<tbody>
<tr>
<td>Acute, elderly and general</td>
<td>147,778</td>
<td>168,042</td>
<td>167,547</td>
<td>167,007</td>
<td>-1,035</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Paediatric nursing</td>
<td>14,005</td>
<td>15,807</td>
<td>15,629</td>
<td>15,607</td>
<td>-200</td>
<td>-1.3%</td>
</tr>
<tr>
<td>Maternity/neonatal</td>
<td>22,299</td>
<td>26,654</td>
<td>27,693</td>
<td>28,405</td>
<td>+1,750</td>
<td>+6.6%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>36,962</td>
<td>41,320</td>
<td>40,052</td>
<td>39,325</td>
<td>-1,995</td>
<td>-4.8%</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>7,955</td>
<td>5,254</td>
<td>4,787</td>
<td>4,454</td>
<td>-800</td>
<td>-15.2%</td>
</tr>
<tr>
<td>Community services</td>
<td>38,410</td>
<td>47,779</td>
<td>46,399</td>
<td>46,035</td>
<td>-1,744</td>
<td>-3.6%</td>
</tr>
<tr>
<td>Education staff</td>
<td>805</td>
<td>1,279</td>
<td>1,241</td>
<td>1,290</td>
<td>+11</td>
<td>+0.9%</td>
</tr>
<tr>
<td>All areas of work</td>
<td>268,214</td>
<td>309,139</td>
<td>2,997</td>
<td>305,060</td>
<td>-4,079</td>
<td>-2.2%</td>
</tr>
</tbody>
</table>
The RCN is extremely concerned that the areas which have seen the greatest proportional workforce losses are also those where investment is urgently needed. In mental health services, the workforce has seen a decrease of nearly 2,000 full time nursing staff since 2010. This is despite years of rising demand for mental health care. In England, 48,631 people were detained in hospital for assessment and/or treatment of mental disorder under the Mental Health Act in 2011/2012, and a further 4,220 patients were subject to community treatment orders (CTOs) – a 5 per cent increase in detentions and 10 per cent increase in CTOs compared to the previous year (CQC, 2013a). Mental health services are now showing increasing levels of strain, with evidence suggesting at least 1,711 mental health beds (9 percent of the total) were closed between April 2011 and August 2013 (Buchanan, 2013). The learning disability nursing workforce has also seen significant long-term decline, with 800 full time roles lost since 2010, a fall of around 15 per cent.

Community nursing is also an area of grave concern. After a decade of workforce expansion, peaking in 2009-2010, the last three years have seen a fall of 1,744 full time roles, or 3.6 per cent of the workforce. Despite rhetoric of a shift from acute to community models of care, the proportion of nurses working in community services has changed very little, from 14.3 per cent of the total nursing workforce in 2002, to 15.1 per cent in 2012. Table 4 shows that losses have been particularly acute in the district nursing workforce, which has been declining year on year for the last decade, with 1,312 full time posts lost since 2010 (a 17 per cent decrease).

In addition to those posts lost so far, the RCN’s 2012 report on the community nursing workforce identified that services would suffer disproportionately more from an aging nursing workforce. In the community workforce, 38 per cent of nurses were found to be aged 50 and over, compared to 23.6 per cent of the acute, elderly and general nursing workforce. With 59.2 per cent of the community nursing workforce aged 45 and over, a large proportion will reach the opportunity to take retirement in the next decade, compounding the urgent need to build the community workforce capacity in the future (RCN, 2012a).

Table 4: FTE change in district nursing staff, NHS hospital and community services, 2002 – 2012 (HSCIC, 2013d)

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</thead>
<tbody>
<tr>
<td>District nurses</td>
<td>10,446</td>
<td>7,693</td>
<td>6,937</td>
<td>6,381</td>
<td>-1,312</td>
<td>-17.1%</td>
</tr>
</tbody>
</table>
3. The current state of staffing levels

Concerns in recent years about a declining nursing workforce have been accompanied by an increased focus on the impact of inadequate staffing levels. This has recently been borne out in high profile care failings at Mid Staffordshire NHS Foundation Trust and a number of trusts investigated as part of the Keogh Mortality Review. Inadequate nurse staffing was heavily implicated in a number of serious patient safety lapses at these hospitals, and the findings shed light on issues that appear to be widespread across the health care system.

3.1 Safe staffing in focus: the Mid Staffordshire NHS Foundation Trust Public Inquiry and Keogh Mortality Review

Concerns about quality of patient care at Mid Staffordshire NHS Foundation Trust were prompted by unusually high reported mortality rates between 2005 and 2008. Following an initial investigation and independent inquiry, a public inquiry was commissioned, led by Robert Francis QC. The public inquiry, published in 2013, identified significant shortcomings in leadership, workforce planning, and nurse staffing levels. Financially-motivated reconfigurations resulted in many serious cases of understaffing, and Francis noted that “the numbers had always been tight, and declined during the period with which the inquiry [was] concerned” (Francis R, 2013a). The workforce also suffered from skill mix dilution, as a ratio of 60 per cent registered to 40 percent unregistered nursing staff fell to a 50:50 split, with intentions to further reduce the proportion of registered nurses (Francis R, 2010).

