Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Thursday, 5 March 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

At its meeting on 25 February 2015 the Committee resolved under Standing Order 17.42(ix) to exclude the public for item 1 of the meeting on 5 March 2015. The Committee subsequently agreed to reorder the business scheduled for the meeting on 5 March 2015, and to meet in public for item 1.

1 Introductions, apologies and substitutions (09.00)

2 Safe Nurse Staffing Levels (Wales) Bill: evidence session 12 (09.00 - 09.45) (Pages 1 - 19)

Dr Jean White, Chief Nursing Officer
Fiona Davies, Lawyer
Helen Whyley, Nursing Officer

3 Safe Nurse Staffing Levels (Wales) Bill: evidence session 13 (09.45 - 10.45) (Pages 20 - 34)

Mark Drakeford AM, Minister for Health and Social Services
Dr Jean White, Chief Nursing Officer
Fiona Davies, Lawyer

4 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from items 5, 6 and 11 of the meeting (10.45)

5 Safe Nurse Staffing Levels (Wales) Bill: consideration of evidence received (10.45 - 11.00)

6 The Committee's forward work programme (11.00 - 11.20) (Pages 35 - 44)

Lunch (11.20 - 13.00)

7 Inquiry into the performance of Ambulance Services in Wales: evidence session 1 (13.00 - 13.40) (Pages 45 - 51)

Stephen Harrhy, Chief Ambulance Services Commissioner
Professor Siobhan McClelland, Chair – Emergency Ambulance Services Committee

8 Inquiry into the performance of Ambulance Services in Wales: evidence session 2 (13.40 - 14.20) (Pages 52 - 58)

Mick Giannasi, Welsh Ambulance Services NHS Trust
Tracy Myhill, Welsh Ambulance Services NHS Trust

Break (14.20 - 14.30)

9 Inquiry into the performance of Ambulance Services in Wales: evidence session 3 (14.30 - 15.10)

Adam Cairns, Cardiff and Vale University Health Board
Alison Williams, Cwm Taf University Health Board

10 Papers to note (15.10)

Correspondence from the Petitions Committee: P-04-625 Support for Safe Nursing Staffing Levels (Wales) Bill (Pages 59 - 60)

Safe Nurse Staffing Levels (Wales) Bill: Summary of evidence received from the Royal College of Nursing campaign (Pages 61 - 64)

11 Inquiry into the performance of Ambulance Services in Wales: consideration of evidence received (15.10 - 15.20)

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Chief Nursing Officer – SNSL(Org) 23 / Tystiolaeth gan Prif Swyddog Nyrsio – SNSL(Org) 23

Safe Nurse Staffing Levels (Wales) Bill

Evidence from the Chief Nursing Officer

Health and Social Care Committee, 25 February 2015

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Introduction

Professor Jean White is giving evidence to the Health and Social Care Committee in her role as Chief Nursing Officer/Nurse Director NHS Wales. As such, she is providing evidence regarding the areas where the Bill will impact on the profession of nursing and has focused on the consultation questions that relate to this area.

In this evidence paper

- "NHS in Wales" is used to refer to NHS local health boards and NHS trusts
- "acute ward" means medical and surgical adult in-patient acute wards
- "establishment" means the total number of staff allocated to work in a ward

Is there a need for legislation to make provision about safe nurse staffing levels?

Much work is already being done to ensure safe nurse staffing levels in adult acute medical and surgical wards, using existing Welsh Ministers' powers. This work started over three years ago when the current Chief Nursing Officer (CNO) came into post.

CNO's Nurse Staffing Principles

The CNO and Nurse Directors of NHS Wales have discussed the matter of safe staffing levels at many of their routine monthly meetings. The responsibility for determining a safe, appropriately skilled workforce lies with NHS organisations, however, in this instance a partnership approach across NHS Wales and Welsh Government has been established to develop tools to assist individual organisations in this area.

The Welsh Government has not set mandatory minimum ratios of registered nurses to support staff, nor minimum numbers of staff per in-patient bed. However, working in partnership, in May 2012 the CNO and Local Health Board (LHB) Chief Executive Officers (CEO) agreed a set of principles for nurse staffing levels to be used during the time it would take to develop, fully test then implement a workforce acuity and dependency tool for adult in-patient wards. It was agreed at that time to establish a programme of work to develop a suite of tools that will ensure staffing levels and skill mix are tailored to meet the specific needs of patients in each care setting.

In May 2012 the CEOs also agreed to develop individual organisational plans to comply with the nursing principles for medical and surgical wards over a three-year period. In July 2013, following publication of the Francis Enquiry into Mid Staffordshire Foundation NHS Trust, the Minister for Health and Social Services allocated an additional £10 million (recurring) funding to support these plans.

The principles are:

- Professional judgement will be used throughout the planning process
- Ward activity and demand will be considered when establishing staffing levels as well as the number of beds, environment and ward layout
- Nursing establishments on acute wards should not normally fall below 1.1 Whole Time Equivalent (WTE)/bed including a head-room of 26.9% (to cover annual leave, mandatory training, etc)
- Numbers of patients per Registered Nurse should not exceed 7 by day
- The skill mix of Registered Nurse to Health Care Support Worker in acute areas should generally be 60/40
- The Ward Sister/Charge Nurse should not be included in the numbers when calculating patients per Registered Nurse ratio

LHBs have been asked to provide progress reports to the CNO that includes details of their compliance with the principles, utilisation of the additional funding, and of the assurance frameworks or processes they have in place for continued safe nurse staffing levels.

Monitoring of the compliance of the principles has been on-going since 2012. Over that period:

- Health Boards have continued to actively address nurse establishments in adult acute medical and surgical wards.

- All Health Boards have made significant improvements to the number of wards with more that 1.1 WTE nurse/support worker per bed, with some areas now reaching 100% compliance.

- All organisations have assurance frameworks and action plans to continue to ensure appropriate safe staffing levels.

- Skill mix has improved significantly with the majority of wards with a 60:40 registered nurse to support worker skill mix.

- Some areas have not managed to recruit to the establishments identified, and have had to consider their recruitment plans. This compounds the issue of trying to reach compliance due to current demand for nurses.

- There has been an improvement in the compliance of their medical wards; in respect of no more than 7 patients per nurse, the number of compliant wards has increased by up to 75% in some Health Boards.

Acuity tool

The Committee has been provided with copies of the NHS documents:

- *Fundamentals of Care System User Guide: Adult Acute Nursing Acuity & Dependency Tool*
- *Adult Acute Nursing Acuity & Dependency Tool Governance Framework.*

The acuity tool for adult acute medical and surgical in-patient settings was rolled out in April 2014. It is a robust, evidence based tool which measures acuity and dependency of patients to help LHBs plan for future workforce requirement. It is easy to use and apply, but it cannot be used in isolation, rather it is one key tool in the determination of staffing levels in conjunction with professional judgement and nurse-sensitive indicators such as the number of patient falls.

Two validation runs are needed before the results of the acuity tool can be relied upon. A validation run is used to confirm that LHBs are correctly identifying the factors used to determine levels of acuity and dependency essential to the application of the tool. Learning shared by colleagues in England has revealed that data needs to be captured for several cycles before any significant changes to staffing establishments should be implemented. This is because the tools algorithm is for a long term forecast of staffing needs and therefore several indices must be added to make the outputs valid. The first validation run was undertaken in June 2014 and the second was undertaken in January 2015. The results will inform the triangulated approach used to determine staffing levels at local level.

Once data has been captured and validated within the national system, organisations should develop local reports which triangulate local workforce data and nursing metrics to provide intelligence which can be used to support local decision making about deployment of nursing resource within the overall workforce planning process.

The acuity tool works as a forward planner, not as a day-to-day allocator of nurses. It is essential therefore that along with use of the tool, professional judgement and nurse sensitive indicators should be used to consider the correct staff establishments. For example, a patient who is confused and disoriented may have a relatively low level of acuity and dependency but would still require a one to one observation schedule to ensure their safety. Similarly understanding the information from falls or pressure area development may change the staffing required to a particular patient group or clinical setting. The research shows that the issue of nurse staffing levels is a complex one and therefore use of a triangulated methodology is advocated. For this reason it would not be appropriate for the outcome of the tool alone to always be adhered to, hence Health Boards should be required to utilise the tool but to consider its results using the triangulated methodology.

Professional Standards

Appropriate staffing is a collective responsibility of boards and executive teams. Board members who are registrants and hold senior positions such as director of nursing or director of medicine are not individually responsible for appropriate staffing in an organisation but have a shared corporate responsibility with the whole board. However, they function in their corporate roles within the framework of professional standards set by the respective health regulator.

All professional health regulators are clear that their codes and standards apply to every registrant whatever their role and scope of practice, similarly all professional health regulators will inform the appropriate system regulator if they uncover concerns about a provider when they are investigating a fitness to practise referral or as part of their work in quality-assuring education . Such concerns could include claims of unsafe staffing or the suppression of concerns raised by staff.

Are the provisions in the Bill the best way of achieving the Bill's overall purpose (set out in Section 1 of the Bill)?

The Welsh Government does not intend to set any form of minimum ratios for the NHS in Wales as the evidence indicates that this area is too complex to take a reductionist approach. Working in partnership with the NHS in Wales, the Welsh Government has developed a triangulated approach for LHBs and Trusts to implement based on the use of: the acuity tool, professional judgement and nurse-sensitive indicators. The CNO's principles were agreed as an interim measure while the adult in-patient acuity and dependency tool was being developed.

The Bill only focuses on nurse staffing whereas Welsh Government policy is to integrate care across the professions and the sectors. The Welsh Government has defined its health policy as a move towards an integrated health and social care framework, with patients' needs at the centre of service delivery, as evidenced in the Social Services and Well-being (Wales) Act 2014. This integrated approach requires multi-disciplinary and multi-professional working with each profession utilising their

skills when the patient needs them. It seeks to eliminate unhelpful demarcations of different roles.

The CNO fully agrees that adequate staffing levels and skill mix are an important factor in delivering quality care; however mandating nurse staffing levels alone is not the answer to reducing poor care. Using the evidence-based triangulated approach, professional judgement, the acuity tool and nurse-sensitive indicators gives the NHS the flexibility necessary to assess patient needs and to change and develop services and initiatives in response to those needs. This Bill is too prescriptive and does not allow for different operational models to accommodate the flexibility required by the NHS in Wales in order to respond effectively to rapidly changing patient needs There is a significant and wide ranging number of factors other than nurse staffing levels which influence patient care and outcomes (Ball & Catton 2011; McGillis Hall & Buch 2009; Coombes & Lattimer 2007). These include the range of services a ward provides, ward layout, team mix, deployment of staff, work environment and safety, regulatory systems, communication of change and costs, medical staffing and relationship between the ward sister/charge nurse and medical consultants The education, knowledge and experience of registered nurses is an important factor as well as the management structure and roles, strong nurse leadership, teamwork and clinical governance.

The RCN's guidance published in 2010, *Guidance on safe nurse staffing levels*, notes that:

> "In virtually every case, minimum staffing ratio recommendations made by specialist bodies are accompanied by guidance that staffing levels should be locally determined to take into account the level of clinical need and local factors that influence staffing requirement (such as range of services, unit/ward layout, team mix). Some bodies recommend specific tools be used to enable staffing levels to be planned in relation to workload and clinical needs." [RCN 2010, p 42]

What, if any, are the potential barriers to implementing the provisions of the Bill? Does the Bill take sufficient account of them?

