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Data-driven change

The NMC-Census England and Wales dataset: opportunities to understand a key profession

November, 2025

Iain Atherton
Edinburgh Napier University and
ADR Scotland

UKRI Economic and Social Research Council

Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study

Linda H Aiken, Douglas M Sloane, Luk Bruyneel, Koen Van den Heede, Peter Griffiths, Reinhard Busse, Marianna Diomidous, Juha Kinnunen, Maria Kózka, Emmanuel Lesaffre, Matthew D McHugh, M T Moreno-Casbas, Anne Marie Rafferty, Rene Schwendimann, P Anne Scott, Carol Tishelman, Theo van Achterberg, Walter Sermeus, for the RN4CAST consortium*

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See Comment page 1789

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Summary

Background Austerity measures and health-system redesign to minimise hospital expenditures risk adversely affecting patient outcomes. The RN4CAST study was designed to inform decision making about nursing, one of the largest components of hospital operating expenses. We aimed to assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data were associated with variation in hospital mortality after common surgical procedures.

Methods For this observational study, we obtained discharge data for 422 730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries. Administrative data were coded with a standard protocol (variants of the ninth or tenth versions of the International Classification of Diseases) to estimate 30 day in-hospital mortality by use of risk adjustment measures including age, sex, admission type, 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission. Surveys of 26 516 nurses practising in study hospitals were used to measure nurse staffing and nurse education. We used generalised estimating equations to assess the effects of nursing factors on the likelihood of surgical patients dying within 30 days of admission, before and after adjusting for other hospital and patient characteristics.

Findings An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% (odds ratio 1·068, 95% CI 1·031–1·106), and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7% (0·929, 0·886–0·973). These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients.

Interpretation Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

Funding European Union's Seventh Framework Programme, National Institute of Nursing Research, National Institutes of Health, the Norwegian Nurses Organisation and the Norwegian Knowledge Centre for the Health Services, Swedish Association of Health Professionals, the regional agreement on medical training and clinical research between Stockholm County Council and Karolinska Institutet, Committee for Health and Caring Sciences and Strategic Research Program in Care Sciences at Karolinska Institutet, Spanish Ministry of Science and Innovation.

Introduction

Constraint of health expenditure growth is an important policy objective in Europe despite concerns about adverse outcomes for quality and safety of health care.[1,2] Hospitals are a target for spending reductions. Health-system reforms have shifted resources to provide more care in community settings while shortening hospital length of stay and reducing inpatient beds, resulting in increased care intensity for inpatients. The possible combination of fewer trained staff in hospitals and intensive patient interventions raises concerns about whether quality of care might worsen. Findings of the European Surgical Outcomes Study[3] across 28 countries recently showed higher than expected hospital surgical mortality and substantial between country variation in hospital outcomes.

Nursing is a so-called soft target because savings can be made quickly by reduction of nurse staffing whereas savings through improved efficiency are difficult to achieve. The consequences of trying to do more with less are shown in England's Francis Report,[4] which discusses how nurses were criticised for failing to prevent poor care after nurse staffing was reduced to meet financial targets. Similarly, results of the Keogh review[5] of 14 hospital trusts in England showed that inadequate nurse staffing was an important factor in persistently high mortality rates. Austerity measures in Ireland and Spain have been described as adversely affecting hospital staffing too.[6,7]

Research that could potentially guide policies and practices on safe hospital nurse staffing in Europe has been scarce. Jarman and colleagues[8] reported an

Aiken, L.H., Sloane, D.M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kózka, M., Lesaffre, E. and McHugh, M.D., 2014. *Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study.* The lancet, 383(9931), pp.1824-1830.

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REGULAR ARTICLE

ACTA PAEDIATRICA WILEY

Midwife-to-newborn ratio and neonatal outcome in healthy term infants

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Abstract

Aim: To assess the effect of midwife-to-infant ratio on healthy term infant outcome.

Methods: Infants were enrolled in an inhospital midwife-led centre and an obstetrician-led centre with different midwife-to-infant ratios (1:2.5-1:5 vs 1:7-1:15). The primary endpoint was exclusive breastfeeding rate; secondary endpoints were neonatal admission in neonatal care unit rate and length of hospital stay.

Results: One hundred and ten infants were enrolled in both midwife- and obstetrician-led centre. Exclusive breastfeeding rate at discharge was higher (88% vs 78%, $P = .048$) in infants born in the midwife- than in the obstetrician-led centre. Admission rate in neonatal care units (9% vs 2%, $P = .017$) and stay in hospital duration (3.1 ± 1.8 vs 2.6 ± 0.8 days, $P = .008$) were higher in the obstetrician- than in the midwife-led centre. Birth in the midwife-led centre increased the likelihood of exclusive breastfeeding (OR: 2.04, 1.07-3.92), while newborns' admission in neonatal care units decreased it (OR : 0.17, 0.07-0.43).

Conclusion: Healthy term infants' neonatal outcome is negatively associated with a low midwife-to-infant ratio which decreases exclusive breastfeeding rate and is associated with a higher likelihood of admission in neonatal care units and longer stay in hospital.

KEYWORDS
breastfeeding, midwife-to-infant ratio, outcome, term infant

1 | INTRODUCTION

In recent decades, freestanding and inhospital birth midwife-led centres have opened in several countries with the objective of optimising the mothers' experience of childbirth and maternal and infant outcomes[1] by promoting continuity of care and limiting intervention and use of medical technology in low-risk pregnancies.

A large meta-analysis, including 15 trials and involving 17 674 women, demonstrated that women who had midwife-led continuity models of care were less likely to experience interventions (ie: regional analgesia, amniotomy, episiotomy) and more likely to be satisfied with their care.[2] Moreover, they had comparable adverse outcomes for themselves (ie induction of labour, perineal laceration requiring suturing, postpartum haemorrhage caesarean section) and their infants (ie low birthweight, 5-minute Apgar score ≤ 7, neonatal seizures, admission of infant to special care or neonatal intensive care unit) than women who received other models of care.[2] Despite these important results, yet little is known about the exact mechanisms that allow these beneficial effects for mothers and infants in midwife-led centres.

