# Fatigue among NHS staff poses serious risks to patient safety and worker wellbeing



An investigation by the Health Services Safety Investigations Body (HSSIB) has revealed that exhausted NHS staff are putting both themselves and patients at risk due to fatigue stemming from excessive workloads, long shifts of 12 hours or more, and inadequate breaks. The findings were detailed in a report highlighting how these conditions contribute to medication errors, impaired decision-making, reduced vigilance, and even disruptive behaviour among healthcare workers.

The HSSIB report emphasised that fatigue "contributes directly and indirectly to patient harm" but noted a lack of comprehensive data to understand fully the scale of the problem. This has led the organisation to call for a formal review of processes to capture related information better.

During the investigation, several patient safety issues were cited. For example, one case involved a staff member who inaccurately performed a pregnancy scan, contributing to concerns for mother and baby safety at birth. This individual was reported to have a health condition and experienced poor sleep, both of which were exacerbated by increased staffing pressures and a significant workload. The staff member indicated to the investigators that fatigue was not considered during the safety event's learning process and that they were excluded from the subsequent investigation.

Another incident involved a young patient receiving the wrong chemotherapy infusion. The two staff members responsible for checking the medication were near the end of lengthy 12.5-hour shifts, and trust investigators determined that fatigue was "likely to have been a factor" in the error.

Alarmingly, fatigue is not routinely recorded in patient safety event reports, nor is it regularly factored into learning from such incidents. Additionally, the NHS Staff Survey, which gathers data from over 700,000 healthcare workers, contains no specific questions about fatigue. However, the 2024 survey revealed that two in five staff members reported feeling worn out by the end of their shifts, and one in five said that every waking hour felt tiring.

The report also shed light on the implications of fatigue for staff safety. Some NHS employees have been involved in fatal car accidents or near misses while driving home after shifts, attributed to exhaustion. The causes of fatigue are varied and include heavy workloads, prolonged shifts, insufficient rest between duties, and inadequate break times. Personal factors such as menopause, pregnancy, religious practices, and financial pressures leading to additional work were also recognised contributors.

The HSSIB expressed concern about a prevailing culture within NHS trusts that views fatigue predominantly as an individual issue with limited organisational accountability. This perspective fosters a “blame culture," which may hinder open discussion and effective management of fatigue-related risks. Saskia Fursland, senior safety investigator at HSSIB, said: “Fatigue is more than just being tired – it can significantly impair decision-making, motor skills and alertness. We must move away from viewing fatigue as an individual issue and putting the onus on personal responsibility and instead treat it as a system-level risk that deserves urgent attention.”

The investigation revealed entrenched “norms” within the health service that normalise long working hours. Some staff shared that working extended hours was regarded as a “badge of pride,” especially among senior personnel. Additionally, staying beyond contracted hours was sometimes encouraged by healthcare organisations. However, the report acknowledged that workforce shortages and financial constraints limit organisations’ ability to manage fatigue risks effectively.

The HSSIB recommended that NHS England and the Department of Health and Social Care should review current processes to improve data collection on staff fatigue. Enhancing such oversight would aid in understanding associated risks and help develop strategic responses to mitigate the issue.

Responding to the report, Patricia Marquis, executive director of the Royal College of Nursing, stated: “They [nursing staff] are overstretched, understaffed and regularly work beyond their hours caring for too many patients. This drives dangerous levels of fatigue which not only harms patients but also follows staff home, with sometimes devastating consequences. Nursing fatigue is deadly and in health and care services should be treated as a public safety emergency.”

An NHS spokesperson commented on the findings, acknowledging the hard work of staff and the challenges they face. They said: “NHS staff are working incredibly hard to meet rising demand for care, but we know that this can take a toll on their wellbeing and we’re committed to tackling burnout by ensuring staff get the support they need, so they can continue to provide safe and effective care for patients. Staff should always feel confident to report patient safety concerns, including those that are linked to fatigue, and we will work with local NHS systems to address any issues – while there is more we could and should do, the NHS is offering more flexible working options than ever before, and there is a range of mental health support available for staff, including access to wellbeing resources.”

Saffron Cordery, interim chief executive of NHS Providers, added: “Steps to protect and enhance staff wellbeing and reduce the risk of fatigue must be a priority at every level, and HSSIB is right to highlight the potential risks associated with staff fatigue in implementing national initiatives on workforce challenges and care delays.”

A Department of Health and Social Care spokesperson addressed the report’s context, stating that the Government “inherited a broken NHS with an overworked, demoralised workforce” and that the report highlights “the profound consequences this can have for patients and staff alike.”

As the NHS prepares for reform, the HSSIB urged coordinated, system-level action to address staff fatigue, emphasising its significant impact on patient safety and staff wellbeing.

Source: [Noah Wire Services](https://www.noahwire.com)

## Bibliography

1. <https://www.hssib.org.uk/patient-safety-investigations/fatigue-risk-in-healthcare-and-its-impact-on-patient-safety/launch-report/> - This HSSIB report directly supports the claim that NHS staff fatigue due to long shifts and excessive workloads leads to risks such as medication errors and impaired decision-making, impacting patient safety. It also highlights that fatigue is rarely reported as a factor in safety incidents and more data collection is needed.
2. <https://pmc.ncbi.nlm.nih.gov/articles/PMC6780563/> - This systematic review shows the proven relationship between healthcare staff burnout and poor patient safety outcomes, corroborating the article's assertion that fatigue and burnout impair clinical performance and increase risks for patients.
3. <https://www.pslhub.org/learn/investigations-risk-management-and-legal-issues/investigations-and-complaints/investigation-reports/hsib-investigations/hssib-investigation-report-workforce-and-patient-safety-primary-and-community-care-co-ordination-for-people-with-long-term-conditions-10-april-2025-r13021/> - This investigation report details patient safety issues linked to workforce exhaustion and fatigue, including examples of errors caused by tired staff. It also supports concerns about how fatigue is not well captured in safety event reporting and learning processes.
4. <https://www.nursingtimes.net/news/workforce/staff-fatigue-major-risk-for-patient-safety-and-staff-wellbeing-says-hssib-23-04-2025/> - This Nursing Times article covers the HSSIB findings on NHS staff fatigue, including how fatigue contributes to both patient and staff harm, the culture of long hours, and the call for system-wide recognition and management of fatigue as a safety risk.
5. <https://www.rcn.org.uk/news-and-events/news/rcn-stress-survey-2024-230424> - The Royal College of Nursing's 2024 survey results confirm that a high proportion of NHS staff feel physically worn out by their shifts and experience constant tiredness, supporting the article's data from the NHS Staff Survey about fatigue levels among healthcare workers.
6. <https://www.england.nhs.uk/supporting-our-nhs-people/wellbeing-and-health-support/fatigue-management/> - NHS England's official guidance on staff wellbeing and fatigue management acknowledges the challenges of long shifts and heavy workloads on staff health and patient safety, aligning with the article's mention of flexible working and mental health support while recognizing ongoing systemic issues.
7. <https://www.irishnews.com/news/uk/nhs-staff-fatigue-factor-in-patient-harm-and-deserves-urgent-attention-report-QAQPIO6F3RKUJMGVBUDWE6HM6Y/> - Please view link - unable to able to access data