Some issues which could be interpreted as a barrier to implementation are discussed in the section about unintended consequences and vice versa.

There are many factors to be taken into account when managing the staffing of a ward. They include the complexity of the care individual patients require - including their physical, emotional and mental health needs - the numbers of patients, the layout of the ward and the services provided by other professionals. These factors will all impact on the numbers of nurses and healthcare support workers that are required. Other factors include the experience of the staff, the handover time, and the continuing professional development requirements of the staff such as mandatory training.

Experience in the new hospitals such as Ysbyty Ystrad Fawr in Caerphilly has shown that single room style wards require more staff as patients can not be easily seen from one central location thus requiring slightly higher numbers of staff to accommodate this. The hospital has 269 beds, all in single en-suite bedrooms.

The ability to use a single set ratio will be affected by the number of beds on the ward. For example, setting a ratio of one nurse to seven patients is not practical if the ward has 23 beds as the ratio can never be achieved close to 1 to 7; either there are three nurses making the ratio too high at 1 to 8 or there are four nurses making the ratio too low at 1 to 6. These ratios may not be appropriate at all for the clinical setting. This is also the case for all ward environments where the number of beds is not divisible by the nurse to patient ratio. This may also mean that staff are moved around from ward to ward just to comply with a ratio rather than because of the need of the clinical area. There is some evidence of this argument in the literature although it is mainly anecdotal.

Some ward areas will have ward clerks who can undertake some administration duties for clinical staff but others will not. Other roles such as housekeepers and ward domestics vary across Wales again affecting the responsibilities staff need to undertake and thus the numbers required. These practical issues make it impracticable to apply a set ratio to all acute wards.

The issue of when the ratio is set for is also problematic. The guidance would need to say when the ratio applies during a 24 hour cycle. Similarly, the issue of meeting the ratio shift by shift is problematic. There is no standard shift system in the NHS in Wales. The complexity of a patient's needs within a ward can change mid-shift as can the movement of patients within the hospital. Defining shift by shift compliance would therefore be difficult. Various factors would need to be considered e.g. shifts vary in length from seven to twelve hours and staff also work half-shifts and twilight shifts. It would be difficult to establish a standard definition of the meaning of a "shift", as well as agreement on when the ratio would apply and how it would be calculated e.g. whether an average would be taken of the staff on a single shift or of the staff on all the shifts during one day or one week or a month.

To fix a number across the board could potentially put patents at risk. For example, an acute surgical ward with some high dependency beds is likely to have a high number of complex diagnostic procedures and treatments being undertaken. This type of clinical environment is likely to require significantly more staff than a ward where planned routine surgery is being undertaken.

The Welsh Government's prudent healthcare initiative aims to: minimise avoidable harm; carry out the minimum appropriate intervention and promote equity between the people who provide and use services. Of necessity, this will require reconfiguration of some existing services. A mandatory nurse staffing ratio could hinder such developments. Also, an emphasis on having enough nursing staff to meet the mandatory ratio could lead to fewer cleaning or clerical staff, for example, and increase the risk of adding non-clinical tasks to nurses' workloads.

Similarly the role and responsibilities of staff who support wards is not necessarily considered in the ratios. For example, many adult acute medical and surgical wards have an Advanced Nurse Practitioner service, where nurses with advanced level of practice undertake complex assessment and treatments of patients. The availability of such services can effect the requirement for staff, depending on how much interaction these roles have with the patients on a ward. In order to continue with the development of new, innovative roles and service models, in line with the aims of prudent healthcare, consideration on how these affect the minimum ratios needs to

be considered. It is possible that such innovation will be stifled to ensure compliance with a ratio.

The proposed minimum nurse staffing levels would need to be addressed as part of the Integrated Medium Term Plans, where the planning and prioritisation would be undertaken.

Are there any unintended consequences arising from the Bill?

There are numerous such potential consequences. Some are discussed in the section regarding barriers to implementation.

Failure to comply with the duty in the Bill

The Bill does not state that there will be any consequences if the NHS in Wales does not comply with its duty to maintain safe nurse staffing levels nor is there any express power of redress set out in its provisions. However, LHBs may well choose to err on the side of caution, because of the direct and indirect impacts of the Act. Awareness of the Act could encourage health boards to focus on meeting the ratios to the exclusion of other important factors such as using professional judgement and the acuity tool. It could be easier for health boards to comply by reducing the number of beds to match the number of staff available. Faced with a legal requirement to maintain such a ratio, hospitals will face difficult choices.

Placing undue emphasis on minimum nurse staffing ratios

There are several recent reports and publications that have commented on the issue of nurse staffing levels and/or measurement of technical standards. Many of these make reference to the limitations of placing an emphasis on a number or a technical specific standard.

The Berwick Review of patient safety, carried out in 2013, concluded

> "Neither quality assurance nor continual improvement can be achieved through regulation based purely on technically specific standards, particularly where a blunt assertion is made that any breach in them is unacceptable." [Berwick 2013, p 11]

> "The system needs to be agile, responsive and proportionate. This cannot be achieved through a series of prescriptive, technical standards that attempt to delineate between "acceptable" and "unacceptable" according to a tick-box or list." [*Ibid.* p 30]

It also advised

> "Use quantitative targets with caution. Goals in the form of such targets can have an important role en route to progress, but should never displace the primary goal of better care. When the pursuit of targets becomes, for whatever reason, the overriding priority, the people who work in that system may focus too narrowly." [*Ibid.* p 4]

The recent NICE review of the literature in this area concluded that:

> "There is a lack of high-quality studies exploring and quantifying the relationship between registered nurse and healthcare assistant staffing levels and skill mix and any outcomes related to patient safety, nursing care, quality and satisfaction. All of the identified studies were observational and the majority were not for UK populations. Where evidence was available it tended to be associational with limitations due to confounding factors that affected the outcome.
>
> There is a lack of appropriately designed interventional studies relating to the outcomes of interest with appropriate control for confounding variables, such as studies designed to identify the outcomes associated with increasing numbers of available nursing staff. The outcomes identified generally report on failures of care rather than the more positive aspects of quality of care. There is also a lack of research on measures of missed care that could be routinely monitored and therefore easily collected and investigated." [NICE 2014 p.32]

Thus it would appear that it would be easy to place undue emphasise on the ratio rather than the outcome. These reports and published evidence support the CNO and Nurse Directors adopted approach in Wales of a triangulated methodology to analysis, understand and set safe nurse staffing levels.

Recruitment issues

Expectations of nursing establishments have changed in recent years due to a number of factors such as more acutely ill patients, response to reports into failings in care in various parts of the UK and any new national/professional guidance. The introduction of legislation in this area is likely to further affect the expectations of nursing establishments thus increasing the demand. The workforce planning system responds well to fluctuations in the system; however an increased demand can not always be foreseen. The commissioning and education cycle means it takes four years from the point of commission to the production of a registered nurse (the education programme is 3 years) and therefore there is a degree of lag in the system.

This is highlighted by the experience in NHS England, where an increased demand for registered nurses followed the publication of the Francis Report in 2013 demonstrating that where an issue is highlighted as a concern a demand is likely to be created. To a degree the demand for registered nurses has increased following the adoption of the CNO and Nurse Director Principles and the associated funding announce to support the work of nurse staffing in adult acute wards. This demand is multifaceted and includes the global market for nurses as well as the changing pattern of, and demand for, services provided both by the NHS and other sectors.

NHS Wales is likely to identify a necessity to train more nurses in order to have enough staff to meet any compulsory ratio. These extra nurses would be commissioned by the Welsh Government, however the commissioning cycle works one year in advance and it takes three years to train one nurse, at a cost of £38,000. The consequences of this planning cycle will not materialise for a number of years. In the meantime, competition for existing nurses will continue, possibly at the expense of other professions.

NHS Wales is already taking action to recruit and retrain nurses, including encouraging those who have left the profession to return to the workplace. In order to comply with a compulsory staffing ratio, LHBs will need to ensure that vacancies are filled more quickly, and hire more agency or bank staff until the vacancies are filled to ensure patient safety. This could lead to increasing competition between hospitals for nursing staff. To keep costs down, hospitals may be tempted to recruit more nurses on lower grades, thus reducing the skills of the workforce. Another option to reduce costs would be to reconfigure existing services, so that more staff nurses are needed than higher grades, which would also reduce the skills of the workforce. A further cost-effective option that Health Boards may consider would be to close beds until the vacancy is filled. This could also be the case if an unexpected shortfall in staff occurred that could not be covered such as a member of the substantive staff being sent home sick. There is a global market for nurses and there are recruitment pressures across the UK, not just Wales.

A mandatory ratio may lead to a higher demand for agency and bank nurses, while hospitals are covering unfilled vacancies or simply because of the usual variation in the numbers of nurses required on a ward. However, agencies are not immune to the problems of recruiting staff so there is a real risk that any suppliers will be unable to recruit new agency staff in sufficient numbers to meet local demand.

Market dynamics

If hospitals need to recruit greater numbers of nurses, care homes will need to compete to recruit and retain their nursing staff too. They will all be 'fishing from the same pool'. The Bill may therefore affect care homes and other private sector providers indirectly, which may means care home/bed closure and the transfer of patients to the NHS.

Multi-disciplinary issues

The Bill does not take a multidisciplinary approach to staffing teams that provide patient care. In particular, the Chartered Society of Physiotherapy has repeatedly expressed concerns. At the evidence session for the Health and Social Care committee on 29 January 2015, representatives of the Society stated that any mandatory ratio would be "unacceptable." The NHS in Wales may pour all resources into nursing, and that may distract from the other disciplines that trying to provide a joined-up approach on a ward.

The duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided

The CNO fully agrees with the aim of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided

Safe nursing care is dependent on a number of factors, not just the number of nurses deployed, and is already a consideration on every ward. However, the Bill would put too much emphasis on maintaining a rigid nurse to patient and nurse to healthcare support worker ratio, whilst neglecting the other factors namely

- using professional judgment to make decisions appropriate to the particular circumstances on a day-to-day basis
- the staff skill mix – the range of qualification and experience; individual clinical competencies; different areas of expertise
- the use of multi-disciplinary approach – doctors, specialist nurses and other healthcare professionals
- the varying nursing needs of individual patients and patient turnover in general
- the time of day - more staff may be needed to help feed patients at mealtimes
- the ward environment – physical layout and size
- using the acuity tool– a practical resource to facilitate the process of calculating the nursing staff requirements for wards or organisations

The duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios, which will apply initially in adult in-patient wards in acute hospitals

It is widely accepted that there are gaps in the evidence base in the area of nurse staffing levels. The evidence that is available along with published reports that consider nurse staffing have informed the work in Wales to adopt the triangulated methodology approach. These publications challenge the use of a 'minimum' ratio and are set out below.

