

Safe Nurse Staffing Levels (Wales) Bill Explanatory Memorandum

This Explanatory Memorandum has been prepared by Kirsty Williams AM and is laid before the National Assembly for Wales.

Declaration of Legislative Competence

In my view, the provisions of the Safe Nurse Staffing Levels (Wales) Bill, introduced by me on 1 December 2014 would be within the legislative competence of the National Assembly for Wales.

Kirsty Williams AM

Member in charge of the Bill

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Part 1: Background and purpose of the Bill

Introduction

1. On 13 December 2013, Kirsty Williams AM was successful in the ballot held under Standing Order 26.87 for the right to seek leave to introduce a Member Bill. Her proposal was for a Bill that would require the setting of minimum nurse staffing levels for acute hospital wards, also taking into account the skill mix of staff and the complexity of patient need. On 5 March 2014, the National Assembly for Wales agreed that Kirsty Williams could introduce a Bill to give effect to the pre-ballot information she provided.
2. This Explanatory Memorandum has been prepared and laid in accordance with Standing Order 26.6. It sets out the background to the provisions and scope of Bill.
3. The Bill seeks to ensure that nurse staffing levels within the Welsh NHS are sufficient to provide safe, effective and quality nursing care to patients at all times. It will strengthen existing arrangements by:
 - placing a duty on health service bodies in Wales to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided;
 - for adult acute hospital wards, requiring the Welsh Government to issue guidance setting out the methods/processes by which NHS organisations will be expected to determine nurse staffing levels that are locally appropriate and at all times safe;
 - placing a duty on health service bodies to take steps to ensure that nurse staffing levels on adult acute wards do not fall below certain levels. These 'minimum' levels are to be included in the statutory guidance as minimum 'nurse to patient' ratios and 'nurse to healthcare support worker' ratios. There is provision for this duty to be extended to other healthcare settings at a future date;
 - ensuring that, when determining nurse staffing levels, certain roles (ward sisters for example) are regarded as supernumerary, and factors such as

staff training and development needs and planned/unplanned leave are properly taken into account;

- placing a duty on health service bodies in Wales to monitor their compliance with the safe nurse staffing requirements and to take action where failings occur;
- providing a statutory basis for patients and staff to challenge poor levels of nurse staffing.

Legislative background

4. The National Assembly for Wales' Standing Orders provides for Bills to be introduced by backbench Assembly Members, as well as the Welsh Government, where the National Assembly has legislative competence in a policy area.
5. Section 107 of the Government of Wales Act 2006 (GOWA) provides legislative competence for the National Assembly for Wales (the Assembly) to make laws for Wales known as Acts of the Assembly.
6. Section 108 of GOWA provides that a provision of an Act of the Assembly is within the Assembly's legislative competence if it relates to one or more of the subjects listed under any of the headings of Part 1 of Schedule 7 of that Act and does not fall within any of the exceptions specified in that Part of the Schedule (whether or not under that or any of the headings), and it neither applies otherwise than in relation to Wales nor confers, imposes, modifies or removes (or gives power to confer, impose, modify or remove functions exercisable otherwise than in relation to Wales).
7. The subjects listed under the heading Health and health services in paragraph 9 of Part 1 of Schedule 7, include:

“Prevention, treatment and alleviation of disease, illness, injury, disability and mental disorder.....Provision of health services, including medical, dental, ophthalmic, pharmaceutical and ancillary services and facilities....Clinical governance and standards of health care.....Organisation and funding of the health service”.

The above subjects provide the Assembly with the competence to make the provisions contained in the Safe Nurse Staffing Levels (Wales) Bill.

8. Regulation of health professionals is excepted under the heading to paragraph 9. None of the provisions in the Safe Nurse Staffing Levels (Wales) Bill falls within that (or any other exception).

Context and overall need for the Bill

9. The pivotal role of nursing staff and the importance of ensuring appropriate nurse staffing levels has been highlighted in a number of high-profile reports and research findings.
10. In 2013, publication of the final report of the Inquiry into failings in the Mid Staffordshire NHS Foundation Trust (the Francis report)¹ focussed the UK's attention on the issue. The Inquiry found that a chronic shortage of staff, particularly nursing staff, was a significant factor in the substandard care provided, and resulted from the prioritisation of financial performance over quality of care.
11. The Keogh review² into the care and treatment provided by English hospital trusts with persistently high mortality rates (July 2013) found frequent examples of inadequate numbers of nursing staff in some ward areas, and all 14 trusts involved received recommendations relating to workforce issues, including undertaking urgent reviews of safe staffing levels.
12. In August 2013, the Berwick review into patient safety³ (NHS England) emphasised that the quality of care provided to patients should come before all other considerations in the leadership and conduct of the NHS. It recommended that staffing levels should be consistent with the scientific evidence on safe staffing, and adjusted to take account of patient acuity and the local context.