Many studies have highlighted the association of the nurse-to-infant ratio and nursing workload with neonatal outcome: lower ratios have been correlated with missed nursing care[3] and infant outcomes in neonatal intensive care units,[4] including higher risk of hospital-acquired infection,[5] adverse events,[6] and inhospital mortality.[7-10] Therefore, it is possible that an important advantage of midwife-led

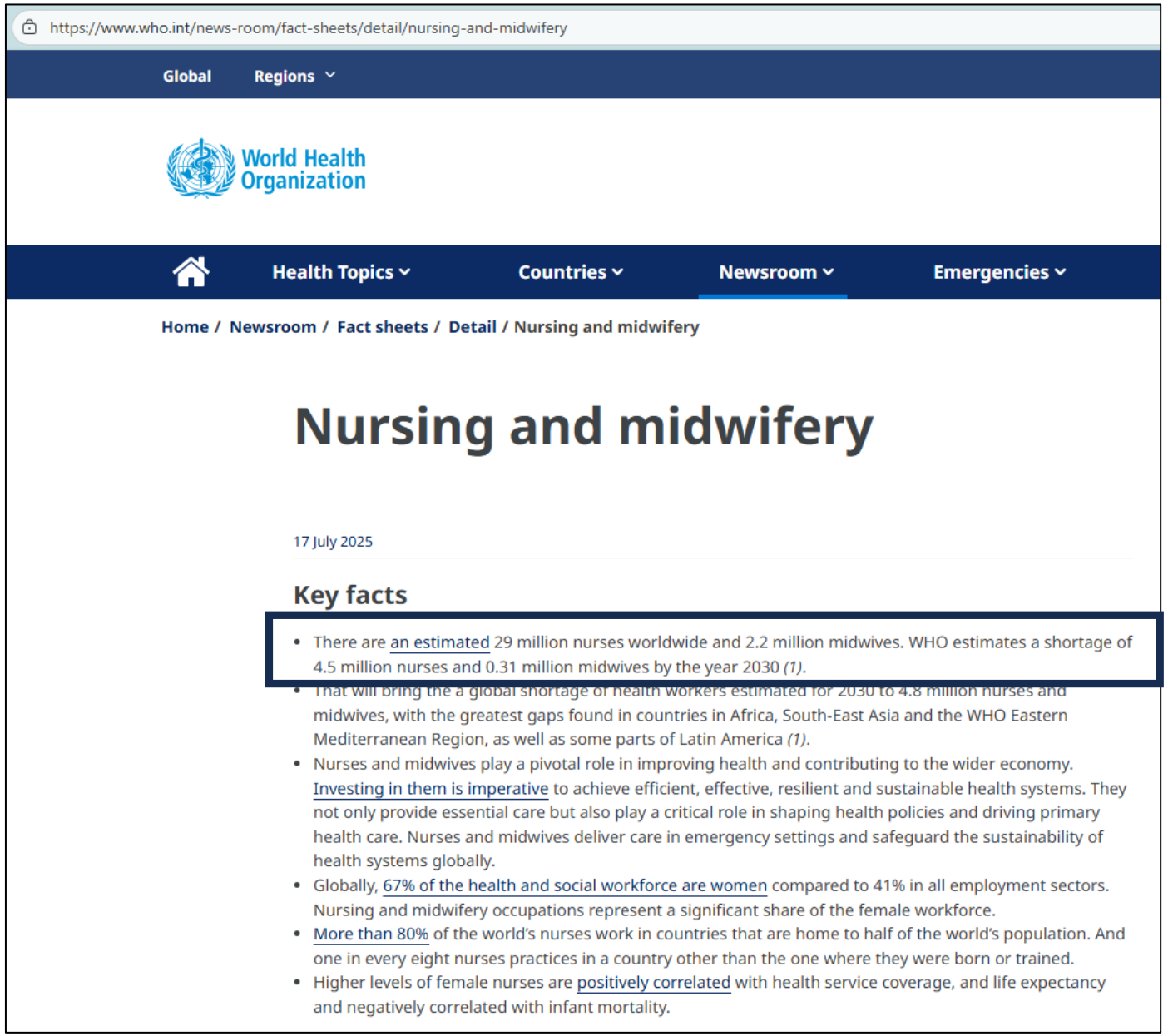
Dani, C., Papini, S., Iannuzzi, L. and Pratesi, S., 2020. Midwife-to-newborn ratio and neonatal outcome in healthy term infants. *Acta Paediatrica*, *109*(9), pp.1787-1790.

Nursing and midwifery

17 July 2025

Key facts

- There are an estimated 29 million nurses worldwide and 2.2 million midwives. WHO estimates a shortage of 4.5 million nurses and 0.31 million midwives by the year 2030 *(1)*.
- That will bring the a global shortage of health workers estimated for 2030 to 4.8 million nurses and midwives, with the greatest gaps found in countries in Africa, South-East Asia and the WHO Eastern Mediterranean Region, as well as some parts of Latin America *(1)*.
- Nurses and midwives play a pivotal role in improving health and contributing to the wider economy. Investing in them is imperative to achieve efficient, effective, resilient and sustainable health systems. They not only provide essential care but also play a critical role in shaping health policies and driving primary health care. Nurses and midwives deliver care in emergency settings and safeguard the sustainability of health systems globally.
- Globally, 67% of the health and social workforce are women compared to 41% in all employment sectors. Nursing and midwifery occupations represent a significant share of the female workforce.
- More than 80% of the world's nurses work in countries that are home to half of the world's population. And one in every eight nurses practices in a country other than the one where they were born or trained.
- Higher levels of female nurses are positively correlated with health service coverage, and life expectancy and negatively correlated with infant mortality.