Requiring minimum ratios of nurses to patients and nurses to healthcare support workers is a very inflexible and impracticable approach which fails to take into account the way in which the NHS operates on a day to day basis. This view is supported in the latest NICE guidance, *Safe staffing for nursing in adult inpatient wards in acute hospitals*. In the accompanying *Frequently Asked Questions* document, NICE states

> "The Safe Staffing Advisory Committee reviewed the best available evidence and concluded there is no single nursing staff to patient ratio that can be safely applied across the wide range of acute adult in-patient wards in the NHS. This is because there is considerable variation in the nursing needs of different patients across different wards and at different times as demonstrated by the real-life data that were examined in the economic analysis and field testing reports.
>
> Having a single recommended nurse to patient ratio would not allow for all the nursing care needs of patients to be adequately accounted for. This guideline recommends the factors that need to be systematically assessed at ward level when determining nursing staff requirements, with the nursing care needs of individual patients being the main driver." [NICE 2014b, p 4]

The paper *How to ensure the right people, with the right skills, are in the right place at the right time* published by the National Quality Board also takes this view, with the CNO for England stating:

> "There has been much debate as to whether there should be defined staffing ratios in the NHS. My view is that this misses the point – we want the right

staff, with the right skills, in the right place and the right time. There is no single ratio or formula that can calculate the answer to such complex questions. The right answer will differ across and within organisations, and reaching it required the use of evidence, evidence based tools, the exercise of professional judgment and a truly multi-professional approach. [National Quality Board undated, p 3]"

"The guide does not recommend a minimum staff-to-patient ratio. It is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, the evidence and their knowledge of the local context. [*Ibid*. p 8]"

This is also the view of the CNO for Wales and the Welsh NHS Executive Nurse Directors.

In its *Guidance on safe nurse staffing levels* published in 2010, the RCN in England succinctly summarised the advantages and disadvantages of a fixed ratio:

Pros	**Cons**
Can halt or reverse reductions in nurse staffing	Defining minimum – does is become average or maximum?
Can encourage workforce stability and reduce use of temps	Measuring minimum – is it calibrated adequately in relation to workload?
Simple to implement and understand	How can compliance be assured? What are the penalties for non-compliance?
Provides standard approach (reduces need for complex systems)	What is cost of compliance – will other staffing be reduced?
If mandatory, can ensure compliance from all employers	Inflexible – can one size really fit all?

[RCN 2010, p 37]

This guidance recommends that

"To make judgements about numbers of staff needed requires insight into the roles and competences of different staff groups (which may vary considerably locally). Need to know who does what, before you can judge how many of each is needed… Triangulation is essential. In other words, use several different approaches to determine staffing from different angles. [*Ibid.,* p 38]"

And it concludes

"The RCN does not advocate a universal nurse-to-patient ratio. This would be meaningless given the range of factors that clearly influence the number and mix of nursing staff needed, and which need to be considered locally to determine staffing. [*Ibid.,* p 40]"

The conclusions also list the ratio of the patients per registered nurse as only one of several indicators that should be monitored regularly namely

Actual nursing staff in post as a proportion of total establishment	To identify current staffing relative to the planned number of nurses required - per

	ward/unit/catchment area.
Proportion of registered nurses (RN) as percentage of total nursing staff	The benchmark average on general hospital wards is 65% RNs
Nursing staffing relative to population served	• In hospitals this is nurses per occupied bed (NPOB) or per bed • In community this is nurse per head of population (and may include measure of socio-economic need of population)
Nurse staffing relative to patients	• Ratio of the patients per RN (on a day or night shift) provides indicator of actual staffing levels on hospital wards • Nursing hours per patient day (provides global measure) • In the community this is typically captured through caseloads
Staff turnover	For example using 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). Length of service can be used as a proxy.
Sickness absence	Sickness absence rate is calculated by dividing the sum total sickness absence days by the sum total days available per month for each member of staff.

[*Ibid.,* p 41]

In 1999, the US State of California introduced legislation to set a mandatory nurse-to-patient ratio in a variety of settings. The law came into effect in 2004 and hospitals were allowed five years to phase in compliance. Much research has been carried out into the effect of mandatory staffing ratios in California and it is often cited. Research carried out by Aiken in 2002 about mandatory ratios in California concluded that

> "Our results do not directly indicate how many nurses are needed to care for patients or whether there is some maximum ratio of patients per nurse above which hospitals should not venture. Our major point is that there are detectable differences in risk-adjusted mortality and failure-to-rescue rates across hospitals with different registered nurse staffing ratios. [Aiken 2002, p 192]"

Research carried out in the UK by Rafferty in 2006 found that

> "Hospitals in which nurses cared for the fewest patients each had significantly lower surgical mortality and FTR [failure to rescue] rates compared to those in which nurses cared for greatest number of patients each… In addition to better outcomes for patients, hospitals with higher nurse staffing levels had significantly lower rates of nurse burnout and dissatisfaction.[Rafferty 2006, pp 179-180]"

However, both authors stopped short of recommending a staffing ratio.

In 2012, review by Cook et al of the research regarding the statutory ratio applied in California found that there was no persuasive evidence that the regulation change improved patient safety in the affected hospitals in California. Empirical results suggested that a mandate reducing patient/nurse ratios, on its own, need not lead to improved patient safety and that improved nurse staffing might be crucial in improving patient safety, but only in combination with other elements.

Research carried out by Aiken in 2014 compared the impact of nurses' qualifications and staffing levels in nine European countries. While she concluded that the degree nurses had better patient outcomes her analysis does not appear to isolate the effects of two separate factors namely the level of qualification the nurses attained, and the number of nurses on duty. Once again demonstrating that patient outcomes and ratios can not necessarily be shown to have a direct causation, indeed the author makes the point regarding education levels and experience. She concluded:

> "Hospitals in which nurses cared for fewer patients each **and** [my emphasis] a higher proportion had bachelor's degrees had significantly lower mortality than hospitals in which nurses cared for more patients and fewer had bachelor's degrees… our data are cross-sectional and provide restricted information about causality. [Aiken 2014, *Discussion*]"

A common theme of much research into staffing levels is that it is cross-sectional i.e. it provides a snapshot of staffing levels at one given time and that it fails to prove causality i.e. a clear link between staffing levels and patient outcomes. Aiken concludes by calling for research into staffing levels to be carried out over longer periods of time:

> "Longitudinal studies of panels of hospitals would be especially valuable to help to establish causal associations between changes in nursing resources and outcomes for patients. [*Ibid*., *Discussion]"*

Since 2004, all registered nurses in Wales have qualified by completing a bachelor degree course. The existing nurse workforce in Wales is a mixture of graduates and nurses who qualified/registered before degrees were introduced. They are supported by health care support workers/nursing assistants.

Research by the National Nursing Research Unit at King's College, London suggested that setting a mandated minimum ratio had major consequences not just in terms of investment required to set up, establish and periodically recalibrate a mandatory ratio, but also in terms of mechanisms needed to monitor compliance and deal with non-compliance. Ratios do not remove the need for robust mechanisms for workforce planning locally, to ensure that the right staff with the right skills are in place to meet patient needs. [National Nursing Research Unit 2012, p 2]

In the first instance, the duty applies to adult in-patient wards in acute hospitals only.

At the evidence session of the Health and Social Care Committee held on 29 January 2014, all the witnesses – RCN, BMA, NHS Confederation and the Chartered Society of Physiotherapy – agreed that whilst there is evidence about safe staffing levels in medical and surgical adult in-patient acute wards, there is as yet little evidence for staffing levels in other settings. The CNO concurs.

If the Bill is enacted, it would seem reasonable to implement this duty in a single setting first and evaluate its impact carefully before considering applying a similar duty to other settings.

Note that it is necessary to make the distinction between an acute ward and an acute hospital. Were the Bill to be enacted, it should be enacted for acute adult medical and surgical wards rather than acute hospitals since an acute hospital may also provide other, non-acute services. There is an opportunity to clarify this in the guidance to be issued, by defining the terms used, as is required by the Bill, or an amendment could be made to set out the definitions on the face of the Bill.

The requirement for the Welsh Government to issue guidance in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which

- **sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing (including methods set out in section 10A(6) inserted by section 2(1) of the Bill)?**

The Welsh Government already provides guidance to health service bodies, such as the CNO's Nurse Staffing Principles discussed above. Guidance has also been issued for the use and governance of the adult acuity tool for use in adult acute medical and surgical wards. Reports and other documents published by professional organisations are considered for application in Wales and often inform guidance that is produced.

- **includes provision to ensure that the minimum ratios are not applied as an upper limit?**

It is difficult to envisage any kind of mechanism that the Welsh Government could use that would prevent a mandatory minimum ratio from becoming a de facto maximum. As discussed above, the pressures and costs of complying with a mandatory ratio may divert resources so much that there is little opportunity to exceed the minimum level of staffing.

- **sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?**

It may be useful for patients to know the number and roles of staff on a ward, but listing each member of staff's responsibilities would be difficult to understand, unnecessary and time-consuming burden. Information on some of the matters covered by the Bill is already in the public domain through the 'My Local Health Service' website, such as levels of staff sickness and absence, and healthcare-acquired infections (at a Local Health Board level).

- **includes protections for certain activities and particular roles when staffing levels are being determined?**

The CNO's Nurse Staffing Principles already require a degree of uplift when working out the required levels of staff, in order to account for sickness absence, training and supernumerary staff such as the ward sister.

Teaching is a requirement of practice and enshrined in the nurses' registration with the Nursing and Midwifery Council, their regulator. Nurses mentor students and

others throughout the shift, sometimes for a short period while undertaking a task and sometimes for longer periods working though students' competency requirements.

Induction for temporary staff is vital and important, however to make a protection against the ratio is practically difficult. Often agency staff arrive on the shift and receives their induction during the handover period. This induction is already planned and delivered and does not require a protection.

Continuing professional development and mandatory training are undertaken using a variety of methods. Some will be away from the clinical area and some will be work-based learning. Some training is delivered by practice facilitators and university clinical lecturers.

To make a protection for these function would be potentially difficult to understand and implement and may not reflect the learning at work ethos we expect from the NHS in Wales.

The requirement for Welsh Ministers to review the operation and effectiveness of the Act as set out in section 3

The Bill lists a minimum of nine indicators, which the Welsh Ministers must consider when reviewing the operation and effectiveness of the Act. This is not an exhaustive list, so other indicators could be added at a later date.

However, there is little evidence that any of these indicators are indicative of safe nursing. For example, if a patient is discharged, slips on ice while walking down his garden path and is re-admitted, this incident has no connection with the nursing care he had previously received.

The NICE guidance on safe staffing published in 2014 is based on an extensive review of existing peer-reviewed research about the relationship between nursing levels and patient outcomes. The *Evidence Review 1* paper concludes that "no direct causal inference can be made from the observed associations." [University of Southampton 2014, p 6]

> "The evidence does not give strong support for the validity of any single outcome as an indicator of adequate nursing staff specifically. However, infections, falls, pressure ulcers, drug administration errors and missed care all remain plausible outcomes although they are potentially difficult to interpret and implement. [*ibid.* p 11]"
>
> "In relation to costs, evidence suggests that increases in nurse staffing and / or a richer skill mix have a potential to be cost-effective but the existing evidence is derived from observational studies in countries with very different contexts and cost bases to the UK and so cannot be used to directly estimate the consequences of change… The diverse evidence base in terms of contexts, outcomes, measures of staffing and methods of analysis renders any attempt to directly derive safe staffing levels that could apply to the NHS context from this research, premature. [*ibid.* p12]"
>
> "Determination of safe staffing levels needs to take into account ward case mix, acuity, dependency and patient turnover. Other factors may also

> influence staffing requirements including ward layout and size but the evidence is not strong. [*ibid.* p13]"

This NICE guidance based on this evidence recommends using the red flag system, coupled with professional judgement, to determine nursing staff requirements. NICE defines a "red flag event "as

> "…events that prompt an immediate response by the registered nurse in charge of the ward. The response may include allocating additional nursing staff to the ward or other appropriate responses. [NICE 2014, p39]"

These events include unplanned omission in providing patient medications; a delay of more than 30 minutes in providing pain relief; failure to assess or record patient vital signs as outlined in the care plan, and a delay or omission of regular checks. The Royal College of Physicians supports this approach.