Francis also found serious flaws in the workforce planning process, and noted that the “trust did not have available to it reliable figures for its nursing establishment, either in theory or in practice” (Francis R, 2013a). Poor data management and workforce planning were compounded by a failure to act on repeated concerns that were raised about staffing levels. The findings of the original Healthcare Commission investigation showed that 37 per cent of the 515 incident forms submitted for three wards referred to understaffing (Francis R, 2010). Staff were directly discouraged from making formal reports, and demoralised by the lack of feedback and action.

The final report of the Mid Staffordshire Public Inquiry made a number of recommendations relating to staffing levels, including that NICE be commissioned to develop nationally validated workforce tools, that trusts be required to risk assess any changes to workforce configurations, and that trusts consult nursing directors on the impact on patient safety of proposed staffing changes (Francis R, 2013b).

Building on the findings of the Mid Staffordshire Public Inquiry, the Prime Minister commissioned a review by Professor Sir Bruce Keogh, the NHS Medical Director for England, into 14 trusts that were consistently high outliers on two measures of relative mortality rates, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator). While the review did not find any failings on the scale of those that occurred at Mid Staffordshire, it did identify a number of significant causes for concern, notably, “inadequate numbers of nursing staff in a number of ward areas, particularly out of hours - at night and at the weekend...compounded by an over-reliance on unregistered support staff and temporary staff” (Keogh B, 2013a). In some cases, “there were insufficient nursing establishments, whilst in others there were differences between the funded nursing establishments and the actual numbers of registered nurses and support staff available to provide care on a shift by shift basis”.

Examples of inappropriate staffing levels and skill mix can be found throughout many of the detailed rapid response review
reports. On some acute medical wards, the team found a ratio of one registered nurse to ten patients during the day, and fifteen patients at night (Keogh B, 2013b). Many wards were found to be running on significantly less than their full complement of staff, for example, one wards with 28 patients should have been staffed by five registered nurses and two HCAs, but in fact had only two registered nurses and two HCAs (Keogh B, 2013c). The ratio of registered nurses to unregistered support staff was a common issue, with one trust regularly operating on 50 percent registered to 50 percent unregistered nursing staff. The review team would have expected a ratio of 65:35, or at the very least 60:40 registered to unregistered staff (Keogh B, 2013d).

The final report of the Keogh Mortality Review recommended the ambition that “nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards”. The report also recommended that “Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.”

3.2 Staffing levels across the NHS

While the Mid Staffordshire NHS Foundation Trust Public Inquiry and Keogh Mortality Review provide a limited snapshot of hospitals under investigation, they shed light on issues around staffing that appear to be widespread across the NHS.

Quantifying the safety of staffing levels across the NHS is a difficult task. This is partly due to limitations in current workforce and care quality data that make it extremely difficult for independent observers to assess staffing levels without physically inspecting hospitals on a ward-by-ward and shift-by-shift basis. Keogh noted that while pre-visit data suggested no cause for concern on staffing levels in eight of the fourteen trusts inspected, the “reported data did not provide a true picture of the numbers of staff actually working on the wards” (Keogh B, 2013a). Significant issues may be masked during the process of coding and aggregation, and it cannot be assumed that the current workforce data and regulation system adequately captures serious cases of understaffing or inappropriate skill mix. While the CQC’s 2012 “state of care” report indicated that 16 per cent of NHS hospitals were failing to meet the regulator’s staffing level standards, inadequate staffing is also likely to be more widespread than this last figure suggests, as the Keogh Mortality Review found significant staffing level issues in a number of hospitals that had previously been registered by the CQC with no conditions (CQC, 2012).

Patient and staff opinion sources confirm fears that understaffing is widespread across the NHS. The Care Quality Commission’s (CQC) 2012 inpatients survey found that 30 per cent of patients thought there were only “sometimes” enough nurses and 11 per cent thought there were “rarely or never” enough nurses (CQC, 2013b). From the staff side, the most recent NHS staff survey found that 55 per cent of acute trust nurses and midwives did not believe there were enough staff in their organisation for them to do their job properly (National NHS Staff Survey Coordination Centre, 2013). The RCN’s own research suggests that almost 90 per cent of nursing staff do not think staffing levels are always adequate to provide safe patient care (RCN, 2013a).