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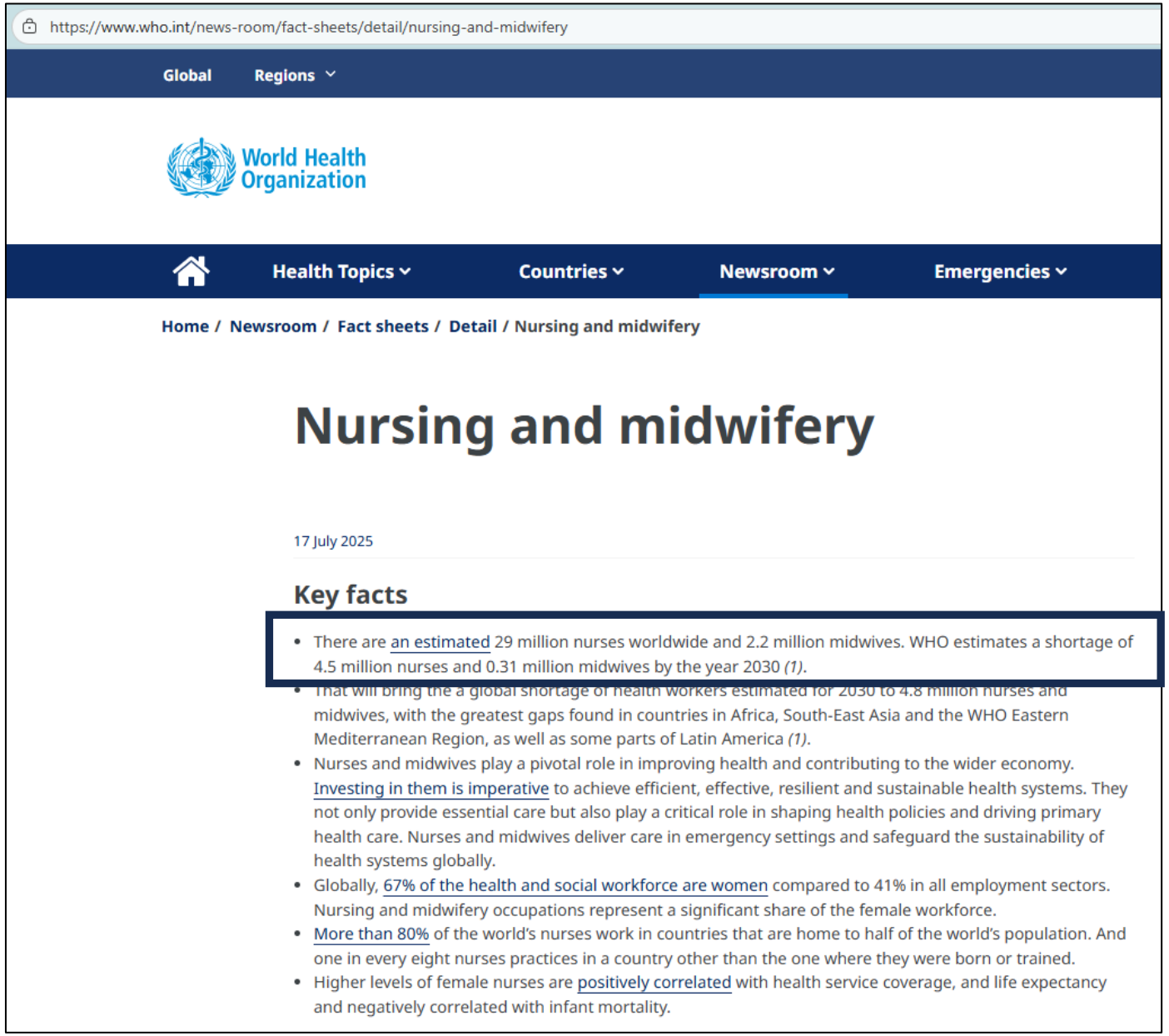

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Fit for the Future: 10 Year Health Plan for England

The 10 Year Health Plan for England seizes the opportunities provided by new technologies, medicines, and innovations to deliver better care for all patients – wherever they live and whatever they earn – and better value for taxpayers.

It is making 3 big shifts to how the NHS works:

- from hospital to community: more care will be available on people's doorsteps and in their homes
- from analogue to digital: new technology will liberate staff from admin and allow people to manage their care as easily as they bank or shop online
- from sickness to prevention: we'll reach patients earlier and make the healthy choice the easy choice

To find out what the next decade of health and care looks like, read Fit for the Future: 10 Year Health Plan for England.

The Long Term Plan, published in January 2019, can be found on The National Archives website.

07

An NHS workforce fit for the future

“Overall, while there will be fewer staff in the NHS in 2035 than projected by the 2023 workforce plan, those staff will be better treated, have better training, more exciting roles and real hope for the future - and so they will each achieve much more.

“The 10 Year Workforce Plan will set out how we will act on retention, productivity, training and attrition with the ambition to reduce international recruitment to less than 10% by 2035.”

“Today, the NHS disproportionately relies on international recruitment in a world where the competition for international staff has never been fiercer.”

Issues with policy relevance

- Recruitment
- Retention
- Migration
- Staff development
- Community nursing and midwifery
- Learning disability nursing
- Ageing
- Health

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The NMC-Census England and Wales dataset: An ADR UK Flagship Dataset

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Nursing and Midwifery Council Register linked to Census 2021 - England and Wales

This dataset is currently being transitioned to the Office for National Statistics Secure Research Service. More information about accessing the data for research will be available soon on this page.