This includes, but is not limited to, nurse-to-patient staffing ratios, skill mixes between registered and unregistered staff, and doctor-to-bed ratios.
13. In Wales, concerns around nurse staffing levels have continued to be reported. In February 2013, in answer to a Written Assembly Question⁴, the then Health Minister, Lesley Griffiths AM, revealed that 7 out of the 12 dignity and essential care inspections undertaken by Healthcare Inspectorate Wales highlighted concerns in relation to safe staffing.

Concerns highlighted have included reference to overall staffing numbers during certain shifts (particularly at night) and the organisation of staff during shifts which impacted on the care and support patients have received.

14. More recently, *Trusted to Care*⁵ (May 2014), the independent review of the Princess of Wales Hospital and Neath Port Talbot Hospital, identified concerns about the way staffing levels were determined, and called on Abertawe Bro Morgannwg University Health Board to review its ward staffing procedures.
15. The Royal College of Nursing employment survey for Wales⁶ (January 2014) highlights a continuing trend of decreasing nurse staffing levels. Its key findings included:
 - across all respondents, over half (55 per cent) reported that levels of registered nurses had decreased, and just over a quarter (28 per cent) stated that levels of healthcare support workers had fallen. In general, reductions in staffing levels were most commonly reported among respondents working in the NHS;
 - 57 per cent of respondents working in the NHS stated that their workplace had instigated recruitment freezes, leaving nursing posts unfilled;
 - 37 per cent of respondents working in the NHS reported that the changes in staffing levels are leading to increased workloads;
 - over half (56 per cent) of nursing staff felt unable to give the level of care they would like to.
16. The Welsh Government's response to the Francis report, *Delivering Safe Care, Compassionate Care*⁷, recognised that 'key to patient safety and good care is the need to determine the right staffing levels to meet patient's needs'. NHS Wales' organisations echoed this in their responses to the consultations undertaken in developing this Bill. The Older People's Commissioner for Wales' report, *Dignified Care: Two Years On*⁸ also described a clear link between staffing levels and the safety and quality of care on hospital wards.

Research findings

Patient outcomes

17. The relationship between nurse staffing levels and safety/quality of care has been demonstrated in a number of academic studies. A major European study into nurse staffing and hospital mortality⁹ published in *The Lancet* medical journal (February 2014) revealed that an increase in a nurse's workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7 per cent. It also highlighted the impact of increasing the ratio of registered nurses to healthcare support workers:

These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients.

The same relationship between nurse staffing and mortality was demonstrated in each of the nine countries included in the study (this included England), despite the variation between these countries in terms of health service organisation, financing and resources given to health services.

18. A 2007 study¹⁰ across 30 English acute trusts revealed that patients in hospitals with the highest numbers of patients per nurse had 26 per cent higher mortality rates, and nurses were twice as likely to report low or deteriorating quality of care. A US study¹¹ the same year also found that higher registered nurse to patient ratios were associated with reduced levels of hospital-related mortality, failure to rescue, cardiac arrest, hospital acquired pneumonia, and other adverse events.

Impact on staff

19. The impact of inadequate staffing levels on nursing staff themselves has also been evidenced, with studies pointing to an increased risk of health problems such as musculoskeletal disorders, cardiovascular disease, anxiety and depression. A large scale study by Aiken¹² (2002) found that an increase of 1 patient per nurse led to a 23 per cent increased risk of burnout and 15 per cent increased risk of job dissatisfaction.

20. The 2013 RCN Employment Survey for Wales¹³ found that workload and stress are the main personal concerns for nursing staff, ranked above all other concerns about their and their families' health, their own job security and that of their partner or household income and expenditure. The Survey also showed high levels of 'presenteeism', with nursing staff feeling pressure to attend work despite feeling unfit or unwell. Over half of respondents (55 per cent) stated they had attended work two or more times in the previous 12 months despite not feeling well enough to do so.

21. The Berwick review into patient safety¹⁴ emphasised that NHS staff are committed to providing quality care for their patients:

Neither at Mid Staffordshire, nor more widely, is it scientifically justifiable to blame the staff of the NHS or label them as uncaring, unskilled, or culpable. A very few may be exceptions, but the vast majority of staff wish to do a good job, to reduce suffering and to be proud of their work. Good people can fail to meet patients' needs when their working conditions do not provide them with the conditions for success.

Economic impact

22. Research in 2009¹⁵ considered in depth the economic value of professional nursing. This work found that as registered nurse staffing levels increase, patient risk of complications and hospital length of stay decrease, resulting in medical cost savings and improved national productivity, as well as lives saved. The economic value, in terms of reduced medical costs and improved national productivity, was estimated to be over \$60,000 annually for each additional registered nurse employed.