Do you have a view on the effectiveness and impact of the existing guidance?

The CNO and Nurse Directors principles agreed in May 2012 have had a significant impact on nurse staffing levels. They have embraced best evidence in this area and allowed a narrative to be formulated at local level to inform the allocation of nurse staffing establishments. While progress to achieve such principles has been monitored it has always been considered as requiring a time frame in which movement towards compliance would be incremental. The additional monies announced by the Minister for Health and Social Services to support work in the area of hospital nurse staffing levels has aided that journey. The NHS in Wales can demonstrate where progress has been made, even in the difficult current market for registered nurses.

- Health Boards have continued to actively address nurse establishments in adult acute medical and surgical wards.
- All Health Boards have made significant improvements to the number of wards with more that 1.1 WTE nurse/support worker per bed, with some areas now reaching 100% compliance.
- All organisations have assurance frameworks and action plans to continue to ensure appropriate safe staffing levels.
- Skill mix has improved significantly with the majority of wards with a 60:40 registered nurse to support worker skill mix.
- Some areas have not managed to recruit to the establishments identified, and have had to consider their recruitment plans. This compounds the issue of trying to reach compliance due to current
- There has been an improvement in the number of their medical wards in respect of no more than 7 patients per nurse by up to 75% in some Health Boards.

All NICE guidance is issued specifically for health and care in England. However, the latest NICE guidance *Safe staffing for nursing in adult inpatient wards in acute hospitals* informs the Chief Nursing Officer's work. As discussed elsewhere, this

guidance does not prescribe a fixed staffing ratio. Existing guidance such as that for the acuity tool already incorporates much of the advice from NICE and the All Wales Professional Nurse Staffing Group (AWPNSG) is considering revising other guidance if it is thought necessary in light of the latest NICE guidance.

It is too early to tell what the impact has been of the NICE guidance in NHS England.

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Agenda Item 3

Evidence Paper

Health and Social Care Committee

Date: 5 March 2015
Time: 9:30 – 10:30
Venue: Senedd

Title: Safe Nurse Staffing (Wales) Bill

Purpose

To provide an evidence paper for the Health and Social Care Committee. The evidence paper provides additional evidence to support the paper provided by the Chief Nursing Officer.

In this evidence paper:

- "NHS in Wales" is used to refer to NHS local health boards and NHS trusts
- "acute ward" means medical and surgical adult in-patient acute wards
- "establishment" means the total number of staff allocated to work in a ward

General

The need for legislation to make provision about safe nurse staffing levels

1. The Welsh Government fully agrees with the need for safe staffing levels and already has a number of policy initiatives in place to achieve this aim for nursing and other professions, to improve the patient outcomes under existing powers.

2. In Wales the responsibility for determining a safe, appropriately skilled workforce lies with the Local Health Boards and NHS Trusts, since they have the statutory authority to respond to the needs of the population they serve.

3. The factors that support the decision making framework for safe staffing levels are complex and the 'All Wales Nurse Staffing Principles Guidance' was developed in recognition of that fact. The Welsh Government has deliberately never set mandatory minimum ratios of registered nurses to Healthcare Support Workers nor minimum numbers of staff per in-patient bed. However working together with Local Health Boards, these principles were agreed, along with the introduction of an acuity tool as an interim measure, pending the full validation of the acuity tool.

4. The adult acute acuity tool is robust and evidence based; it measures acuity and dependency of patients and helps determine the appropriate nursing establishment for the clinical area. Acuity describes how sick a patient is and dependency how much nursing care a patient requires. It is therefore a tool for forward planning rather than being designed for day to day rostering. The validation of the tool will be completed shortly and it will then be fully implemented across NHS Wales. Staff use a triangulated approach, which

includes the acuity tool, professional judgement and nurse-sensitive indicators to provide safe levels of staffing, which is a more responsive and effective approach than imposing rigidly-defined fixed staffing numbers.

5. Research highlights the importance of quality initiatives and sound evidence of the effectiveness of nurse staffing levels to be determined through quality patient outcomes/nurse-sensitive indicators. Transforming Care is an example of a quality initiative in Wales, introduced under the 1000 Lives improvement programme, which has reaped significant rewards in terms of ward organisation, management and quality patient care using patient outcomes/nurse sensitive indicators.

6. The Bill places undue emphasis on reporting against a list of indicators by the Welsh Ministers, overshadowing the responsibility of the NHS in Wales to ensure the provision of safe services, assess that provision and report upon it.

7. The existing tools and levers that the Welsh Government has deployed already go some way to satisfying the aims of the Bill, and could be further strengthened, for example by mandating the use of the acuity tool once it has been fully validated.

8. Subject to the Committee's recommendations, the Government's view is that legislation as introduced would require amendment in order to add value to the current policy direction.

Achieving the Bill's overall purpose

9. The Welsh Government does not intend to set any form of minimum ratios for the NHS in Wales as the evidence indicates that this area is far too complex to take such a reductionist approach. Working in partnership with NHS Wales, the Welsh Government has developed a triangulated approach for NHS organisations to implement, based on the use of the acuity tool, professional judgement and nurse-sensitive indicators.

10. The Bill focuses on only nurse staffing, whereas Welsh Government policy is to integrate care across the professions and the sectors. The Welsh Government has defined its health policy as a move towards an integrated health and social care framework, with patients' needs at the centre of service delivery, as evidenced in the Social Services and Well-being (Wales) Act 2014. This integrated approach requires multi-disciplinary and multi-professional working with each profession utilising their skills when the patient needs them, and seeks to eliminate unhelpful demarcations of different roles.

The barriers to implementing the provisions of the Bill

11. The reporting requirements for Welsh Government as set out in the Bill present a significant barrier because many of the existing reporting mechanisms are not currently aligned to these requirements, both in terms of the structure of the reporting mechanism and the frequency of reporting. The Explanatory

Memorandum does not explain clearly why there is considered to be the need for reports every two years. The Welsh Government considers it more cost effective and efficient to follow the three year planning cycle that Local Health Boards already use, so that the frequency of reporting appropriately responds to emerging patterns in data. The NHS planning framework which follows a three year cycle supports the development of Integrated Medium Term Plans which Local Health Boards and NHS Trusts are required to develop. The NHS Planning Framework simplifies and clarifies the planning requirements and process within NHS Wales. The Integrated Medium Term Plans contain information that support the calculation/assessment of staffing levels, but the data in its current format do not report on each of the indicators identified in section 3(5)(a) to (i) of the Bill.

12. Data collection to support reporting is currently driven through different management information systems within NHS Wales. As with other data collection systems, to report accurately on the Bill, the existing data collection would not only require significant modification, it would also need quality assurance from hospital ward level and upwards.

13. The Explanatory Memorandum, paragraph 220, acknowledges evidence from the Royal College of Nursing that the ICT systems in Local Health Boards are not identical, but nonetheless suggests that these systems would not need to change in order to implement the Bill. The Welsh Government considers that a full impact assessment would need to be carried out on the existing systems because these systems were not designed to report on the indicators set out in the Bill requirements; rather they are for the collection of patient information or other aims. The assessment would need to identify how to ensure that data were collected at ward level, were consistent, quality assured and fully triangulated to the indicators set out in s3(5). However this is not just a matter of gathering and reporting information; there is a wider issue of analysing the data to make sense of it. The systems available in the NHS are not designed or intended to support the kind of fine-grained analysis that would be required, nor are there currently experts in place either in Local Health Boards or Welsh Government to make sense of the raw data for the purpose of the Bill.

14. Careful and detailed analysis of data gathered would need to be undertaken to understand any causal link between the patient outcome information and the nurse staffing level. Given the absence of evidence base to substantiate any direct causal links of nurse staffing to the listed patient outcome indicators, this analysis would need to establish such an evidence base in order to have validity. For example a patient may be cared for in hospital and on discharge may have an injury or a different illness that requires readmission. It would be entirely wrong to link the staffing levels on one or more wards from the initial admission to the cause of the readmission. It would be wrong to suggest that hospital acquired infections can be solely linked to nurse staffing when the reality is there are many factors that needs to be considered, such as: antibiotic prescribing, competence of staff in infection prevention measures; hand hygiene of all staff; introduction of infection by visitors; cleanliness of the clinical area; availability and competence of cleaning staff; layout and maintenance of the clinical area.

Unintended consequences arising from the Bill

15. Some of the unintended consequences arising from the Bill are:

16. The Welsh Government's Prudent Healthcare initiative, introduced in 2014, aims to minimise avoidable harm; carry out the minimum appropriate intervention and promote equity between the people who provide and use services. As a result, some existing services will need to be reconfigured to the new requirements. A mandatory nurse staffing ratio could hinder these developments, as it creates an inflexible set number for staff that does not allow for role development and the contribution of other professionals to patient care on the ward.

17. The demand for registered nurses increased following the adoption of the Chief Nursing Officer and Nurse Director Principles and the associated funding announced to support the work of nurse staffing in adult acute hospital wards. One way to mitigate the impact of meeting a mandatory level of staffing that is not achievable due to difficulties in recruitment, could be bed closures, thus reducing capacity in the acute setting.

18. Where there is an increased demand for registered nurses the effect of this demand will mean that care homes will need to compete to recruit and retain their nursing staff as well. Following a White Paper consultation on the Regulation and Inspection of Social Care in Wales, the Welsh Government has prepared a Bill which will be introduced to the Assembly on the 23 February 2015. The Regulation and Inspection of Social Care (Wales) Bill will propose a new requirement for local authorities and Welsh Ministers to consider and publish reports on the stability of the care sector, in the present and in the future, which will include staffing information, and may be used to help mitigate against this unintended consequence of the Bill.

19. As this Bill is only focussed on nurse staffing, one consequence may be that NHS organisations will pull resources to fund other staff, such as cleaners to fund the mandatory minimum ratio or nurses. This may result in pressures on nurses to carryout non nursing duties. Similarly as the Bill is only focused on adult acute hospitals, one consequence may be that resources of registered nurses will be pulled away from other settings to satisfy the statutory requirement.

20. The Bill makes no mention of grade/experience mix in its requirements; it merely focusses on nurse numbers. Therefore a consequence may mean a bias towards recruiting junior nurses rather than more senior nurses with enhanced and advanced skills as they may be deemed as too expensive. This lower level of experience and competence within the nursing team will have a material impact on the quality of patient care.