This dataset brings together the Nursing and Midwifery Council (NMC)'s UK-wide register with the Census 2021 for England and Wales. The dataset enables cross-sectional and longitudinal analysis from the register of nurses, associate nurses, and midwives. This data comprises information provided by nurses, nursing associates, and midwives when they first join the register, and then every three years when they revalidate to maintain their registration.

https://www.adruk.org/data-access/flagship-datasets/nursing-and-midwifery-council-register-linked-to-census-2021-england-and-wales/

Core documentation

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- Blog: Migration patterns of nurses and midwives

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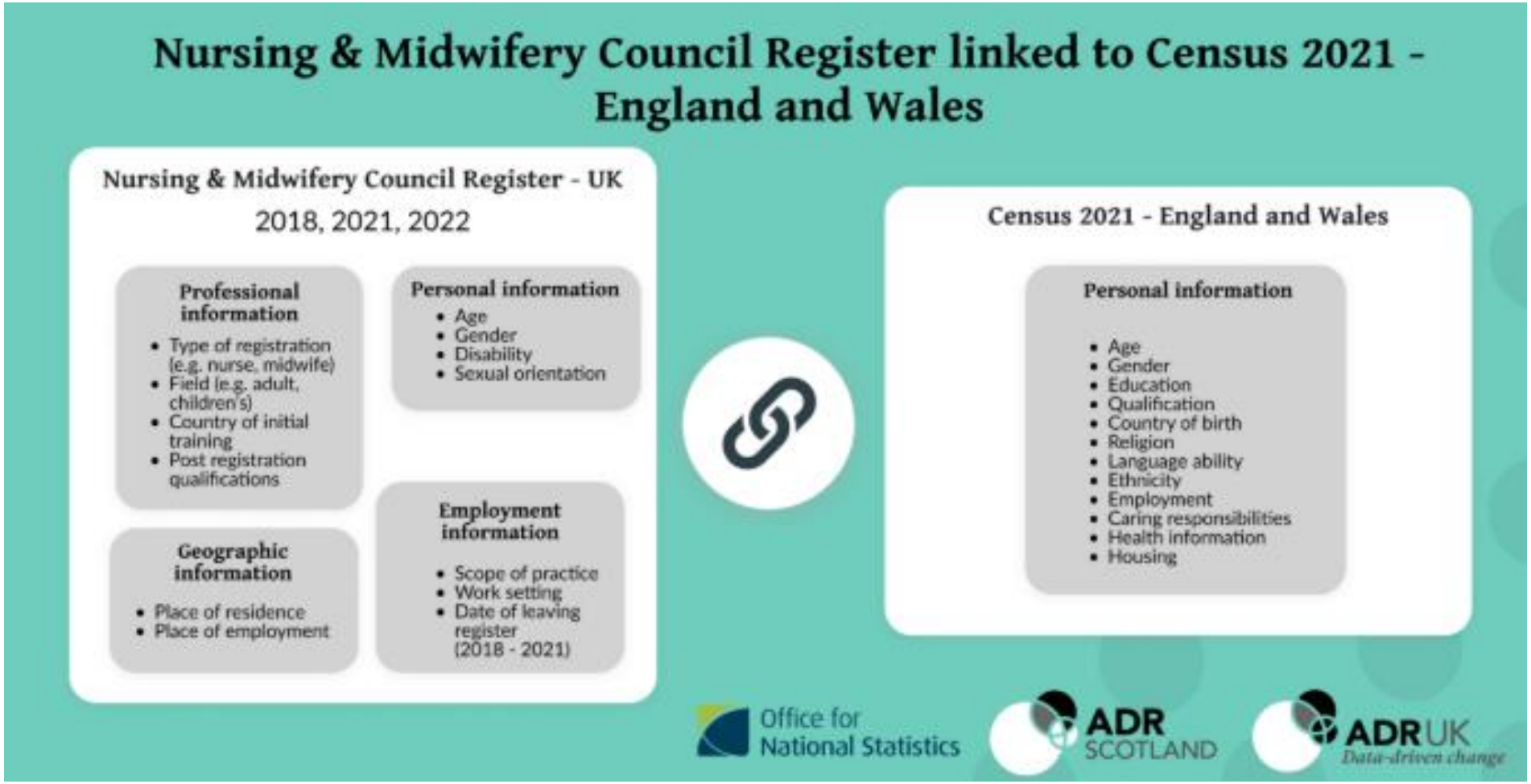
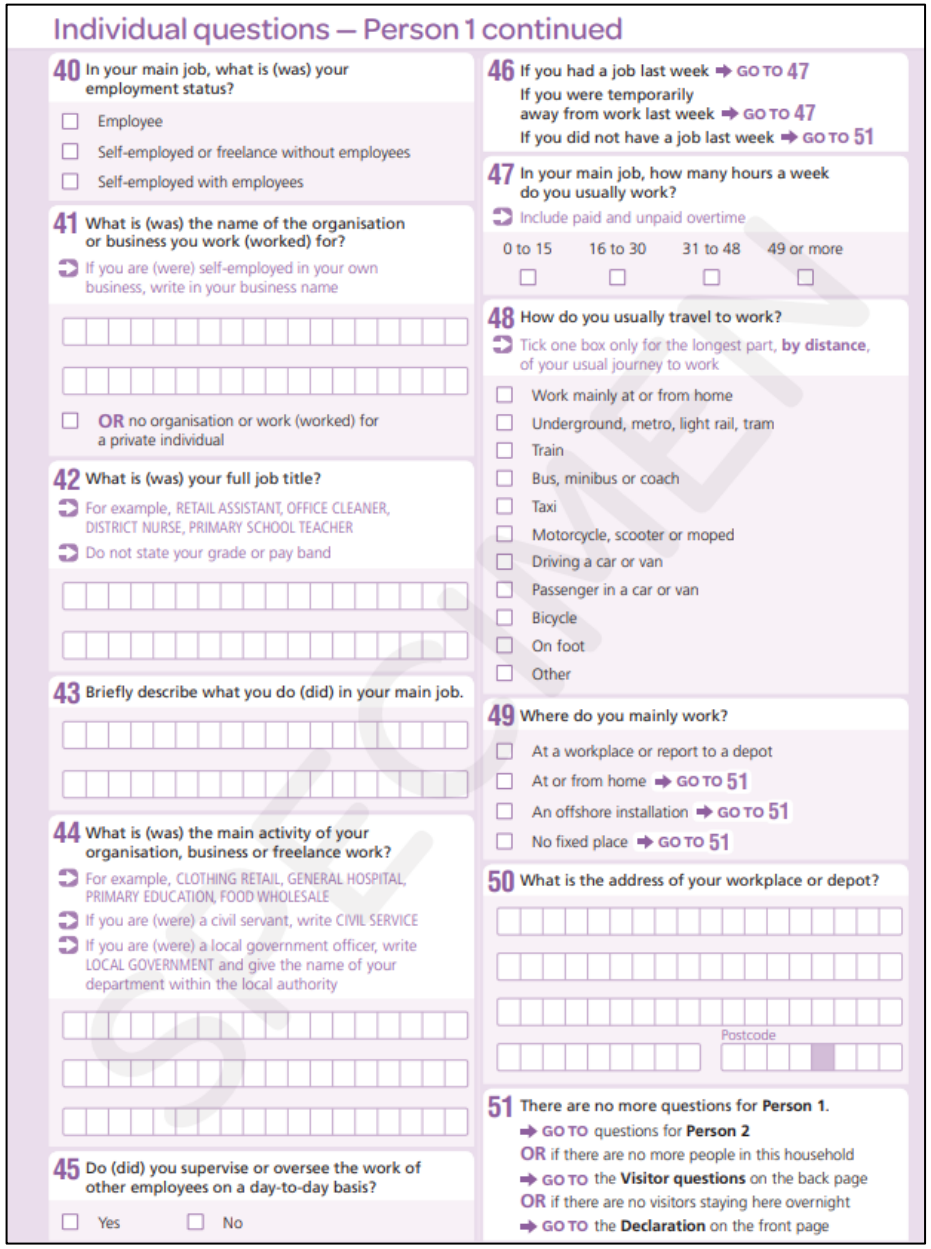
Find out more