23. This reflected the findings of a 2006 study¹⁶ which highlighted potential cost savings resulting from the avoided deaths, reduced lengths of stay, and decreased adverse patient outcomes associated with higher nurse staffing levels.

24. An economic evaluation¹⁷ accompanying NICE's 2014 safe staffing guideline noted that none of the existing economic studies on nurse staffing and patient outcomes were from the UK nor did they use ward level data. It states however that there is still evidence that nurse staffing levels and skill mix have an impact on patient outcomes, consistent with the extant literature.

Two specific outcomes considered in the evaluation were falls and medication errors. The evaluation found that the Incremental Cost Effectiveness Ratios were £1,412 per fall averted and £128,779 per drug error avoided. It also states that improved data collection and outcomes monitoring is needed. These outcomes should include patient mortality, failure to rescue, infection rates, incidence of bed sores, medication errors, falls and validated measures of nursing quality, patient and relative satisfaction.

25. It has also been shown that inadequate staffing levels can lead to a reliance on overtime and temporary (agency and bank) staffing, which can be costly and inefficient. In a 2013 report, the RCN stated:

While temporary staff may provide much needed flexibility in addressing short-term staffing issues, there are significant disadvantages to long-term reliance on agency and temporary staff. These include higher ongoing costs, and the fact that these staff may be unfamiliar with the ward environment, its patients and its permanent members of staff.¹⁸

26. A 2011 study¹⁹ found that hospital wards with temporary staff had poorer staffing levels, higher workloads, more sickness absence and lower ward quality scores than wards that were staffed by permanent nurses only.

27. The Keogh mortality review²⁰ in 2013 found an over-reliance on temporary nursing staff in the hospital trusts it looked into, noting that there were often restrictions in place on the clinical tasks temporary staff could undertake.

28. According to research undertaken by the RCN, Health Boards in Wales have spent approximately £132 million on agency/bank staff and overtime in the last three years.²¹

29. Some responses to our consultations described a pattern of high levels of temporary staffing on hospital wards.

Patients need continuity of care, but all too often wards rely upon agency staff for the delivery of care, which brings about increased risk to patients of having members of staff unfamiliar with local processes and procedures, as well as impacting upon the patient experience of care²².

The current position

30. Following Francis and the Berwick review's recommendations, the National Institute for Health and Care Excellence (NICE) has developed an evidence-based guideline²³ on safe nurse staffing in adult acute hospital wards. This guidance applies in England, and is not mandatory.

31. Guidance on safe staffing levels has previously been issued in the UK by professional bodies such as the Royal College of Nursing²⁴, and in Wales by the Welsh Government's Chief Nursing Officer, but again, is not subject to a statutory requirement.

32. Issued to Health Boards in Wales in April 2012, the Chief Nursing Officer's guidance set out the following core principles:

- numbers of patients per registered nurse should not exceed 7 by day;
- a night time ratio of 1 nurse to 11 patients;
- the skill mix of registered nurse to healthcare support worker in acute areas should generally be 60/40;
- nursing establishments on acute wards should not normally fall below 1.1 whole time equivalent per bed, including a headroom of 26.9% to allow for staff leave and training;
- professional judgement will be used throughout the planning process;
- the ward sister/charge nurse should not be included in the numbers when calculating patients per registered nurse;
- ward activity and demand will be considered when establishing staffing levels as well as the number of beds, environment and ward lay-out;
- for specialist areas and wards with tertiary services, professional standards, guidelines and national frameworks should be used to determine nurse staffing levels.

33. In May and June 2013, figures provided by Health Boards²⁵ showed that this guidance was not being consistently met across Wales.

Table 1

Health Board	Number of patients per registered nurse		Ratio of registered nurses to nursing support workers
	day	night	
Abertawe Bro Morgannwg	8 (average)	13 (average)	60:40
Aneurin Bevan	7 (average)	14 (average)	Working to 60:40
Betsi Cadwaladr	2 – 7.5	3 – 15	Varies between 46:54 – 76:24
Cardiff and Vale	Work towards 7 – 8	Work towards 11, but this varies by ward up to 13	47:53 – 74:26 (range of lowest and highest figures by individual wards)
Cwm Taf	Does not exceed 7	Does not exceed 11	Should be no less than 60:40
Hywel Dda	4 – 8	9 – 15	72:28

Source: Local Health Boards (individual responses to Freedom of Information requests)

34. Giving evidence to the Assembly’s Health and Social Care Committee on 30 January 2014²⁶, the Chief Nursing Officer stated that Health Boards were working towards implementing the core principles by April 2014, but described varying levels of compliance to date.