In terms of staff to patient ratios, evidence suggests that hospitals are regularly breaching a level of more than eight patients to one registered nurse, a level determined to be definitely unsafe by the Safe Staffing Alliance. The RCN’s most recent employment survey found that on an average shift, each registered nurse on a hospital ward was caring for 8.0 patients, with an average skill mix of 61:39 per cent registered to unregistered staff. However, this masked
significant variation between specialties. In wards for older people, nurses were
caring for an average of 10.2 patients, with
a 49:51 per cent registered/unregistered
ratio. On children and young people’s wards
nurses were caring for an average of 4.5
patients, with an 80:20 per cent registered/
unregistered ratio (RCN, 2013b).
A similar result was found in the National
Nursing Research Unit’s (NNRU) 2012
RN4CAST nurse survey in England (NNRU,
2012). Registered nurses were found to be
caring for an average of 8.0 patients during
the day, and 10.8 at night, but findings
varied significantly between trusts, ranging
from 5.2 to 10.9 patients per registered
nurse on daytime shifts. Overall, the
research indicated that nurses on 43 per
cent of wards regularly care for more than
eight patients per nurse (Smyth, 2013).
The RCN believes that unsafe staffing levels
are having a serious impact on the physical
and mental health of nursing staff. The RCN's
2013 employment survey found that 73 per
cent of respondents reported increased
stress and 80 per cent reported increased
workloads (RCN, 2013b). Stress was reported
as a key factor in workplace sickness, with
55 per cent of nurses reporting being made
unwell by stress over the previous year.
Despite this, the vast majority of nurses (82
per cent) reported that they had gone to work
despite feeling too ill to do so (RCN, 2013c).
With high stress levels and inadequate
staffing preventing nurses from performing
their role to the quality they would wish,
morale is currently extremely low, with
around 60 per cent of nurses considering
leaving their job in the previous 12 months
(RCN, 2013b). The RCN is concerned that
unless urgent action is taken to reverse this
trend, there is a high risk that many nurses
will decide to take early retirement or leave
the profession, further damaging the ability
of the NHS workforce to meet current and
future health care demands.

The RCN has noted that with the recent
publication of the Francis, Keogh and
Berwick reports, attitudes may be shifting
as the impact of cutting staff on patient
safety becomes apparent. Many of the
implicated trusts have initiated recruitment
drives to replace a number of nurses lost
in recent years. However, a number of
outstanding issues mean that optimism may
be misplaced.

Firstly, there is a risk that if safe staffing
does not remain high on the political
agenda, investment in the nursing workforce
will be reactive and short term. The
continued drive for savings and efficiencies
may constrain investment or lead to further
cuts to the workforce in the long term. A
recent Health Service Journal survey found
that although 33 percent of NHS provider
HR directors were “not confident” their
organisation had sufficient staff to meet
demand on services, 27 percent were still
planning to further reduce their nursing
headcount due to continued financial
pressures (Lintern S, 2013c). This was
corroborated by Monitor’s 2013/2014 review
of NHS Foundation Trust’s three year plans,
which showed that although there was a
planned increase of 2 per cent in registered
nursing staff numbers over the first year,
this would be reversed by longer term
disinvestment in nursing, reducing numbers
by 4per cent between 2014/15 and 2015/16
(Monitor, 2013).

Secondly, the ability of employers to reverse
workforce disinvestment may be limited
by workforce factors outside their control.
Evidence suggests that there is an emerging
national shortage of nurses, both in the
right numbers and with the right skills to
meet future demand. With providers already
struggling to meet the needs of current
patients, future ambitions such as a truly 24-
hour, 7-day health service, and a shift from
acute to community models of care, will be
extremely difficult to achieve.
4. The future nursing workforce

With the NHS already struggling to ensure it has safe staffing levels in place, the challenge is likely to grow over the next five to ten years as growing demand for nursing care outstrips a stagnating or declining supply of registered nurses. Current workforce models have identified a high likelihood of a significant nursing shortage, and urgent action will need to be taken to secure the future ability to provide safe levels of staffing in the England health service.

4.1 The supply of registered nurses

A number of workforce models have projected that according to current trends, the supply of registered nurses is likely to stagnate or decline over the next five to ten years. These models are based on a number of factors impacting on the inflow to and outflow from the nursing supply, including annual intakes to pre-registration nurse training, international movement of nurses, retirement rates and other labour market joiners and leavers.

Workforce modelling from the Centre for Workforce Intelligence (CfWI) considers the supply of nursing care over the period 2010 to 2016 (table 5), and models the size of the active nursing workforce in England. All CfWI scenarios project a decrease in the supply of registered nurses by 2016. The most likely baseline projects a fall of 30,272 (-5.3 per cent) registered nurses, with a worst case scenario of 64,257 (-11.2 per cent) and a best case scenario of 3,615 (-0.6 per cent).

The RCN has conducted similar supply-side workforce modelling looking at the NHS England workforce over a longer period leading up to 2021/22 (Buchan J and Seccombe I, 2011). This found that if current trends remain steady the NHS in England will lose 42,800 (-12.2 per cent) nurses between 2010/2011 to 2021/22. However, a worst case scenario, assuming reductions in training completions and progression to the NHS workforce, and higher rates of retirement and other leavers, raises the number of nurses lost as high as 99,000 (-28.0 per cent). Achieving even a modest 9.5 per cent increase in the supply of registered nurses would require that retirement remains at current rates along with a great improvement on current retention rates – something that will prove increasingly challenging with an ageing NHS workforce.