[Nursing and Midwifery Council Register linked to Census 2021 - England and Wales - ADR UK]



Individual questions – Person 1 continued

40 In your main job, what is (was) your employment status?

- ☐ Employee
- ☐ Self-employed or freelance without employees
- ☐ Self-employed with employees

41 What is (was) the name of the organisation or business you work (worked) for?

If you are (were) self-employed in your own business, write in your business name

☐ **OR** no organisation or work (worked) for a private individual

42 What is (was) your full job title?

For example, RETAIL ASSISTANT, OFFICE CLEANER, DISTRICT NURSE, PRIMARY SCHOOL TEACHER

Do not state your grade or pay band

43 Briefly describe what you do (did) in your main job.

44 What is (was) the main activity of your organisation, business or freelance work?

For example, CLOTHING RETAIL, GENERAL HOSPITAL, PRIMARY EDUCATION, FOOD WHOLESALE

If you are (were) a civil servant, write CIVIL SERVICE

If you are (were) a local government officer, write LOCAL GOVERNMENT and give the name of your department within the local authority

45 Do (did) you supervise or oversee the work of other employees on a day-to-day basis?

☐ Yes ☐ No

46 If you had a job last week ➡ GO TO 47
If you were temporarily away from work last week ➡ GO TO 47
If you did not have a job last week ➡ GO TO 51

47 In your main job, how many hours a week do you usually work?

Include paid and unpaid overtime

0 to 15	16 to 30	31 to 48	49 or more
☐	☐	☐	☐

48 How do you usually travel to work?

Tick one box only for the longest part, **by distance**, of your usual journey to work

- ☐ Work mainly at or from home
- ☐ Underground, metro, light rail, tram
- ☐ Train
- ☐ Bus, minibus or coach
- ☐ Taxi
- ☐ Motorcycle, scooter or moped
- ☐ Driving a car or van
- ☐ Passenger in a car or van
- ☐ Bicycle
- ☐ On foot
- ☐ Other

49 Where do you mainly work?

- ☐ At a workplace or report to a depot
- ☐ At or from home ➡ GO TO 51
- ☐ An offshore installation ➡ GO TO 51
- ☐ No fixed place ➡ GO TO 51