So, for example, Hywel Dda health board has mostly complied with the principles that have been set, but, in some areas, not all of its ward sisters are supernumerary for the duration of the week’s rota; they will be it for a part. Other areas, like Betsi Cadwaladr health board, have been attempting to recruit additional staff, but they are finding it quite difficult to fill their vacancies. So, we are finding variations, if you like, across the country against what we set out as a set of principles to work towards.

35. The response to Francis in Wales has not been one of complacency. The Welsh Government progressed plans to introduce workforce planning tools

based on the severity of patients' conditions (acuity), to assist NHS organisations in determining appropriate nurse staffing levels at a local level. The first of these, which focussed on adult acute hospital wards, was introduced in April 2014. Work is underway to develop this approach for other areas.

36. In July 2013, the Minister for Health and Social Services, Mark Drakeford AM, announced recurrent funding of £10 million to allow Health Boards to recruit additional nurses for acute medical and surgical wards. This funding, and the development of workforce planning tools, has been welcomed.

37. There remains significant concern among the nursing profession however that without legislation to mandate compliance, guidance on its own will not ensure that recommended staffing levels are adhered to, that NHS organisations' performance in this regard is measured and monitored, and that appropriate action is taken where there is non-compliance. As noted by Professor Dame June Clark in her response to the consultation on the draft Bill:

Legislation changes behaviour: guidance, however strong, may not.

38. With increasing pressures on health service bodies to meet spending limits, there are fears that nursing posts will be reduced and patient safety and quality of care will be compromised. Nursing may be perceived as a 'soft target', as savings can be quickly achieved by reducing nurse staffing whereas savings through improved efficiency may not be immediately realisable. This legislation is needed to ensure that sufficient priority is given to achieving and maintaining an appropriate level of nurse staffing.

39. It will also provide both patients and staff with a statutory basis on which to challenge poor or unsafe practice. The July 2014 review of complaints handling in NHS Wales²⁷ described a culture in which complaints are not welcomed, and patients and staff do not feel sufficiently supported to raise concerns. Specifically in relation to staffing levels, the review made the following recommendation:

Correct staffing levels, with trained up teams, operating under professional leadership must be enhanced so that compassionate care can be provided. Compassion takes time so it should be strongly recommended that management

assesses and provides correct human resource levels in this area, building on initiatives for minimum staffing levels introduced over the last year.

40. Failures in NHS workforce planning have previously been identified. In 2008, the Assembly's Health, Wellbeing and Local Government Committee found that planning is 'too often based on historic patterns rather than on future needs'. This same issue was reported in response to our recent consultations on the Bill:

Historical funded establishment figures exist in areas where the change in clinical services and levels of acuity are unrecognisable to those that existed when the levels were set.²⁸

41. Concerns remain about the capacity of the current and future nursing workforce to meet demands. Consultation responses described a shortage of registered nurses, resulting in the practice in some areas of recruiting nurses from overseas to meet the shortfall. By placing safe nurse staffing on a statutory footing, this Bill will strengthen accountability for the safety, quality and efficacy of workforce planning and management.

42. A 2013 report by the International Council of Nurses described how several countries, including the United States and Australia, were turning to mandated minimum nurse to patient ratios as a strategy to improve working conditions and facilitate the return of nurses to practice,

Shortly after the implementation of mandated ratios in Victoria, Australia "five thousand unemployed nurses applied to return to work and fill vacant posts in the health services" (Kingma 2006 p.225). Further, research commissioned by the Australian Nursing Federation (ANF) found that "more than half of Victoria's nurses would resign, retire early or reduce their hours if mandated, minimum nurse:patient ratios were abolished" (ANF 2004 p.1).²⁹

43. Similarly, the ratio legislation in California is considered to have achieved its goals of reducing nurse workloads and improving the recruitment and retention of nurses, as well having a positive impact on quality of care.³⁰

What the Bill does and why

Duty on NHS Wales organisations

44. The Bill places a duty on health service bodies in Wales to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided.
45. Nursing, midwifery and health visiting is the largest group of staff employed by the NHS, accounting for almost 40 per cent of directly employed staff. Nurses provide 24 hour care for patients, work in every type of healthcare setting and area of clinical practice, and care for people from before birth through to death. As such, nurses are uniquely positioned to have a significant impact on the health and wellbeing of all members of the population.
46. The Bill will help ensure there is an appropriate level of nurse staffing in all settings where NHS nursing care is provided, allowing nurses the time to care for patients sensitively, efficiently and effectively. By placing safe nurse staffing on a statutory footing, the Bill will strengthen accountability for the safety, quality and efficacy of workforce planning and management, and help ensure the sustainability of the nursing workforce going forward.
47. The NICE guidance provides the following definition of 'safe nursing care'.