The RCN’s workforce modelling does not project the most likely scenario, but it does indicate the size of the NHS nursing workforce is extremely vulnerable to changes in policy, particularly around the number of training places commissioned and the impact of pension and retirement policies. The majority of the RCN’s eight scenarios project a declining nursing workforce, with only two projecting small to moderate increases.

The commissioning of nurse training places will be a key lever for addressing issues of supply. In recent years there has been significant disinvestment in pre-registration nursing education in England. Figure

Table 5: Supply of registered nurses in England (headcount), 2010–2016 (CfWI, 2013)

<table>
<thead>
<tr>
<th>Year</th>
<th>Low scenario</th>
<th>Baseline</th>
<th>High scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>N/A (assumed to be same as baseline)</td>
<td>572,034</td>
<td>N/A (assumed to be same as baseline)</td>
</tr>
<tr>
<td>2011</td>
<td>557,937</td>
<td>N/A</td>
<td>572,493</td>
</tr>
<tr>
<td>2016</td>
<td>507,777</td>
<td>541,762</td>
<td>568,419</td>
</tr>
<tr>
<td>% change 2010–2016</td>
<td>-11.2%</td>
<td>-5.3%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Total change 2010–2016</td>
<td>-64,257</td>
<td>-30,272</td>
<td>-3,615</td>
</tr>
</tbody>
</table>
shows that since 2009/10, 3,033 annual nursing places have been lost, a significant decrease of nearly 15 per cent at a time of growing demand for health care. While the commissioning of student places now seems to have stabilised, with a small increase of 391 more places for 2013/14, the lower rates of newly registered nurses entering the workforce are likely to cause serious issues in undersupply for years to come. In section 5 of this report we see the symptoms of domestic undersupply already emerging, with thousands of unfilled vacancies and employers recruiting internationally.

4.2 The demand for registered nurses

With the majority of supply-side scenarios projecting a fall in the number of registered nurses over the next decade, maintaining the quality of care will prove increasingly challenging, even if demand remains the same. However, the challenge will be compounded by a strong likelihood of a marked increase in demand for nursing care in coming years.

The CfWI’s demand scenarios (table 6) look at factors including demography, skill mix, activity and productivity. Projections vary greatly. The most likely baseline change in demand projects an additional 17,273 (+3.0 per cent) registered nurses required by 2016, but estimates range from a modest decrease in demand of 38,345 (-6.7 per cent) fewer nurses required to a worst case scenario of an additional 129,905 (+22.7 per cent) nurses needed.
Table 6: Demand for registered nurses in England (headcount), 2010 – 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Low scenario</th>
<th>Baseline</th>
<th>High scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>N/A (assumed to be same as baseline)</td>
<td>572,034</td>
<td>N/A (assumed to be same as baseline)</td>
</tr>
<tr>
<td>2011</td>
<td>550,268</td>
<td>N/A</td>
<td>603,755</td>
</tr>
<tr>
<td>2016</td>
<td>533,689</td>
<td>589,307</td>
<td>701,939</td>
</tr>
<tr>
<td>% change 2010-2016</td>
<td>-6.7%</td>
<td>+3.0%</td>
<td>+22.7%</td>
</tr>
<tr>
<td>Total change 2010-2016</td>
<td>-38,345</td>
<td>+17,273</td>
<td>+129,905</td>
</tr>
</tbody>
</table>

Modelling nursing demand is a complex process, but the RCN believes that even a small decrease in demand for nursing care is an extremely unlikely scenario. A baseline estimation of a 3 per cent increase in demand may also be rather conservative. The population in England is growing and ageing, with the number of people over the age of 85 expected to double between 2010 and 2030 (Office for National Statistics, 2011). The number of people living with long-term conditions is already increasing dramatically, with chronic kidney disease up by 45 per cent, diabetes up by 25 per cent, and dementia up by 25 per cent between 2006-07 and 2010-11 (Department of Health, 2012). This serious combination of factors is unlikely to be offset by efficiency and productivity savings, which may be increasingly difficult to achieve.

4.3 The net effects of supply and demand

Figure 5 illustrates the CfWI’s projected changes over time in supply and demand for registered nurses. While there is a small margin where the supply and demand ranges do overlap, there is a large difference between the upper estimate for demand and the upper estimate for supply. Therefore, the report states that “it is possible for supply to meet demand, but more likely that it will not”. The difference between the most likely baseline projections suggests that by 2016 there will be a shortfall of 47,545 nurses, but this could range as high as 194,162. Even assuming the best case scenario for the supply of nursing, demand for nurses would have to fall by 0.6 per cent over the same period just to maintain the state of care at levels in 2010, when current signs point to a steady increase in demand.
5. Symptoms of a national nursing shortage

According to projections, the health system in England should already be experiencing a deepening national nursing shortage. While it is difficult to pinpoint the difference between supply and demand at any given point, the RCN believes there is growing evidence that employers are starting to experience serious challenges in recruiting staff in the right numbers and with the right skills to meet demand.