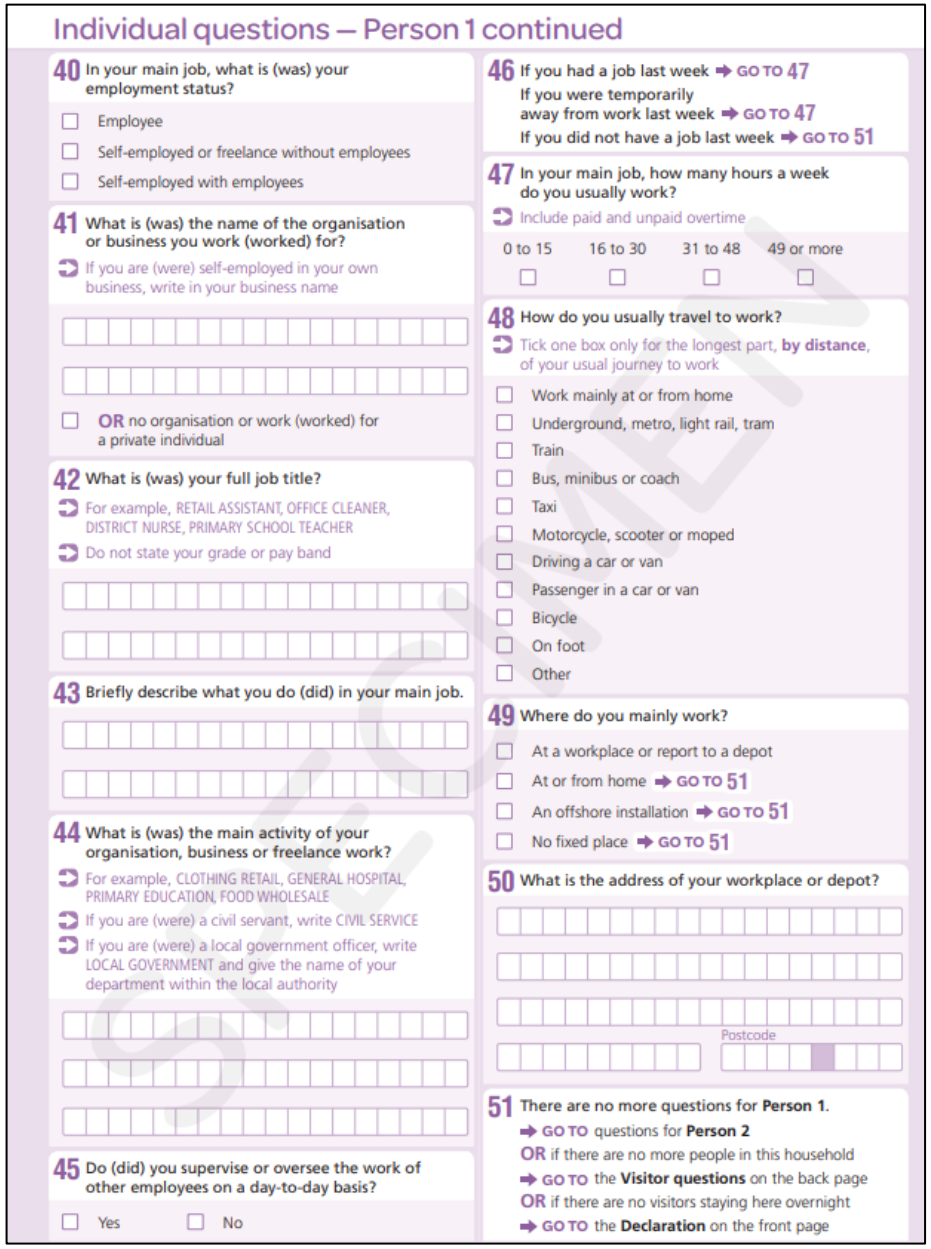
50 What is the address of your workplace or depot?

Postcode

51 There are no more questions for **Person 1**.

➡ GO TO questions for **Person 2**
OR if there are no more people in this household
➡ GO TO the **Visitor questions** on the back page
OR if there are no visitors staying here overnight
➡ GO TO the **Declaration** on the front page

https://www.ons.gov.uk/census/censustransformationprogramme/questiondevelopment/census2021paperquestionnaires



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- Household data
- Occupation
- Travel to work
- Geography
- Qualifications
- Health
- Caring responsibilities
- English language ability
- Country of birth

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Last Name

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Our register shows who can practise as a nurse or midwife in the UK, or as a nursing associate in England

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Pin number	First name	Last name	
	Iain	Atherton	Search

Please note

- More than one person may have the same name.
- If possible, use the Pin when searching. A nurse, midwife or nursing associate should tell you their PIN, when asked, if you're using their services.
- You can search using a variety of fields, but cannot search using the first name alone.

Search results are accurate to 09 November 2025.

Your search returned 1 results

Full name	Status	Location	Details
Iain Maitland Atherton	✓	Lothian	View details

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NOT ALL FIELDS ARE MANDATORY

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Please note this documentation and data availability may be subject to change as the transition of this dataset to the ONS Secure Research Service progresses.

Research highlights

- Impact case study: New linkage of nursing and midwifery data paves the way for future insights
- Blog: Migration patterns of nurses and midwives

Accessing the data

More information about how to apply to access this dataset will be available on this page soon.

You must apply to become an accredited researcher under the Digital Economy Act 2017. Find out more.

For questions about the data, please contact adrcuration@ons.gov.uk.

For questions about data access and the Office for National Statistics Secure Research Service, please contact srs.customer.support@ons.gov.uk.

ADR UK Research Fellowships

ADR UK is funding policy-relevant research using ADR England flagship datasets. Research Fellows will address priority research questions, generate insights and demonstrate the value of ADR England data. These datasets are held securely in the Office for National Statistics (ONS) Secure Research Service or other trusted research environments. Research undertaken by Fellows extends to Wales and uses ADRC data held in SAIL Databank at Swansea University.