When reliable systems, processes and practices are in place to meet required care needs and protect people from missed care and avoidable harm.³¹

Guidance on safe staffing

48. For adult inpatient wards in acute hospitals, the Bill requires the Welsh Government to develop guidance on safe nurse staffing, which NHS organisations in Wales must take into account when making day to day staffing decisions, and to inform longer term workforce planning.
49. The guidance must set out the methods by which NHS organisations in Wales should ensure there is, at all times, an appropriate level of nursing staff to meet patients' needs. It must also set out minimum 'nurse to patient' and 'nurse to healthcare support worker' ratios for these settings (see paragraphs 52–67 below).

50. The fundamental reason for setting the ratios and methods out in guidance, rather than including these on the face of the Bill, is to ensure that NHS Wales organisations have the necessary flexibility to respond to changes in service provision and delivery of care, and ensure that the requirements of the Bill in terms of staffing levels do not hinder future service development.
51. To ensure the guidance remains up to date and any relevant developments in healthcare delivery are taken into account (including technological advances for example), the Welsh Government will be required to review the operation and effectiveness of the legislation at regular intervals.

Nurse staffing ratios

52. The Bill requires the setting of minimum ‘nurse to patient’ ratios and ‘nurse to healthcare support worker’ ratios for adult acute hospital ward settings. It places a duty on health service bodies in Wales to take all reasonable steps to ensure that nurse staffing levels do not fall below these minimum levels. The ratios themselves are not included in the Bill, but will be set out in the statutory guidance following consultation with relevant stakeholders.
53. The Bill initially requires ratios to be set for adult acute wards as this reflects the initial focus of work carried out by the Chief Nursing Officer and NICE on nurse staffing levels, lessons learned from recent work such as the Francis report, the Keogh mortality review and the Berwick review into patient safety, and the evidence base demonstrating the link between nurse staffing levels and patient outcomes in these settings. The Royal College of Nursing’s guidance on safe nurse staffing levels in the UK highlights that most of the research evidence relates to hospital-based care, and there is currently a lack of equivalent research in primary and community care. The Bill includes provision for minimum ratios to be prescribed for other areas as the evidence base for these areas develops.
54. The concept of statutory minimum staffing ratios is not new to the UK. Mandatory staffing ratios have for some time been in place for registered childcare settings for example. In Wales, the National Minimum Standards for Regulated Child Care³² set out the maximum number of children for whom a child minder may care, and minimum staffing ratios for day care settings. The Standards clearly state that the outcome of having staffing ratios is that

‘children benefit because the ratio of adults to children conforms to best practice’.

55. Another example can be seen in relation to air crew, whereby to protect the safety of aircraft passengers, EU legislation³³ prescribes minimum numbers of cabin crew required.
56. It has often been questioned, in the UK and beyond, why similar protection is not afforded to patients in hospital, who are arguably among the most vulnerable people in society.
57. Mandatory registered nurse to patient staffing ratios were established in California in 1999 and in Victoria, Australia in 2001. Evidence as to the impact of this legislation suggests that mandated nurse to patient ratios have a positive impact on staffing levels, and can lead to more manageable workloads for nursing staff and greater stability in the workforce.³⁴
58. In a May 2013 statement, the UK’s Safe Staffing Alliance of nurse leaders set out its position on registered nurse to patient ratios:

Under no circumstances is it safe to care for patients in need of hospital treatment with a ratio of more than 8 patients per registered nurse during the day time on general acute wards including those specialising in care for older people.

(...)

For the sake of clarity: 1:8 is the level at which care is considered to be unsafe and putting patients at risk; it is not a recommended minimum. For nurses to provide compassionate care which treats patients with dignity and respect higher levels will be needed and these need to be determined by every health care provider.

59. The NICE safe staffing guideline does not set out minimum nurse staffing ratios, as this was not within its intended scope. It does however recommend that managers should take into account the evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts, and should take action to ensure patient needs are being adequately met if the available registered nurses for a particular ward (excluding the nurse in charge) are caring for more than 8 patients.

60. The Francis report did not include a recommendation on statutory minimum nurse staffing numbers. However, speaking before the Care Quality Commission on 31 July 2013³⁵, Robert Francis referred to the Safe Staffing Alliance's evidence, and suggested this issue should be revisited. He suggested that a minimum staffing level ought to be considered in terms of it being a 'benchmark' which, in a similar way to mortality rates, could act as an alarm bell and raise questions about the safety of a service.
61. The Trusted to Care review team specifically recommended the adoption of a 'risk assessment protocol' if staffing levels fall below a safe level.
62. The minimum staffing ratios required by this Bill will set a baseline below which staffing levels must not fall, and will thus act as a warning signal that, where levels are below this baseline, patient care may be compromised.
63. The need for an appropriate skill mix among nursing staff has been widely emphasised, including for example in guidance issued by the Royal College of Nursing, the Chief Nursing Officer in Wales and the recently published NICE safe staffing guideline. It was also a strong theme in responses to our consultations.
64. In 2006, the Royal College of Nursing recommended that a skill mix ratio of 65 per cent registered nurses to 35 per cent healthcare support workers should be regarded as the benchmark in acute ward areas, but subsequently reported that the average skill mix had fallen below this level. The 2012 guidance from Wales' Chief Nursing Officer set out that the skill mix of registered nurses to support workers in acute areas should generally be 60:40.
65. The Bill therefore requires that minimum ratios be set in relation to proportion of registered nurses to healthcare support workers, as well as nurse to patient ratios. This skill mix ratio is also a baseline, and must be regarded as upwardly adjustable.
66. A concern about setting minimum staffing ratios is that these may become misinterpreted as maximum or target levels. Although no evidence has been produced to support this assertion, it is a view that has been often expressed, including in response to the consultations on this Bill.