5.1 Vacant nursing posts

The RCN believes that a key cause of inadequate staffing levels is under capacity in the workforce, with a great many vacant posts across the system. The RCN undertook a survey in early 2013 of around 2,000 ward sisters and found that 69 per cent reported a difference between the total funded establishment and the number of staff actually employed in post. Of these, 52 per cent reported that actual staffing complements were slightly under the funded establishment and 34 per cent reported they were significantly under the funded establishment. Reasons for understaffing included cuts to posts (reported by 27 per cent of respondents) and vacancy freezes (25 per cent), but difficulty recruiting was found to be by far the most significant cause, reported by 53 per cent of respondents.

While many unfilled vacancies in recent years may have been the result of deliberate recruitment freezes due to financial challenges, shifting attitudes over the last year have placed the focus firmly on patient safety, with signs that employers are seeking to re-invest in their nursing workforce (Lintern S, 2013a). However, with decreasing supply of nurses, employers will face significant challenges in recruiting to vacancies. The Keogh Mortality Review identified significant issues around recruitment, with problems particularly acute for hospitals in more isolated areas of the country (Keogh B, 2013a). In order to gain an idea of the scale of the issue, the RCN has conducted preliminary research into vacancies through freedom of information requests. In June 2013, we asked trusts in England to provide information on the number of the vacancies they had compared to the full establishment of nursing staff (both registered and unregistered). Based on a sample of 61 trusts in acute, community and mental health care, across England, the RCN found an average 6 per cent vacancy rate, but there was significant variation, with around one in seven trusts reporting vacancy rates over 10 percent, and some as high as 16 per cent.

With 307,492 full time nursing, midwifery and health visiting staff in post in June 2013, an average six per cent vacancy rate would equate to an estimated 19,526 vacant full time posts. Depending on various estimates of full to part-time working, this could represent between 22,106 and 34,195 individuals. The RCN is therefore concerned that while the NHS in England has lost 3,859 full time nurses, midwives and health visitors since May 2010, the scale of the problem may be far larger, with the NHS potentially operating on nearly 20,000 fewer full time nursing staff than planned. This will have serious consequences for patient safety and finances as trusts struggle to fill the gaps with temporary staff and new recruits.

In terms of a historical comparison, table 7 shows total nursing vacancy rates for the NHS in England, available for 2008 to 2010. Due to potential differences in the way the NHS Information Centre and the RCN collected data, caution must be shown in comparing data sets directly. However, our preliminary estimate of a 6 per cent vacancy rate for 2013 appears much higher than the 2.5 per cent vacancy rate given for 2010. Indeed, nearly 82 per cent of trusts in the RCN’s research reported vacancy rates higher than 2.5 per cent. As a more recent comparison, similar vacancy data is still collected for the NHS system in Scotland,
which reported a 2.8 per cent nursing and midwifery vacancy rate for June 2013 (Information Services Division, 2013). The RCN will continue to develop its monitoring of nursing vacancy rates through its Frontline First campaign, and will provide further information in future reports.

The RCN notes that the annual NHS vacancies survey was suspended in 2011 and discontinued permanently as part of the Department of Health’s Fundamental Review of Data Returns, which aimed to “reduce the burden of collection on data suppliers”. The Government response to the consultation noted that HSCIC would continue to “explore whether data on vacancies can be obtained through the NHS jobs website...to allow NHS vacancy figures to be collected via this mechanism for 2013” (Department of Health, 2013b). So far, no vacancy data has been made available for the years 2011 to 2013. The RCN believes this data is a helpful indicator for ensuring workforce supply and calculated patient demand are balanced, providing staffing levels for delivering safe, high quality patient care. We are concerned that lacking this information will negatively impact on the ability to make fully informed national workforce planning decisions.

5.2 International recruitment

With increased focus on staffing levels and patient safety since the Francis Report, employers in many regions have renewed nurse recruitment drives. However, many trusts are finding local nursing sources severely depleted and are having to recruit internationally.

The RCN conducted research in June 2013 which found that, of 140 NHS trusts that responded to the RCN’s freedom of information requests, 22 per cent were recruiting from abroad (particularly from Spain, Portugal and Ireland), with a further 9 per cent considering the possibility. Trusts revealed a number of factors such as local shortages of UK-trained nurses, difficulty recruiting to specific settings such as older people’s wards, and a lack of local candidates with the necessary specialist skills such as theatre nursing. There was also significant variation between different areas, with as many as 60 per cent of trusts in the Eastern and South East regions having to seek staff internationally, but very few in the Northern and West Midlands regions.