Provisions in the Bill

The duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided under section 10A(1)(a)

21. NHS Wales has a legal framework and governance structure in place to ensure that all health service bodies meet the obligations and duties placed upon them. There are also non legislative support mechanisms in place such as the e-governance manual which supports NHS organisations in defining, implementing and maintaining their governance arrangements. It provides direction, guidance and support to Board members and NHS staff to enable them to fulfil their own responsibilities and ensure their organisations meet the standards of good governance set for the NHS in Wales.

Duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios

22. Evidence has been used to inform the work in Wales to adopt the triangulated methodology approach to setting staff levels, which challenges the effectiveness of using a 'minimum' ratio. It is the Welsh Government's deliberate decision not to set minimum ratios for nurse staffing levels as this is not considered to be workable or an efficient use of resources.

23. Requiring minimum ratios of nurses to patients and nurses to healthcare support workers is a very inflexible and impracticable approach which fails to take into account the way in which the NHS operates on a day to day basis. This view is supported in the latest NICE guidance, *Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals* published in 2014.

24. The Health and Social Services Committee has received a copy of the *Fundamentals of Care System User Guide: Adult Acute Nursing Acuity & Dependency Tool*. It includes care quality indicators that can be linked to nurse staffing issues, such as leadership, establishment levels, skill-mix and training and development of staff, for use at a local level. This information can be used together with the acuity and dependency information to help determine local ward staffing requirements.

Duty under section 10A (1) (b) which applies to adult inpatient wards in acute hospitals only

25. If the Bill is enacted, the Welsh Government considers it appropriate to implement this duty in a single setting first and evaluate its impact carefully before considering applying a similar duty to other settings.

26. However, there needs to be a distinction between an acute ward and an acute hospital. Were the Bill to be enacted, it should be enacted for acute adult medical and surgical wards, rather than acute hospitals, as an acute hospital may also provide other, non-acute services. There is an opportunity to clarify this in

the guidance to be issued, by defining the terms used, as is required by the Bill, or an amendment could be made to set out these key definitions on the face of the Bill, which is the preferred option of the Welsh Government.

Guidance to be issued by Welsh Ministers to include provision about the publication to patients of information on the numbers, roles and responsibilities of nursing staff on duty under section 10A(5)(g)

27. The Welsh Government already makes data available to patients through My Local Health Service. This is a website specifically designed for the transparent communication of data on the performance of the NHS in Wales, so that the public are kept informed and are able to prompt and recognise improvement. The site uses intuitive graphs and charts and detailed explanations to present NHS Wales quality and safety data from health boards, hospitals and primary care.

28. The website currently publishes data at a local acute hospital level on a suite of mortality rate indicators, and at Local Health Board Level on hospital-acquired infections and staff sickness levels. The website also publishes data on the number of nurses per available bed, stating that "*in the light of recent reports, it seems clear that the level of nursing staff on wards is important in ensuring that the right quality of care can be provided for patients. The Welsh NHS is accordingly giving closer attention to this matter. Work is in hand on developing a revised calculator* (i.e. the adult acute medical and surgical in patient acuity tool) *to help ensure that staffing levels match the needs of patients on acute hospitals wards*."

29. The Welsh Government considers that when prescribing (through guidance), the publication requirements for compliance with the duty under 10A (1) (b), it is important that the information is meaningful for patients and families. Information on 'quality experience measures' for example, would be far more relevant to patients as a means of quality assurance.

The requirement for Welsh Ministers to consult before issuing guidance section 10A (8) inserted by section 2(1)

30. It is standard policy for the Welsh Government to consult with stakeholders and citizens before issuing new guidance. Consultation helps the Welsh Government to understand how a law, policy or guidance might affect the people of Wales. It also helps to find out their views and citizen input helps to improve ideas and shape work to make policies more effective.

31. When a new consultation is launched, the Welsh Government makes the relevant documents available to organisations and individuals with an interest in the area of consultation.

The monitoring requirements set out in 10A (9) inserted by section 2(1)

32. Section 10A (9) the Bill suggests that the NHS Delivery Framework could be suitable for the purpose of monitoring the Bill. The NHS Delivery Framework provides clarity about delivery priorities and is aligned with Ministerial policy and

the need to drive up standards and outcomes. However, the Framework in its current form does not meet the monitoring requirements set out in the Bill, and would therefore need significant adaptation to be fit for such a purpose.

The requirement for each health service body to publish an annual report under section 10A (10)

33. It is presumed that the obligations on Welsh Ministers to report on the review of the Bill at section 3 must be based on the requirements for Local Health Boards and NHS Trusts to publish their own annual reports (10A(10)). However, for such a reporting regime to be workable in practice, it would need to be aligned to existing reporting systems and cycles which already in operation. Currently they all relate to an annual cycle, with the main Annual Report being published and presented at an Annual General Meeting before the end of September each year.

34. Section 10A(10) has a mixture of reporting and planning obligations that would, under standard Local Health Board business, be discharged by different publications, either through their Annual Report or through an Integrated Medium Term Plan. Both are annual cycles but different, the former to be completed by end of September after the end of each financial year and the latter before the end of March following the next planning period.

35. Any new reporting requirement which a Local Health Board could not incorporate into existing reporting and publication systems would necessitate additional workload and costs, diverting resources away from patient care. Additionally, separate new reporting requirements on one group of clinical staff potentially consolidates a silo approach to staffing and is against the general direction of both integrated multidisciplinary services and integrated reporting.

Requirement for Welsh Ministers to review the operation and effectiveness of the Act under section 3

36. The Explanatory Memorandum suggests a number of existing vehicles for reporting on the operation and effectiveness of the Bill to help minimise the administrative burdens of health service bodies. These include the NHS Delivery Framework and the Annual Quality Statement. However, these methods of reporting do not align fully with the requirements in section 3 of the Bill and would therefore need to be adapted. For example:

    - The NHS Delivery Framework sets out the processes in place to monitor progress and provide support and intervention as necessary. Allocation and use of resources (staff and finance) is one of the areas covered by the framework. This platform is currently not being used for public reporting, but does capture the data to support the indicators set out in 3(5), with the exception of overtime and agency/bank nursing. The data are not currently provided to Welsh Government at ward level, with the majority (but not all) of data being reported at hospital level for major acute sites. To meet the reporting requirements of section 3 of the Bill, additional data would need to be collected and would need to drill down to ward level, which would be costly and resource intensive.

- The Annual Quality Statement is designed to outline progress by health boards and other NHS organisations by comparing data and patient feedback to previous years. It is published by Local Health Boards in ways adapted to local circumstances and does not have a statutory footing. It would not therefore offer a suitable framework to report progress against this Bill.

- The NHS Planning Framework is the mechanism by which Health Boards and Trusts respond to day to day pressures without losing sight of how they plan to align key services, staff, finance and the public to delivering the outcomes intended for the populations they serve over a medium term (three year) time frame. The existing template for the Integrated Medium Term Plans that are produced by Local Health Boards already includes information such as the overall change in nursing levels and recruitment difficulties. It is possible that the template could be adapted further to capture information that will track the progress of a Local Health Board in terms of achieving the aims of the Bill, but this would require a significant change to the framework which would again incur further costs.

37. The Welsh Government is moving towards an NHS Outcomes Framework as a method of measuring performance. The NHS Wales Outcomes Framework 2015/16 will demonstrate the annual improvement in the health and wellbeing of the citizens in Wales. It is a set of outcomes and indicators for the population of Wales supported by the NHS Delivery Framework as set of measures identified to focus NHS delivery in year. The aims of the Outcomes Framework are to:

    - Determine the NHS' success in planning and delivering quality safe care;
    - Determine the NHS' success in planning and delivering services to support the public to achieve and maintain health and wellbeing and;
    - Be the foundation for the future direction of health and care for Welsh Government, the NHS and the public.

38. The Outcomes Framework will be measured annually and reported at an all Wales level, and broken down to individual health board/trust level as appropriate. The NHS Outcomes and Delivery Framework will allow better reporting by exception and will use a range of different indicators that could be assessed to identify 'trigger points of concern' which would require further attention and review, part of which would include an assessment of nurse staffing levels.

39. The Bill as currently drafted requires Welsh Ministers to include progress against a list of indicators at section 3(5). This relies on a number of management information systems at various levels which may not be consistent, requiring the need to undertake a full assessment to establish an alignment of information and quality assurance. The causal link between these indicators and safe nurse staffing levels also remains a central concern.

Frequency of reporting

40. Many of the mechanisms for reporting are on an annual basis, rather than every two years as specified in the Bill. If a new reporting mechanism were to be developed and set to report every two years, it would not be consistent with other planning and reporting cycles. The Welsh Government considers that the NHS Planning Framework may potentially offer an appropriate fit for Local Health Boards to prepare to demonstrate compliance with the Bill as part of a rolling three year planning cycle, if the Bill's requirements were amended, for the following reasons:

    - Local Health Boards and Trusts could have a lead in period to become fully compliant with the requirements in the Bill after guidance is published.

    - Integrated Medium Term Plans already include data on nursing levels to support planning over a three year rolling period, which will also reflect how an Local Health Board is preparing and planning for compliance with the Bill

    - It would allow for a lead in time to develop and implement new guidance, similar to the existing guidance 'All Wales Nurse Staffing Principles Guidance' that used a three year introductory phase.

41. The NHS Planning Framework could accommodate both a lead in period for Local Health Boards to familiarise themselves with the guidance requirements, and feature as part of the longer term data collection to support a modified reporting mechanism.

Impact of existing guidance

Existing Guidance

42. The Explanatory Memorandum recognises the £10 million funding issued to Local Health Boards to enhance medical and surgical hospital nurse staffing introduced in July 2013 on a recurrent basis. The funding was allocated based on the needs of the population, using the Townsend formula. This is exactly how safe staffing needs to be determined, by the Local Health Boards and NHS Trusts, in order that they can take into account of changing circumstances when and as the arise.

43. The Explanatory Memorandum sets out some of the impact of the CNO principles on nurse staffing levels. Paragraph 174 on page 40 states "*The introduction of the national principles has led to an improving picture for nurse staffing levels across adult acute in-patient wards in NHS Wales. The principles included a requirement of 1:7 registered nurse to patient ratio by day; the majority of areas now comply with this."* The CNO's principles are an interim measure to be used until the acuity and dependency tool can be fully implemented and do not mandate a staffing ratio.

44. The CNO and Nurse Directors principles agreed in May 2012 have had a significant impact on nurse staffing levels. They have embraced best evidence in this area and allowed an approach to be formulated at local level to inform the

allocation of nurse staffing establishments. While progress to achieve such principles has been monitored, it has always been considered as requiring a time frame in which movement towards compliance would be incremental. The additional monies announced to support work in the area of hospital nurse staffing levels has aided that journey. The NHS in Wales can demonstrate where progress has been made, even in the difficult current market for registered nurses.

- Local Health Boards have continued actively to address nurse establishments in adult acute medical and surgical wards.
- All Local Health Boards have made significant improvements to the number of wards with more that 1.1 WTE nurse/support worker per bed, with some areas now reaching 100% compliance.
- All organisations have assurance frameworks and action plans to continue to ensure appropriate safe staffing levels.
- The skill mix of nurses has improved significantly with the majority of wards with a 60:40 registered nurse to support worker skill mix.
- There has been an improvement in the number of their medical wards in respect of no more than seven patients per nurse by up to 75% in some Local Health Boards

45. The latest NICE guidance entitled *safe staffing for nursing in adult inpatient wards in acute hospitals* informs the Chief Nursing Officer's work. This guidance does not prescribe a fixed staffing ratio. In the accompanying *Frequently Asked Questions* document, NICE states

    ""The Safe Staffing Advisory Committee reviewed the best available evidence and concluded there is no single nursing staff to patient ratio that can be safely applied across the wide range of acute adult in-patient wards in the NHS."