Find out more

Core documentation

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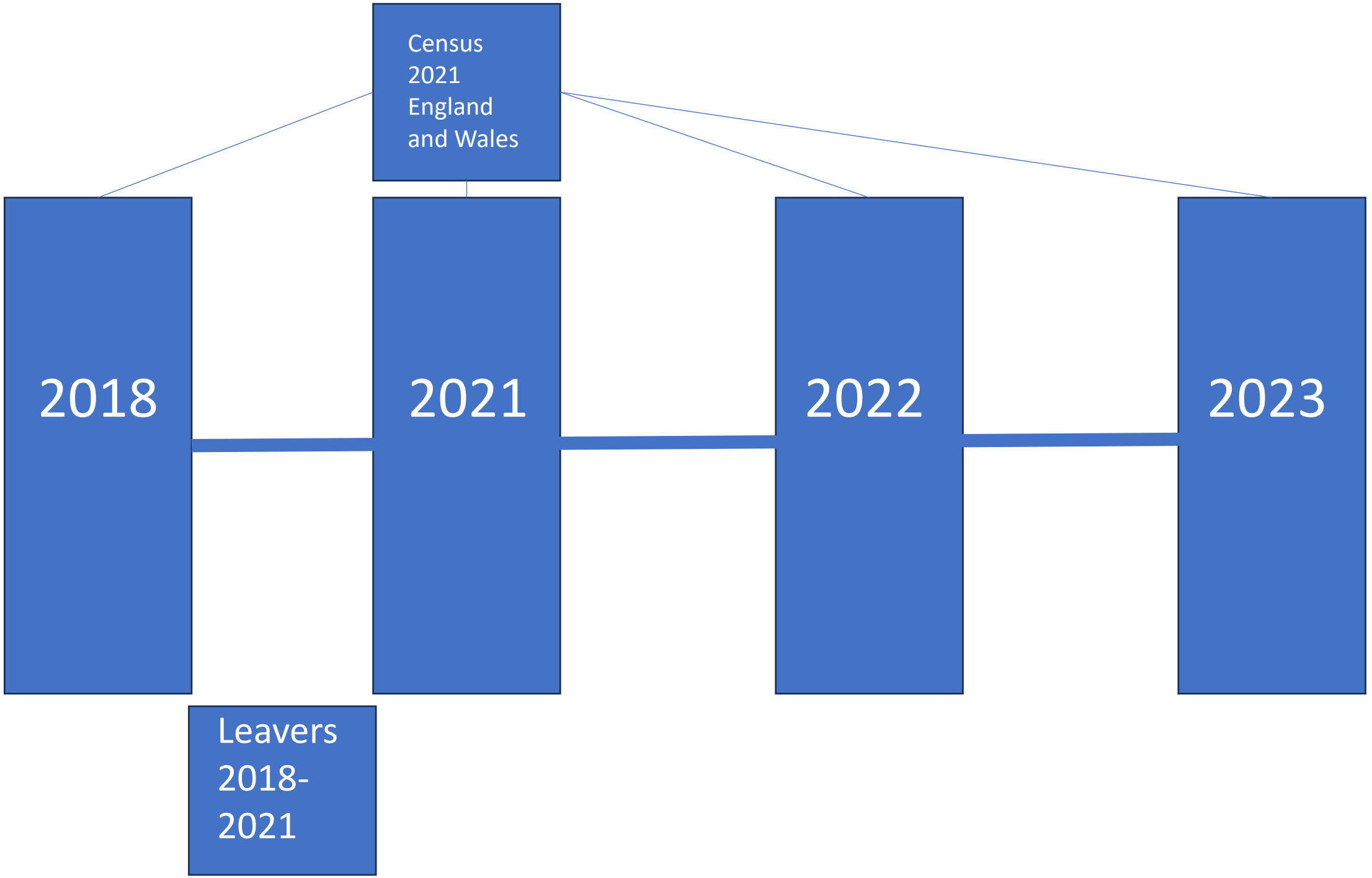
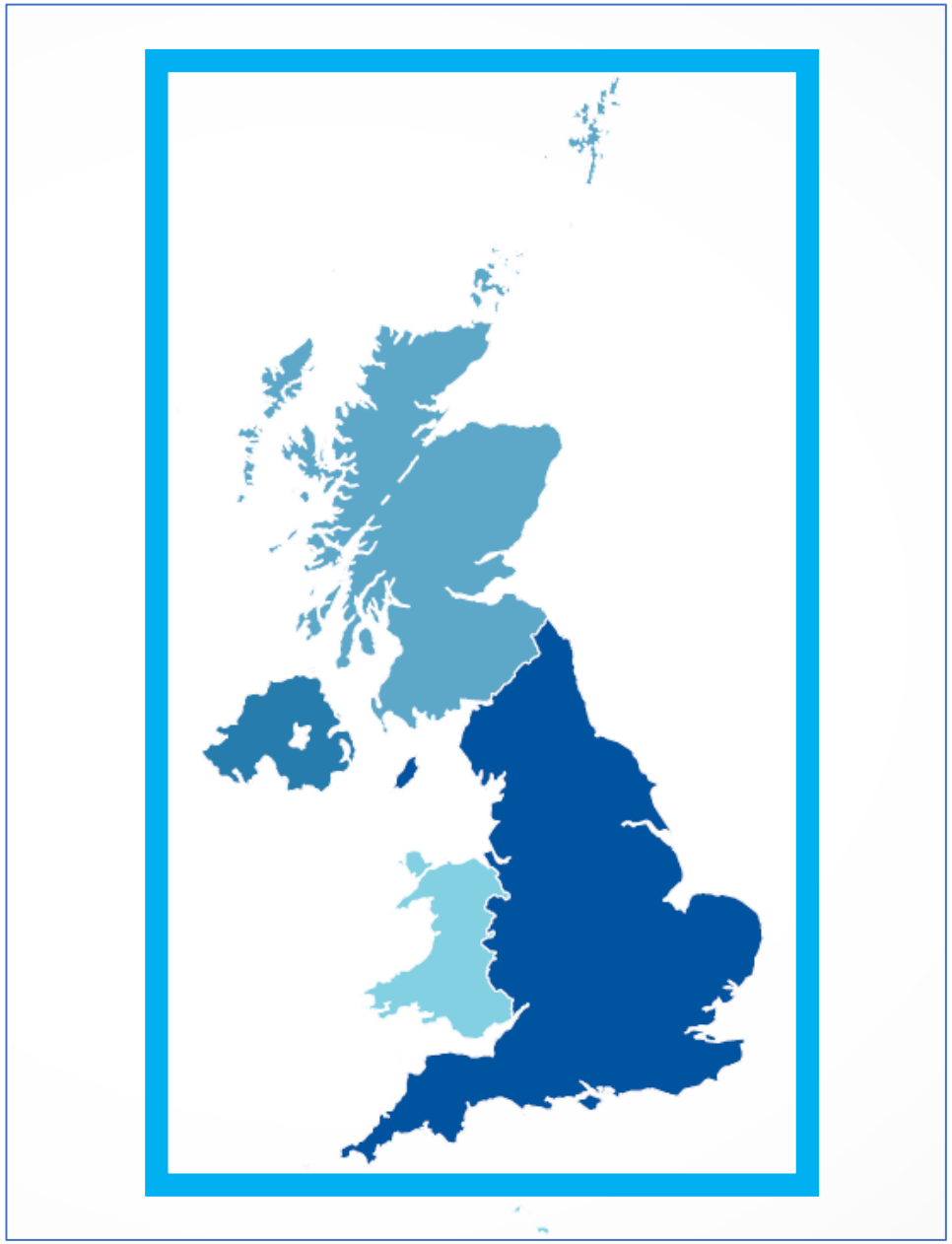