67. To address this concern, the statutory guidance must include provision to ensure that the minimum ratios are not applied as an upper limit. It will be for those developing the guidance to set out how this should be achieved and monitored in practice.

Ensuring nurse staffing levels meet local patient need

68. The Bill recognises that a pre-determined ratio does not, in itself, equate to safe, quality care, and that staffing levels must be adjusted at a local level to take account of individual patients' needs and local circumstances, including for example the ward environment and the skills of nursing staff on shift. The minimum nurse staffing ratios are therefore only one element of this legislation to ensure safe staffing levels.

69. The guidance required by the Bill must set out the methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing to meet patients' needs on a day to day/shift by shift basis. This includes the use of validated acuity/workforce planning tools, the exercise of professional judgment, and the application of relevant standards/guidelines developed by professional nursing groups.

70. As noted earlier, the Chief Nursing Officer in Wales has been leading work on the development of acuity tools for different healthcare settings. The first of these, the Adult Acute Nursing Acuity & Dependency Tool, was introduced in April 2014. The tool will be used to capture acuity and dependency data across acute medical and surgical wards in NHS Wales on a twice yearly basis, in order to provide evidence based information for setting nursing establishments that meet patient and service needs. It is not intended as a daily tool to identify staffing needs on a shift, day or weekly basis. As highlighted in the Acuity & Dependency Tool's accompanying guidance, information obtained through use of the tool should be used in combination with professional judgment and other care quality indicators in order to obtain 'a more comprehensive picture of nurse staffing requirements within a clinical area'.

71. NICE's safe staffing guideline also recommends use of a 'decision support toolkit' to facilitate a systematic approach to determining nurse staffing levels. It also emphasises the need for informed professional judgement to

assess staffing requirements on a day to day basis, taking into account local circumstances, variability of patients' needs, and previously reported nursing 'red flag events'³⁶.

72. This need for a 'triangulated' approach to setting staffing levels was also widely emphasised in response to both consultations on the Bill's proposals. The Bill aims to facilitate this approach. By requiring methods of the kinds described above to be set out in statutory guidance, the Bill seeks to ensure that all relevant information, tools and expertise are utilised when determining appropriate nurse numbers for individual ward settings and shifts.

Publication of nurse numbers

73. To facilitate openness and transparency, the guidance required by this Bill must set out a process for the publication to patients of information on the numbers and roles of nursing staff on duty. This must aim to provide patients and visitors with an understanding of the level of staffing on a ward. It will be for those developing the guidance to set out the way(s) in which nurse numbers should be published.

74. The Bill also requires each health service body in Wales to publish an annual report setting out the actions it is taking to comply with the safe staffing requirements, and which records the number of occasions when nurse staffing may have fallen below the specified minimum levels. This information may be published as part of a wider report, such as the annual quality statement which NHS Wales organisations are already required to produce.

75. The Older People's Commissioner for Wales' report, Dignified Care: Two Years On³⁷ stated that 'routine and public reporting about the adequacy of staffing levels must be an immediate priority for the Welsh Government and the NHS'.

76. Since September 2013, some information on nurse staffing has been publicly available via the Welsh Government's My Local Health Service website, which was established as part of a move towards providing more transparent information on NHS patient safety and quality of care. The nurse staffing

information available via this website relates to ‘nurses per available bed’, however this is not always regarded as an accurate or meaningful measure of nurses’ workload.³⁸ Responses to the consultations on the Bill’s proposals welcomed more detailed, ward level information on nurse numbers and roles to be made accessible to the public. There was no clear view however as to the manner in which this should be done. There was some concern that simply publishing numbers without context or explanation may not provide meaningful information to patients about the level/quality of service being provided.

77. The Bill itself does not set out a process for the publication of nurse staffing information. This will be included within the statutory guidance in order to ensure that it is aligned with, and reflects, the relevant processes/mechanisms for ensuring safe staffing, which are to be brought together in the guidance.