    The existing guidance issued with the Wales acuity tool already incorporates much of the advice from NICE.

46. It is too early to tell what the impact has been of the NICE guidance in NHS England.

Powers to make subordinate legislation and guidance

47. The Welsh Government considers that the affirmative procedure is appropriate for the powers to make subordinate legislation at section 10A (3) to extend the application of the duty to maintain minimum staff ratios to other settings. Extending this duty could have a substantial impact upon the NHS in terms of staff resources and administration/operational costs, and thorough consideration would need to be given as to how any such duty could work in practical terms within the particular characteristics of the NHS in Wales.

48. The Welsh Government has no plans to bring forward any subordinate legislation under these powers for the foreseeable future and would want to

review how effective the Bill was in acute medical and surgical settings before applying it to other settings, if evidence supported the need.

Financial Implications

Start up costs

New guidance or the revision of guidance to reflect the provisions in the Bill

49. The estimated one off cost in the Explanatory Memorandum for the revision and communication of guidance over a three month period is £45,000. The information to support this amount draws on an estimated amount used for the NHS Finance (Wales) Act 2014, whereby guidance was updated to reflect moving from a one-year financial duty to a three-year rolling financial duty, and was issued to Local Health Boards only.

50. However, the guidance proposed under the Bill would be far more complex to produce. There would be a need to draw together guidance based on best practice and robust evidence. The Explanatory Memorandum states that the "*Welsh Government must issue guidance, which must be consulted upon with experts and those organisations that will be impacted upon by this guidance*". Therefore the guidance will need to be developed with stakeholder, lay and expert input. This is a significant change from the current guidance that supports the adult acute in-patient acuity tool, which is a 'how to' guide.

51. The Explanatory Memorandum states that "*the intention of this Bill is that the statutory guidance will be based on the guidance issued by the Chief Nursing Officer, involving the use of existing validated acuity and dependency workforce planning tools and also professional judgement*". However, this triangulated approach does not allow for the setting of a minimum ratio. The current triangulated approach allows for a local contextual flexibility. It is not described in the *Fundamentals of Care System User Guide Adult Acute Nursing Acuity & Dependency Tool* as this does not set a minimum ratio for staff numbers. If a fixed staffing ratio is set, the guidance would require more detail and explanation than the current documents. For this reason, the model adopted by NICE seems appropriate, where the literature is reviewed and a panel determines the content of the guidance. Such guidance could include recommendations on safe staffing for nursing in adult inpatient wards in acute hospitals, based on the best available evidence. It would also identify the organisational and managerial factors necessary to support safe staffing for nursing, and appropriate methods to measure compliance with the guidance.

52. The requirement for the guidance to "*include provision for ensuring that the recommended minimum ratios are not applied as an upper limit in practice*" introduces a new concept that is not included in the existing guidance. There is no evidence base in the literature of a method or approach to do this, and therefore this aspect of the guidance would require further work. It is not possible to cost this without significant analysis.

Changes to IT systems for the purpose of reporting

53. The Explanatory Memorandum does not recognise any additional costs associated with the reporting requirement against the list of indicators described in section 3(5) (a) – (i) of the Bill. It suggests that there will be no additional costs in terms of ICT administration for the implementation of this section.

54. Many of the indicators in section 3(5) (a-i) are available at hospital or Local Health Board level. They are Local Health Board management information, held by the NHS Wales Informatics Service (NWIS).

55. An initial consultation with the NHS in Wales about the availability of the indicators at ward-level shows the differences in how each organisation collects and processes the data that would needed to provide these indicators.

- One Local Health Board collects all of the indicator data at ward-level, although their data about patient and public satisfaction with services are collected using a paper-based system.
- Two Local Health Boards collect most of the indicator data at ward-level, but not mortality rates, readmission rates or hospital-acquired infections.
- One Local Health Board collects most of the indicator data at ward-level, but not mortality rates or readmission rates.
- One Local Health Board collects data at ward level for readmission rates, hospital-acquired infections and number and severity of hospital-acquired pressure ulcers, but not the other indicators. The Local Health Board commented that such information "isn't all available at ward level. Some is, some is only available by service area and is collected in different ways and with different systems."

56. Collecting all of the indicators at ward-level would impose a considerable burden on the NHS in Wales in terms of staff resource to adapt NWIS systems to receive ward-level data, to input the additional data and to generate and analyse reports based on these data.

Data Collection

57. The Explanatory Memorandum (paragraph 218) states that Local Health Boards have data management systems at ward level, but this is not the case for all of the indicators, as discussed above in paragraph 57.

58. Local Health Board staff have also confirmed that the existing IT systems cannot produce a report which integrates the indicators listed in section 3(5) (a) – (i) of the Bill into a single report.

ICT changes

59. Currently there is no single information solution that has been specified to collect all the data required for the indicators listed in section 3(5) (a-i) of the Bill **at ward-level** and collate them into a single report. It would therefore be necessary to carry out scoping and development work to create any new information

sources. This could involve the design and construction of a dedicated database to hold these data; the modification of existing NHS IT systems, and processes to quality assure the data fed into any new solutions by Local Health Boards. An analysis would need to be undertaken to consider the information requirements and the best way of meeting them. Without such an analysis, it is very difficult to estimate the costs of establishing a solution that will generate the information required to monitor the indicators.

60. Also, it will be important to consider any other factors that may affect progress against the indicators, not just nurse staffing levels.

Impact on the workforce

61. A mandatory ratio is likely to have an impact on the nursing workforce; however, it is not possible to estimate the cost of this impact. Local Health Boards put forward the number of nurses to be trained every year, based on their requirements to fulfil the health needs of their population. The Welsh Government can not anticipate the nursing levels required by Local Health Board nor the numbers of registered nurses available to the Welsh NHS. It is therefore not possible to estimate a cost.

On-going costs

Review of guidance after the first year and every two years thereafter

62. The Welsh Government agrees with the estimated review costs set out in the Explanatory Memorandum of £37,500 over a five year period. However, even though the guidance will be reviewed every two years, in light of the current fast - changing environment in the NHS in Wales, is likely that a major review of the guidance would be required after the first five years. This change environment includes the implementation of the regional service reconfiguration plans, the adoption of prudent healthcare principles, developing new advance practice roles and the introduction of a new Primary Care Plan as well as change in other areas. Therefore the workforce and roles of today's staffing requirements are likely to look very different in the next five years. This guidance must prescribe set ratios that need to ensure they consider these changes as well as reflecting the ever increasing evidence base in this area. A major review is considered likely. Again the method proposed to undertake would be the model used by NICE, which draws on additional expertise and utilises the most recent evidence from a Welsh NHS context. Further expenditure would be incurred if the Welsh Government followed this anticipated approach.

Welsh Ministers to publish a report of the operation and effectiveness of the Act

63. The Explanatory Memorandum does not recognise a cost for Welsh Government in terms of reporting. It assumes that the NHS Delivery Framework or Annual Quality Statement can be used as a mechanism for reporting in paragraphs 223 and 224.

64. The Welsh Government is preparing to launch the NHS Outcome Framework supported by the Annual Quality Delivery Framework in March 2015. The purpose of both the NHS Outcomes Framework and the Quality Delivery Framework is to measure delivery across a wider area than just the acute hospitals to reflect the structure and accountability of the Local Health Boards. It starts to focus on health and well being across the whole of the NHS and wider partners. The NHS will work to the Outcomes and Quality Delivery Framework from April 2015. The NHS Delivery Framework includes reporting on some of the indicators listed in section 3(5) (a) – (i) of the Bill to some extent namely mortality indicators, readmission rates for chronic conditions, healthcare acquired infections, pressure ulcers (just the number), patient and public satisfaction, and sickness absence . It may be possible to modify the NHS Outcomes Framework to publish information about the other indicators, but quality-assuring the data and generating a report in the required format will still require extra investment and resource.

65. As already explained in this evidence paper, there are a number of planning and reporting mechanisms that could potentially be used to report on the operation and effectiveness of the Bill. However, each mechanism does not reflect entirely the requirements in section 3(5). Costs would need to be identified to either modify an existing reporting mechanism or create a new reporting platform to meet the duty to report as currently drafted. The ongoing costs would further increase if the reporting mechanism was modified to take into account new settings prescribed by regulation in section 10A (3).

Points of clarification requested by the Health & Social Care Committee in respect of the written evidence provided by the Minister for Health and Social Services.

Paragraph 7: The existing tools and levers that the Welsh Government has deployed already go some way to satisfying the aims of the Bill, and could be further strengthened, for example by mandating the use of the acuity tool once it has been fully validated. **Could you clarify how this would be mandated?**

Answer

The Minister could use his powers of direction as set out in the National Health Service (Wales) Act 2006 section 12, to direct a Local Health Board to use the Adult Acuity Tool. The Local Health Boards would then be under a statutory duty to comply with these directions and would not be free to use their own discretion to decide whether or not to follow these.

Paragraph 43: The CNO's principles are an interim measure to be used until the acuity and dependency tool can be fully implemented and do not mandate a staffing ratio. **Could you clarify that what the word 'mandated' means in this context given that paragraph 2 of the Welsh Government's Adult Acute Nursing Acuity & Dependency Tool Governance Framework (May 2014) states that 'in April 2012 CNO presented the Nurse Staffing Principles Guidance to the Chief Executive Forum, after which the Guidance was issued with an expectation that each Trust/Health Board would work towards implementation of the Principles in all adult acute in-patient wards'?**

Answer

The word 'mandate' in paragraph 43 is not being used in the context of the governance arrangements for utilising the adult acuity tool; here the term is used to highlight the fact that the ratio is a recommended starting consideration and is not a compulsory requirement in itself.

While the CNO & Nurse Director principles include the principle of a ratio of 1:7 nurse to patients, this is only a guiding figure to assist local considerations of nurse staffing levels. Locally, the triangulated methodology will be used to assess staffing needs on an ongoing basis, utilising an evidence based tool (once fully validated), professional judgement and nurse sensitive indicators jointly to make that assessment.

Agenda Item 6

Document is Restricted

Document is Restricted

Agenda Item 7

Document is Restricted

WELSH AMBULANCE SERVICE NHS TRUST – Evidence to Health and Social Care Committee: March 5, 2015

1. Introduction

1.1. The role of the Welsh Ambulance Service is to provide high quality pre-hospital and emergency care to the people of Wales. The Service is focused on delivering a clinically-led model of care, with a remit which extends beyond the traditional "transport" model of services to one which is firmly rooted in the overall unscheduled care system in Wales.