Census 2021 England and Wales
2018
2021
2022
2023
Leavers 2018-2021

Map by FreeVectorMaps.com



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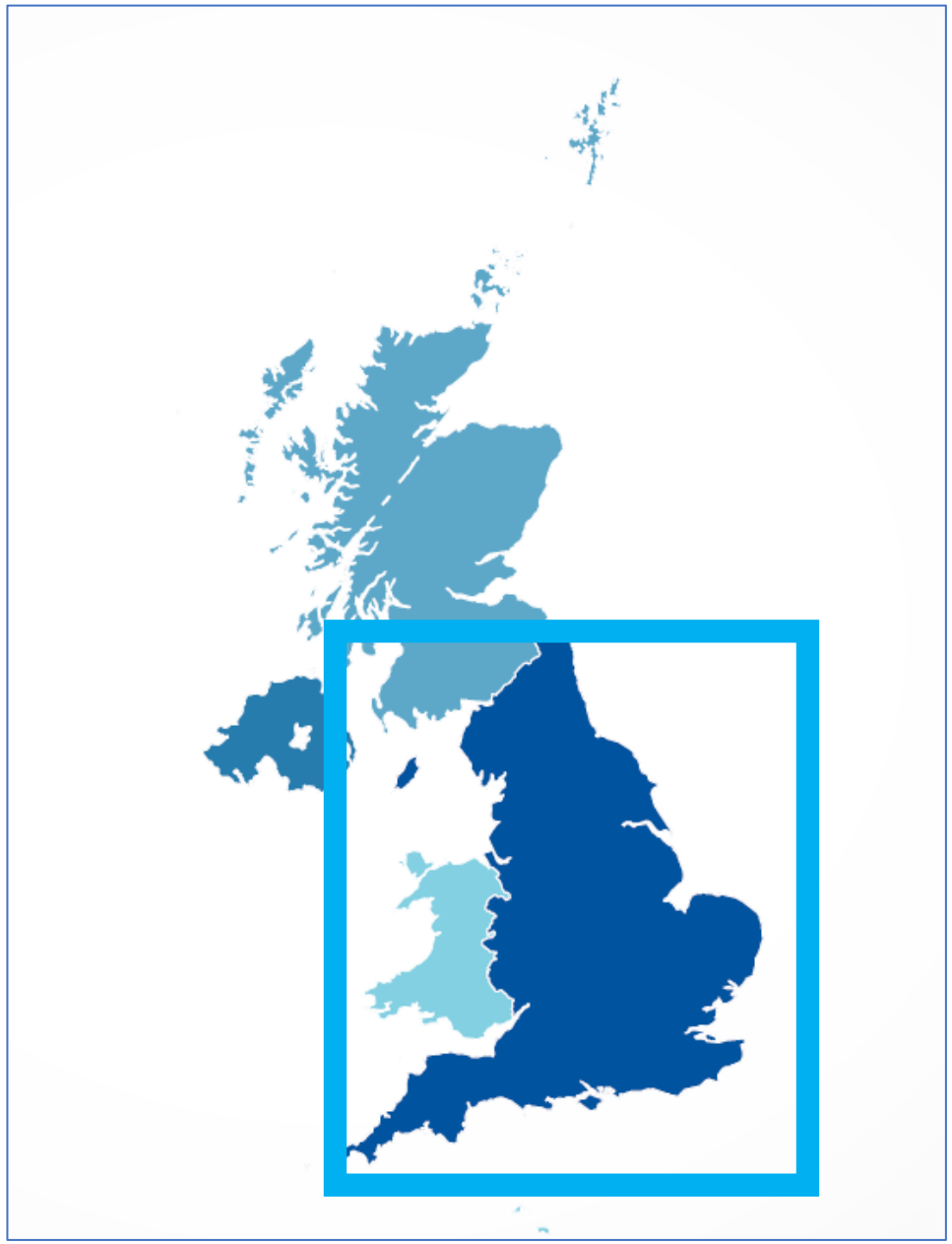

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Find out more

Known issues with the NMC-Census England and Wales 2021 dataset

- Missing records for 2021 and 2023
- Errors in registrant data regarding demographics

Current projects

- The occupations and employment of nurses and midwives in 2021 in England and Wales (Michelle Jamieson and Iain Atherton) - The occupational roles of nurses and midwives in the UK: an analysis of the Nursing and Midwifery Council-census England and Wales 2021 data linkage study | International Journal of Population Data Science

- Migration patterns of nurses and midwives (Iain Atherton, Michelle Jamieson *et al*) - Migration patterns of nurses and midwives - ADR UK

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Data-driven change

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In summary

- A chance to develop a social science of the nursing and midwifery professions
- Powerful dataset that is only just beginning to be realised
- Key group regarding patient outcomes

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