Protections

78. The Bill includes provision to ensure that protection is afforded for certain activities and the status of particular roles when staffing levels are being determined (when establishment-setting and when ensuring the adequacy of day to day staffing). This includes time for training and continuing professional development (including induction periods for newly appointed, agency and bank staff), planned and unplanned absence, and the supernumerary status of particular roles, such as senior nurses in charge and student staff.

79. It is expected that, if and when the duties about statutory guidance and minimum ratios are extended to additional settings, these protections will also then apply to staff in those settings.

80. Protection for the supernumerary status of ward sisters/charge nurses is already set out in the core principles issued by the Chief Nursing Officer in 2012. The principles also identify the need for a ‘head-room’ of 26.9 per cent to allow for staff leave and training needs.

81. The protections included in the Bill therefore are not new requirements on health service bodies in Wales. It is evident however that this principle is not

consistently applied in practice, as described in the Chief Nursing Officer's evidence to the Health and Social Care Committee, and in consultation responses from some Health Boards.

82. The 2013 RCN Employment survey for Wales highlighted particular issues around training and continuing professional development. Its findings included that respondents in Wales are less likely to receive most types of mandatory training than colleagues in the rest of the UK. 53 per cent of all respondents completed their last mandatory training session in normal working time; 32 per cent completed this in their own time with the remainder (15 per cent) spreading the training between work and personal time. 49 per cent of respondents working in NHS hospital settings have received no continuing professional development training in the last 12 months.

83. Consultation responses demonstrated widespread support for training and continuing professional development to be included within the protections set out in this Bill, in order to ensure that nursing staff have the necessary and up to date skills to carry out their tasks safely, effectively and sensitively.

Consultation

84. The Bill requires that the guidance be developed in consultation with relevant stakeholders, including those likely to be affected by the guidance or representing the interests of those likely to be affected.

85. The purpose of this provision is to ensure that the guidance is robust, expertly-informed and evidence-based. It is anticipated that organisations representing members of the wider multi-disciplinary team will be consulted, as well as staff and groups representing the nursing profession. It is also expected that the views of a range of patient groups, including different age groups, will be taken into account.

Monitoring

86. The Bill places a duty on NHS organisations in Wales to monitor compliance with safe nurse staffing requirements and take action where failings occur. The Bill states that organisations' performance in this regard must be monitored in accordance with the relevant national performance

management framework, such as the current NHS Wales delivery framework or its successor.

87. Our consultations highlighted the need for nurse staffing levels to be consistently monitored in order to provide assurance about the adequacy of nurse staffing levels, identify where compliance is an issue and ensure that appropriate action is taken where this may be the case.

88. As described in the Adult Acute Nursing Acuity & Dependency Tool governance framework, NHS organisations in Wales are required to establish their own escalation policy to provide guidance and clarity to staff when raising a concern around staffing levels. Such an escalation policy should set out actions to be taken, identify those who should be involved in the decision-making process, and outline any contingency arrangements where staffing capacity issues cannot be resolved.

89. A number of key priority areas (identified by the Welsh Government) are currently monitored in accordance with the NHS delivery framework³⁹. It is anticipated that such a framework would provide the mechanism for monitoring NHS organisations' performance against the Bill's safe nurse staffing requirements. In relation to tier 1 and statutory delivery requirements, the current delivery framework states that delivery assurance will be provided via Quality and Delivery Meetings (QDM):

The role of the QDMs will be to monitor progress and assurance that delivery is on plan and/or that Boards have taken the necessary rectifying actions to ensure delivery. Where assurance is not provided on delivery or Board approved rectifying actions, escalation arrangements will be instigated.

The escalation levels, as set out in the delivery framework, are:

Table 2

Escalation Level	Performance trigger	Escalation Action	Monitoring	De-escalation
0.	Local delivery of all targets and/ or within	None required – earned autonomy (including potential for reducing the frequency of Q&DM) and minimal monitoring beyond that required for national returns. Proactive assurance mechanisms.		

	trajectory.			
1.	Health Boards/Trusts fail to achieve/maintain one deliverables.	Health Boards/Trusts are responsible for remedial action in response to areas of failure. WG indicates the additional monitoring requirements. Plans brought forward to redress the position with immediate effect.	WG, in conjunction when necessary with DSU (or other intervention mechanism identified by WG), assures and monitors implementation of plans and effectiveness of solutions. Executive highlight report. Support from other agencies if required.	Immediate removal of escalation action upon achievement of plan and return to improving KPIs.
2.	Continued failure to achieve/maintain one or more key deliverables.	WG instigates DSU and/or other intervention. WG and DSU (or other intervention mechanism identified by WG) will be actively involved in determining the necessary changes within the HB/Trust to deliver required outcomes through regular meetings/calls.	WG Representatives to join regular meetings/calls and monitor effectiveness of organisational response with DSU and &/or other intervention mechanisms.	Sustained improvement of KPIs causes removal of escalation actions.