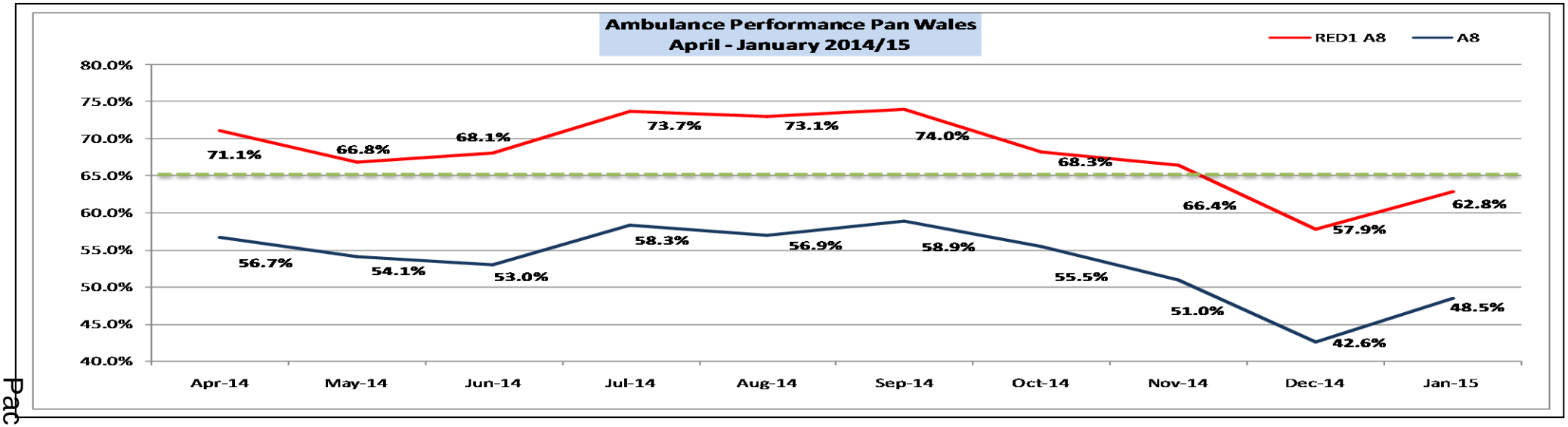
2. Background

2.1. There is much scrutiny currently of the Ambulance Service's performance, particularly in terms of its compliance with the primary A8 target, which requires that 65% of arrivals on scene to the most serious 999 calls are within eight minutes. The most recent validated data available at the time of writing (January 2015) puts current performance at some 48.5% against the 65% target.

2.2. However, it is important to note that response to the most critical and immediately life-threatening calls, which are categorised as RED 1 calls, was 62.8% in the same period; the Welsh Ambulance Service's total A8 performance comprises an aggregation of performance on RED 1 and RED 2 (the next most urgent category) calls.

2.3. Table 1 below shows the trajectory of performance against the primary A8 target in the current financial year and in terms of RED 1 performance over the same period.

Table 1



3. Drivers Influencing Performance

3.1. In considering the Service's current performance, it is important to put it into the context of the overall unscheduled care system and the changing societal, demographic and financial landscape in which the Service is operating. In brief, these drivers can be summarised under the three headings of demand, supply and finance.

4. Demand

4.1. Overall demand on the Emergency Medical Service (EMS) has risen by 3% year-on-year

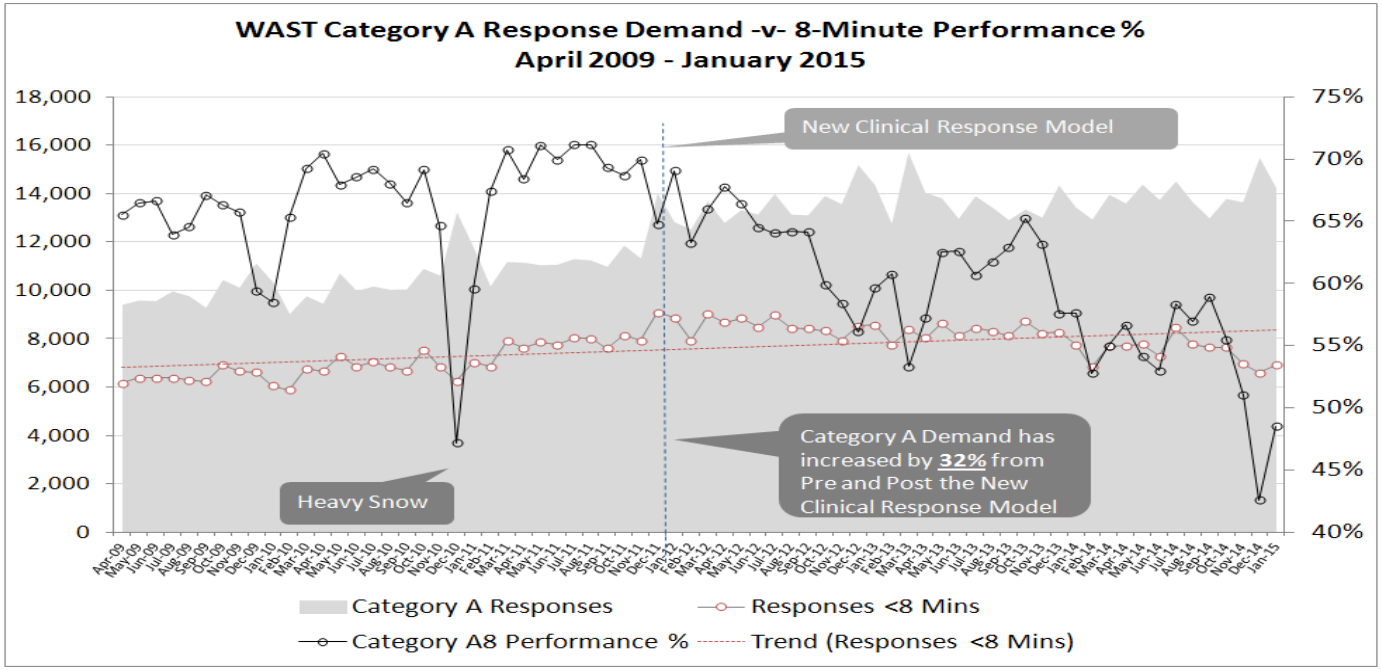
4.2. Patient Demography has altered: the frail/elderly population now accounts for 50% of all ambulance requests

4.3. Health needs are changing: ambulance requests from elderly frequent callers has increased by 253% in 7 years

4.4. There has been a change in public expectation, evidenced by increased demand on the full suite of emergency services

4.5. Table 2 demonstrates that, between April 2010 and December 2011, WAST consistently hit its A8 performance target and, in most cases, performed better than 65%. In December 2011, the Trust changed its clinical response model (CRM) for sound clinical reasons. The CRM is the method by which incoming 999 calls are prioritised. Prior to the change, only the public 999 calls counted towards the 65% target; after the change, both the public 999 calls and relevant (RED1 & RED2 incidents) Health Care Professional (HCP) calls were included within the target. This led to an increase of 32% in Category A incidents requiring an eight minute response and had the effect of destabilising the ambulance deployment model. As can be seen from the graph, there is a very clear correlation between the implementation of the changed CRM and performance against the A8 target.

Table 2

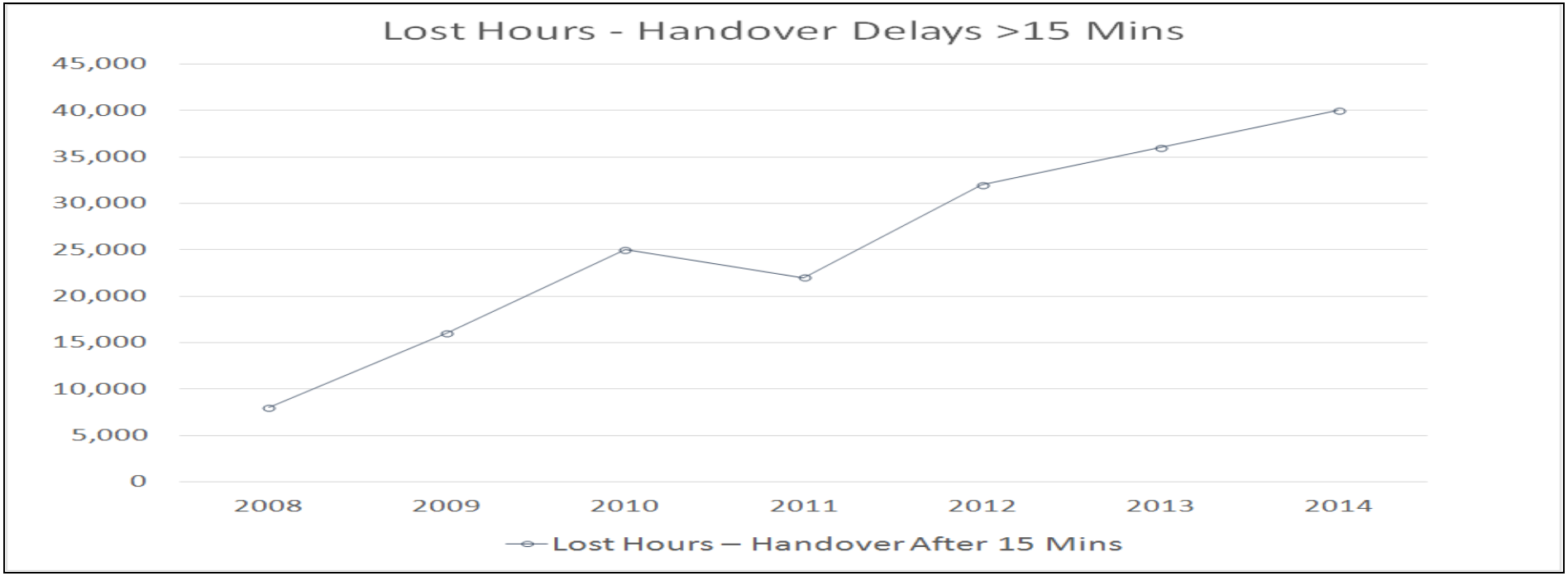


5. Supply

5.1. Pressures on the whole unscheduled care system have sometimes led to significant handover delays at emergency units. This presents risks to patients waiting in vehicles and also removes ambulance resources from the community, which presents an arguably greater risk to those “patients” in the community for whom we have no resource available.

5.2. Table 3 below demonstrates how, as the pressures in the unscheduled care system in Wales have increased, the delays in handover have also increased.

Table 3



5.3. While there is generally a clear correlation between handover delay and performance against the A8 target in discrete LHB areas, this is not always the case. For example, in the Cwm Taf UHB area, handover is consistently the best in Wales but performance is regularly very poor, a function of available resources being “pulled out” of the area to support those neighbouring areas where handover delays are acute, resulting in depleted ambulance resources in those neighbouring communities. The Welsh Ambulance Service, working closely with health board colleagues, is addressing these issues, with a whole system improvement approach being introduced in the Cwm Taf area by April 1, 2015 at the latest.

5.4. Workforce numbers have remained fairly static over the last four years. While there has been some internal skill-mixing, e.g. the development of the advanced paramedic practitioner, there is more work to do to enable and develop the workforce to provide the type of care now needed to meet current and projected future demand. Recent investment in recruitment will pay dividends in this respect, as will a welcome increase in paramedic training numbers.