Further research undertaken by Nursing Times found that of the 105 trusts who responded to freedom of information requests, 40 (38 per cent) had actively recruited nurses from abroad in the last 12 months – leading to more than 1,360 nurses coming to work in England, and 41 trusts (39 per cent) also planned to recruit abroad in the coming year. Of current international recruits, the large majority were sought from Portugal and Spain, but with many also from Ireland and the Philippines (Lintern S, 2013b).

The RCN believes that recruitment abroad is indicative of a developing nursing shortage, and while international recruits can be a valuable addition to a domestic workforce under strain, relying on international recruitment to plug the gaps is not a long-term, sustainable approach to workforce planning. This is supported by Article 5.4 of the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel, which states:

As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should

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Table 7: FTE qualified nursing, midwifery and health visiting staff total vacancy rates, NHS hospital and community services in England, 2008 – 2010 (HSCIC, 2010)

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacancy rate</td>
<td>2.5%</td>
<td>3.1%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>
strive to meet their health personnel needs with their own human resources for health, as far as possible. (WHO, 2010)

England therefore has a national responsibility to secure the domestic supply of health care staff, and nursing should be a key priority. Without investment in the nursing workforce, and increased efforts to retain current staff, providers may face severe challenges in recruiting and delivering quality care for years to come.
Ensuring there are enough nurses with the right skills in the right place is already a significant challenge facing NHS hospitals, and the situation is likely to reach crisis levels in the near future unless urgent action is taken. The right tools and processes must be put in place to protect today’s patients. It is crucial that hospitals are given the right resources and fulfil their duty to achieve the right staffing in the first place, but this will need to be underpinned by a robust reporting and inspection structure that quickly identifies and corrects serious staffing issues. Urgent action will also need to be taken to ensure the nation has sufficient staff available to meet the demands of tomorrow’s patients, through a comprehensive national workforce planning process. The RCN has therefore identified five urgent priorities for achieving safe nurse staffing in England:

1. A mandatory legislated requirement for safe staffing

There should be a mandatory legislated requirement for health care providers and commissioners to ensure staffing levels and skill mix never fall below levels determined to be safe. Determining safe staffing must take place within national frameworks of evidence-based, best practice standards and guidance, developed in conjunction with leading nurses, academics and institutions. This must include flexibility that enables nurses to exercise professional judgement in adjusting local staffing in response to changing patient needs. This should be inspected against by national health care regulators.

Workforce planning, workforce data reporting and safe staffing compliance is currently undermined by inconsistency in approaches. The RCN believes a mandatory legislated requirement for health providers and commissioners to achieve safe staffing would provide an important underpinning for safeguarding patient safety.

Alongside workforce planning tools, best practice standards and guidance should be developed to build on expertise and experience across the health system. Workforce planning should be undertaken based on agreed principles, including triangulation through a variety of methods, with flexibility for nurses to exercise professional judgement. The RCN has experience of producing a number of best practice principles of safe staffing (see Appendix 1) and believes that these should lie at the heart of the workforce planning process.

In England, the Care Quality Commission (CQC) is responsible for regulating health care providers and inspecting the safety of staffing. Clear standards and guidance on how the CQC inspects and reaches a judgement on safe staffing incorporating the use of nationally validated safe staffing level tools developed as stated above, should be produced.

2. The mandatory use of validated workforce planning tools

Safe staffing should be determined through the mandatory use of evidence-based, nationally-validated workforce planning tools. Tools should be developed and validated through extensive consultation, co-ordinated by an organisation such as the National Institute for Health and Care Excellence (NICE).

The RCN believes that the mandatory use of evidence-based, nationally-validated workforce tools would provide an important assurance to workforce planners, staff and patients alike. This would reflect recommendations in both the Francis and Berwick reports (Berwick D, 2013). A number of tools already exist which may require validation or further development for use on a national scale. Validation and the development of tools should involve a wide range of stakeholders, including nurses, academics and institutions, and could be achieved through the establishment of a safe staffing task force, with the objective to develop and validate a range of resources by the end of 2014. The use of similar tools has already been mandated in Scotland and there
may be significant opportunities learn from their development and implementation there.

3. Robust systems of review supported by reliable workforce data

Safe staffing levels should be supported by workforce reviews and robust inspection regimes with the findings presented at board level on a monthly basis. This should be based on reliable, relevant, transparent and publicly available workforce and care quality data. Provider boards must be responsible and accountable for assuring the safety of staffing levels through the monitoring of a range of indicators.

Ensuring robust data collection, management and interpretation processes are in place is essential for conducting effective workforce planning and reviews. Workforce data should form an essential part of the inspection and compliance process and should indicate to organisations such as the CQC where issues may exist around staffing levels.

However, current workforce data is generally only available in aggregated form, and collection and reporting processes can be inconsistent from trust to trust. There are therefore severe limitations in current data reporting that may mask significant variations in staffing levels, between service in a trust, between wards, and between different days of the week and times of day. Indeed the Keogh review found that pre-inspection workforce data “did not provide a true picture of the numbers of staff actually working on the wards” (Keogh B, 2013a).