5.5. Attendance levels have deteriorated. There are multiple factors for this, including an ageing workforce, significant occupational stress and a turbulent/unstable organisational culture. The Interim Chief Executive is bringing a sharpened focus to workforce issues, including relationships with the Trades Unions, engagement and roster planning to support improvement in this critical area.

6. Finance

6.1. While the Welsh Ambulance Service has traditionally broken-even financially each year, this has been achieved with increasing levels of significant non-recurrent support from Welsh Government, Commissioners, non recurrent savings and internal financial recovery measures.

6.2. Such financial instability makes planning effectively more difficult and, while significant additional in-year funding in 2014/15 is welcome and reflects the impact of additional demands on the service, the Trust recognises that its Integrated Medium Term Plan (IMTP) needs a full financial analysis and subsequent financial plan which will allow the organisation to operate on a more sustainable financial footing. The analysis will identify the consistent underlying financial challenge which the organisation faces.

6.3. While commissioning arrangements are new and maturing, the development of a collaborative Commissioning, Quality and Delivery Framework will have a positive impact in supporting a more stable financial planning process in the future.

7. Current Organisational Priorities

7.1. The Ambulance Service is entering a period of significant and accelerated change – it needs to stabilise and re-orientate, with a focus on sustained performance improvement.

7.2. The Trust's Strategic Transformation Programme is making progress and updates are regularly provided to Welsh Government. Similarly, the Trust's Integrated Medium Term Plan will provide a focus for longer term, sustainable change.

7.3. The past six months have seen a very clear focus on securing an accurate diagnosis of the organisation, its performance and what needs to be done, both internally and with partners across the healthcare system, to improve matters. At the heart of this have been a number of priorities including:

- Supporting our workforce to improve performance, for example by improving relationships with Trades Unions, investing in the workforce in key pinch-point areas (currently a major recruitment drive in South East Wales), improved roster planning to align better capacity with demand, a concerted effort to reduce absence, improving morale by working with staff to find solutions to the challenges faced and agreeing in partnership a set of critical workforce policies, to improve performance, safety and working conditions for staff
- Building organisational capacity with a clear clinical focus to drive forward improvement in performance, for example using clinicians in our Clinical Control Centres to provide enhanced clinical triage of calls, introducing "Paramedic Pathfinder" which provides support for clinical decision-making at the frontline and adopting a whole system approach to improve performance in discrete areas, for example in the Cwm Taf UHB area.

8. Organisational Ambition

8.1 There is a very clear understanding within the Welsh Ambulance Services NHS Trust that sustained improved performance must be achieved and that status quo is not an option. 2015/16 will be a critical year in driving improvement, predicated on:

- The introduction of a revised clinical model
- The adoption of the CareMore five step model/ambulance pathway via the Trust's Integrated Medium Term Plan
- A programme of public education in partnership with health boards and other agencies to inform, educate and reduce demand
- Being a significant partner in (if not hosting of) the new 111 service

- Consolidating relationships with commissioners and the Ambulance Commissioner to ensure smooth relationships and a shared understanding of capacity, demand and future model of care
- Being a strengthened and refreshed organisation which is responsive to change, innovative and pro-active in driving sustainable improvement

9. Concluding Remarks

9.1 While recognising that the Welsh Ambulance Service has been through a turbulent and challenging few years, it is important that both the workforce and, importantly, the people of Wales, can have confidence in the service and its performance.

9.2 This will require relentless focus, pace and discipline, which the Board of the Welsh Ambulance Services NHS Trust is committed to providing, predicated on a shared vision of the future which has been developed collaboratively with the organisation's stakeholders and which positions the service firmly at the heart of the unscheduled care system in Wales.

Y Pwyllgor Deisebau
Petitions Committee

Mark Drakeford AM
Minister for Health and Social Services
Welsh Government
Tŷ Hywel
Cardiff Bay
CF99 1NA

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

Our ref: P-04-**625**

26 February 2015

Petition title: P-04-625 Support for Safe Nursing Staffing Levels (Wales) Bill

Dear Mark

The Petitions Committee has received the following petition from Richard Jones MBE, which is currently collecting signatures:

Petition wording
We the undersigned call upon Members of the National Assembly for Wales Health and Social Care Committee to vote in favour of the Safe Nursing Staffing Levels (Wales) Bill once it is introduced into the Assembly.

Additional Information
Kirsty Williams AM is soon going to be introducing the Safe Nurse Staffing Levels (Wales) Bill into the National Assembly for Wales. This bill would enshrine in law Chief Nursing Officer in Wales' core principles regarding staffing levels on all medical and surgical wards. The Royal College of Nursing believes that this piece of legislation is necessary to improve patient safety and will help to restore patients faith in the Welsh NHS as well as ensuring that patients in hospitals in Wales receive the nursing care and attention they need and deserve and allows Nurses to be able to deliver care to the standard that they are trained and want to deliver.

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E-bost / Email: SeneddDeisebau@Cynulliad.Cymru / SeneddPetitions@Assembly.Wales

In advance of our first consideration of this petition the Committee would like to seek your views on the issues raised.

Please forward your response to the Clerking Team at

SeneddPetitions@assembly.wales

A copy of this letter has been sent to the Health and Social Services Committee for information as they are currently undertaking Stage 1 scrutiny of the Safe Nurse Staffing Levels (Wales) Bill.

Yours sincerely

William Powell

William Powell AC / AM
Cadeirydd / Chair

Y Gwasanaeth Ymchwil | Research Service

Safe Nurse Staffing Levels (Wales) Bill

Y Pwyllgor Iechyd a Gofal Cymdeithasol
Health and Social Care Committee

Summary of evidence received from the Royal College of Nursing campaign

1. Background

The Royal College of Nursing has undertaken a campaign in support of the *Safe Nurse Staffing Levels (Wales) Bill.* As a result, the Committee has received e-mail and postcards from nurses and patients.

A total of 315 responses were submitted to the Committee: 283 by e-mail and 32 hard copy postcards. All those who submitted hard copies identified themselves as being members of the Royal College of Nursing. The following is an approximate breakdown by category of respondent:

- 75 per cent from nurses;
- 10 per cent from patients;
- 8 per cent from other medical staff (healthcare support workers; doctors, pharmacists, and a consultant);
- 3 per cent from other staff (administrative staff; security; domestic staff; maintenance);
- 4 per cent unknown.

A summary of responses is set out in two parts below: a summary of the views of staff and a summary of patients' views.

A further 44 hard copy postcards supporting the Bill were received following the preparation of this note. It was not possible to analyse the comments received, however 37 were from nurses, 7 from patients, and 1 from an allied health professional.

2. Views of staff

The vast majority of responses were from nurses. Several respondents stated that they had worked in the profession for many years within a range of different settings. One respondent was a former nurse executive from a Welsh NHS Trust. Some respondents identified the specific settings in which they had worked and these included: acute wards; community wards; elderly wards; neonatal; nursing home for disabled people; intensive care; and mental

RS Ref: 15/0521

health. Some respondents identified themselves as agency nurses. One agency worker said that she had worked in ten different hospitals within four different Health Board areas and that agency staff were offered more work than they could manage as a result of nurses leaving the profession or being ill due to the pressure of the role.

2.1 Key themes

The strong key message from staff who responded is that **there are existing staff shortages and that these are having a significant impact on patient care and safety.** Many respondents also point to nurse staffing levels resulting in **high levels of stress, sickness absence and low morale amongst the nursing workforce**. Further detail is set out below.

2.2 Patient care

The predominant theme from the postcards and emails was that **patient safety** is being put at risk as a result of current nurse staffing levels. It was suggested that there is a **shortage of staff** and that this situation is getting worse. Some respondents pointed to more nurse time being needed as a result of an increasing complexity in patients' care needs coupled with an aging population. Many respondents suggested that nurse staffing levels are having a significant impact on the **quality of the care** provided and that nurses do not have adequate time to spend with patients**.** In turn, it was suggested that this means nurses are **unable to give personalised and dignified care.** Some respondents gave examples of very junior and inexperienced staff being in charge of wards. It was suggested staffing levels resulted in nurses having to **'cut corners'**. Examples were given where there had not been enough time to feed patients properly before their food being taken away and also patients not being washed properly.

Many respondents also suggested that nurse staffing levels mean that **errors are more likely**, putting patients at risk, including the suggestion this could lead to a fatality. A pharmacist pointed to nurse staffing levels leading to an increase in the risk of mistakes being made in the administering medication. One respondent suggested that more nurses would result in a reduced waiting times. A doctor suggested that the throughput of patients into theatre was impacted negatively by a shortage of nurses.

2.3 Impact on staff

The main impact of current nurse staffing levels on nurses themselves were highlighted as being a **risk to the safety of nurses; high stress levels; increased sickness absence; and low staff morale.** It was suggested that current staffing levels are increasing the risk of assaults on staff. Respondents suggested that nurses have to work extra shifts to cover their colleagues' sickness absence. It was also suggested that nurses are 'burnt out' and that they don't have adequate breaks to have food or go to the toilet. High levels of paperwork were also cited as being a problem. One respondent said they had retired early as a result of the

pressure and other respondents pointed to colleagues who were considering taking this course of action. Some respondents pointed to a high turnover of nurses; nurses leaving the profession; and a shortage of nurses being recruited. They said that current staffing levels meant the professions was unattractive and pointed to the use of agency nurses to 'plug the gap'. A small number of respondents expressed concerns that current nurse staffing levels are resulting in nurses being more likely to be referred to the Midwifery and Nursing Council.

2.4 The settings to which the Bill should apply

Several comments were made about the perceived benefits of minimum nurse staffing ratios being applied to settings other that adult in-patient wards in acute hospitals. These included community settings (currently included within the scope of the Bill) and nursing homes and the private sector (not currently included within the scope). It was suggested that the most vulnerable people receive their care in the private care sector.

2.5 Costs

Some respondents suggested that the Bill would lead to a reduction in both the costs associated with litigation and the costs associated with sickness absence. It was also suggested that it would result in a reduction in the use of agency staff. It was suggested that although there might be increased staffing costs when the Bill was introduced, in the longer term, the Bill would be cost effective.

2.6 Management

Some respondents suggested that their managers had not responded positively when concerns about nurse staffing levels were raised with them. One respondent said that they had raised concerns with their management team on numerous occasions and had been told that 'this is the way it is', and suggesting that they were a negative influence on their team. Another respondent suggested that nursing staff 'are controlled by fear and constant threats'. One nurse suggested that management prioritised Accident and Emergency waiting times, suggesting that this was because the data was under more scrutiny.

3. Patients' views

Respondents said they supported the Bill because of concerns that a shortage of nurses on wards was having a **negative impact both on patient care and the well-being of nurses**. Comments were made that more nurses would lead to a reduction in the number of accidents occurring and in mortality rates. One respondent suggested that current staffing levels are dangerous. The quality of patient care was mentioned by several respondents and the role of nurses within this was emphasised. Specific issues highlighted in respect of patient care included: the administration of medication; mealtimes; and the assessment of patients' needs. Comments from patients in respect of the impact of staffing levels on nurses included

that: their role is very important; their workloads are too high; they don't end their shifts on time; they do a fantastic job over long hours; they are overworked and underpaid; and nurses were 'running around' without getting a break. Several patients perceived there to be too much paperwork for nurses to complete. One respondent suggested the Bill would lead to fewer referrals to the Midwifery and Nursing Council.