In order to improve the workforce planning process and facilitate inspection regimes, the RCN believes that relevant workforce data and indicators should be collected and reviewed consistently across hospitals in England on a monthly basis. Boards should review data not only at aggregate level, but should also be presented with an overview of outlying wards and shifts where staffing did not meet planned levels. The CQC should have access to the same data, and in the interests of transparency and candour, staffing data should be publically available.

Some trusts, such as Wrightington, Wigan and Leigh NHS Foundation Trust and Salford Royal NHS Foundation Trust, are already beginning to display real-time planned and actual staffing levels on wards to patients and visitors (Keogh K, 2013). An open approach was also recommended by the House of Commons Health Committee in their report on the recommendations of the Francis Report (House of Commons Health Committee, 2013). The RCN agrees that this is a positive step and would urge boards to consider implementing this measure in their own hospitals.

The RCN has suggested a list of indicators in Appendix 2, which are directly and indirectly connected to workforce, staffing and care quality. While this list is by no means exhaustive, it provides some guidance on the data we believe is necessary to make informed workforce decisions.

4. An end to boom and bust nursing workforce planning

There must be national, long-term and consistent co-ordination of workforce planning that is closely aligned to service planning and balanced with the needs of regional and local providers. Health Education England (HEE) must take urgent action to address an impending nursing shortage and ensure that the necessary investment in the workforce takes place in order to secure the right number of nurses with the right skills to meet current and future health care demands. Efforts to address inadequate staffing in today’s hospitals must be accompanied by a long-term evidence-based national approach to nursing workforce planning. Urgent investment in the workforce is required to ward off a growing crisis in the future supply of registered nurses. The RCN therefore calls for implementation of the recommendation of the Berwick Report, that Health Education England (HEE) “should assure that they have commissioned the required training places to meet future staffing requirements working with Government and NHS England to ensure appropriate planning and
resources” (Berwick D, 2013). After serious disinvestment in nursing education in recent years, the RCN believes there must be a significant increase, of at least 10 percent, in the number of nursing places commissioned for 2014/15, with commitment to continue investment in the longer term.

National workforce planning must be based on a whole-system approach, closely aligned to service planning. Any change in the configuration of health care services, such as a transition from acute to community care, must be considered alongside the future workforce, and vice versa. It is therefore critical that horizon scanning takes place to identify the likely shape of the future nursing workforce, in terms of both numbers and skills. For example, in its submission to HEE’s 2013/2014 workforce planning call for evidence, the RCN recommended that all nursing students have the opportunity to undertake placements in the community, in order to ensure the future workforce has the necessary skills and experience for potential future service models (RCN, 2013f). As seen earlier, the long-term decline of the district nursing workforce is one issue which requires urgent attention.

National workforce planning must also be a multi-disciplinary process. Decisions around the medical, nursing and health care support workforces cannot be made in isolation. Again, these decisions must be closely aligned with service planning and based on careful consideration of the nature of future health care needs. Evidence shows that investment in the nursing workforce often results in significant economic benefits. It is also important that the unregistered nursing workforce is not neglected. The RCN therefore calls for HEE to make progress on standardised training for health care support workers, with clear lines of accountability and delegation.

The RCN believes that for too long the national health workforce planning process has been fragmented and unresponsive to new developments. For this reason we welcomed the establishment of HEE, with its national oversight for workforce planning.

It is crucial that HEE is given the authority and resources to ensure local and national staffing demands are met, and to secure a future workforce with the right numbers and skills to deliver safe care.

5. Investment in the current nursing workforce

The Government and employers must ensure that the necessary investment in the education and working conditions of the current nursing workforce takes place, both to ensure the skills of all nurses reflect the changing health care environment, and ensure the health service retains the staff it urgently needs to meet coming health care challenges.

Given the scale of the challenges facing the health service in England, the undersupply of nurses cannot be addressed just by focusing on new entrants to the workforce. Nurses in employment today will continue to form the bulk of the workforce for many years to come. Employers must therefore ensure that they invest in the education and working conditions of their current staff. Firstly, this is to ensure the current workforce retains and develops the necessary skills and knowledge to meet changing health care needs and care models. Secondly, employers must invest in and incentivise the current nursing workforce to prevent them taking early retirement or leaving the profession altogether.

Despite record levels of stress and low morale, the RCN is impressed by the continued dedication of its members and the wider nursing workforce. Nearly three quarters of our members continue to describe their career as rewarding (RCN, 2013b). After years of rhetoric, we now call for real action by the Government and employers to match the enthusiasm of the nursing workforce, and secure the investment and long term planning that are urgently needed to meet the demands of tomorrow.
Appendix 1: Principles of workforce planning

• **Systematic approach**
  Directors of nursing and trust boards should adopt a systematic, consistent and evidence-based approach to workforce planning. Procedures should be developed to ensure that all wards and all hospitals in a trust meet the required staffing level standards. Adopting a systematic approach across all NHS trusts would be a positive step, and the report of the Keogh Review notes that the “National Quality Board will shortly publish a ‘How to’ guide on getting staffing right for nursing” (Keogh B, 2013a). We welcome Robert Francis’s recommendation that NICE develop “evidence-based tools” and note that we are in a strong position to support this, having developed our own comprehensive guidance on safe staffing in recent years (RCN, 2010a).

• **Staff involvement**
  Frontline staff should be involved in workforce planning processes and the outcomes of reviews. Concerns must be listened to and boards should record the number and content of incident forms and feedback relating to staffing levels, ensuring that any necessary action is taken and that this is fed back to staff.

• **Triangulation**
  Two or more recognised workforce planning methods to measure and model ward staffing should be used to increase the validity of results. These might include patient dependency/acuity-based workload tools, professional judgement and benchmark data from matched comparators.

• **Adequate uplift**
  Planned staffing establishments must be calculated with adjustments to allow for service delivery times (ie shift patterns) and staff time away from the service (ie uplift). This should include estimates of extra staff required to cover annual leave, maternity leave, sick leave, and training and development absence. Current RCN guidance recommends that an uplift of 25 per cent is applied (RCN, 2006).

• **Regular evaluation and review**
  In order to assess whether the staffing level for a service is optimal, managers and boards should have access to reliable workforce and care quality indicators (discussed below) at both aggregate and ward level. Data should be continually reviewed to ensure any concerns about staffing are addressed as soon as possible, but there should also be a standing commitment to regular monthly workforce reviews at board level.
Appendix 2: Workforce and staffing level indicators

• **Nurse to patient ratios**
  This measure records the number of nursing staff to patients on a shift and ward basis. Figures should be broken down as registered and unregistered staff and boards should consider whether the staffing levels are sufficient to deliver quality safe care. Trusts should consider first whether rostered levels of staff are sufficient to deliver safe care, and also instances where actual numbers of staff working fell short of the planned level that was determined to be safe and the reasons behind this.

A number of recommended standards exist to support safe staffing reviews. The Safe Staffing Alliance, for example, recommends that one registered nurse to more than eight patients during the day is definitely not safe, and should be flagged up as a patient safety incident (Safe Staffing Alliance, 2013). However, the actual number of patients it is safe for nurses to care for may be much lower depending on patient dependency and acuity. A number of organisations have produced recommended nurse to patient ratios for certain specialities, including the RCN, which has developed guidance for older people’s wards (RCN, 2012b) and children and young people’s services (RCN, 2013d). Nurse to patient ratios have also been developed internationally, and are enforced in California and Australia. A large amount of research on the impact of ratios there could serve to inform workforce planning in the UK (Aiken et al, 2010).

• **Skill mix**
  The principle measure of skill mix should be the proportion of registered to unregistered nursing staff. The RCN benchmark for general hospital wards is 65 per cent registered to 35 percent unregistered staff (RCN 2006). Boards should be informed of instances when the skill mix is diluted below this benchmark and should also consider whether the staff on duty have the sufficient training, competency and accountability to deliver the types of care that are needed by the patients on their ward.

• **Rates of staff sickness**
  Sickness absence rates are calculated by dividing the sum total sickness absence days by the total number of days staff are due to work (after annual leave and other planned leave). High rates of staff sickness may be linked to high levels of stress and fatigue and can be indicative of serious issues with staffing levels and shift patterns. Sickness levels among the nursing workforce should benchmarked against other groups of staff as well as against regional and national averages and flagged as a concern where significant discrepancies arise.

• **Staff turnover**
  This measure uses data on annual joiners and leavers to provide a stability index (defined as the percentage of staff in the organisation for at least a year). Average length of service can be used as a proxy. High workforce turnover may result in frequent uncovered vacancies and inefficiencies in workforce expenditure, and may also be indicative of a poor working environment.

• **Use of agency/bank nursing staff**
  This measure records the proportion of nursing staff on duty who are agency or bank staff. Frequent use of temporary staff may be indicative of wider workforce issues and may impact on the cost effectiveness and efficiency of the nursing workforce, as temporary staff can be less familiar with the care environment.
• **Supernumerary status of ward sister/manager**

The RCN recommends that adequate staffing measures are put in place to allow ward sisters/managers to have supernumerary status and to lead effectively. Hospitals should monitor the number of occasions when and why it is not possible to achieve this and look to implementing supernumerary status as soon as possible (RCN 2009b).

• **Complaints/incident reports**

As frontline givers or receivers of care, staff and patients are ideally situated to identify serious issues around staffing levels. Trusts must put in place processes to monitor complaints and incident reports relating to staffing levels. Complaints and reports must be investigated and responded to, and if no action is taken, the reason must be given.
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