3	Continued failure and/or a failure to maintain an agreed improvement trajectory following intervention.	Issues raised with Chief Executive NHS Wales. Meeting required between HB Chief Executive, NHS CEO and/or NHS Deputy Chief Executive to determine future requirements and actions.	Regular reporting established between CEO NHS Wales and HB Chief Executives until improving trajectory established.	Maintenance of agreed improvement trajectories causes return to escalation level 2.
4.	Continued failure to improve performance or failure to engage with the national process despite level 3 escalation.	<p>Actions to be determined by NHS Chief Executive which may include the following:</p> <ul style="list-style-type: none"> • Meeting required with Chair, Vice Chair, CEO, Board Secretary and relevant Executives. • Introduction of 'special measure' arrangements. • Review of executive effectiveness. • Review of Board effectiveness. • Removal of appropriate funding streams. 		

Source: NHS Wales delivery framework 2013-14 and future plans

Existing direction and intervention powers – National Health Service (Wales) Act 2006

90. Powers of direction are set out in section 12 of the NHS (Wales) Act 2006 which enable the Welsh Ministers to give directions to health service bodies about how they should exercise functions which have been delegated to them.

91. Intervention powers are also available to the Welsh Ministers through sections 26–28. These powers can be utilised if a Local Health Board is considered to be failing to perform one or more of its functions and can, in certain circumstances, be applied to suspend or remove powers and functions.

Review

92. The Bill will require the Welsh Government to review the operation and effectiveness of the legislation at regular intervals (initially after one year, thereafter at least every two years).

93. There are a number of recognised safe nurse staffing indicators which should be monitored by NHS organisations on an ongoing basis and used to inform local staffing requirements. The Bill requires that the Welsh Government publishes a report of each review which demonstrates the impact of the legislation, by reference to a range of these indicators, including: mortality rates; readmissions; healthcare associated infection rates; medication errors; falls; pressure ulcers; patient/relative satisfaction; protected training time; staff overtime; sickness absence, and; use of temporary nursing staff. These indicators reflect those identified by the Chief Nursing Officer and the NICE safe staffing guidance, as well as responses to our consultations.

Consultation

94. Two formal written consultations were undertaken to inform the development of the Bill. An initial consultation on the proposed content of the Bill was held in May and June 2014. A second consultation, on the draft Bill, was undertaken between July and September 2014. The comments received, from a wide range of stakeholders, have influenced and shaped the proposals.

95. The Royal College of Nursing has provided advice and expertise throughout the development of this Bill.

Initial consultation

96. The initial consultation on the proposed content of a Minimum Nurse Staffing Levels Bill covered a number of issues, including:

- the principle of nurse staffing ratios;
- settings to which minimum nurse staffing ratios should apply;
- how to ensure that staffing levels adapt to meet local patient need;
- protected time for staff training and development;
- protection for patients and staff raising concerns;
- monitoring and compliance; and
- evaluation and measuring of outcomes.

97. 29 written submissions were received from a range of respondents including Local Health Boards, Community Health Councils, trade unions and professional bodies/groups, individuals, and the Older People's Commissioner.

98. The majority of respondents were supportive of the proposed bill. A number of responses highlighted the current lack of consistent, transparent approach to determining and maintaining safe staffing levels, and suggested that the existing arrangements are ineffective and 'leave too much to chance'. Some respondents point to Health Boards not meeting Chief Nursing Officer (CNO) guidance as evidence of this.

99. There was a clear view however, about the need to preserve flexibility in order to respond to varying patient needs and local circumstances. The need for a focus on 'safe' staffing rather than minimum levels emerged as a strong theme.

100. Whilst all the responses received supported the need to ensure appropriate levels of nurse staffing, a small number of respondents questioned whether mandating 'minimum' staffing levels is the best way to achieve this.

Nurse staffing ratios

101. Respondents welcomed the opportunity to comment on nurse staffing ratios, as action to address safe staffing was widely felt to be a priority. It was acknowledged that this is a complex issue.

102. A range of responses described how enforceable staffing levels would be of benefit to both patients and nursing staff.

This proposed bill is very important for the protection of patients and also staff caring for patients. I think this will provide the ward based staff with support and a solid basis upon which to challenge unacceptable care / demands placed on them by higher level managers.⁴⁰

103. It was noted that minimum staffing levels do not necessarily equate to safe staffing levels, and there was some concern that minimum levels could become seen as the norm rather than a baseline. While a significant number of respondents agreed with the proposal to mandate nurse staffing ratios, there was a strong note of caution that flexibility must be retained as this is key to meeting patient need. Some respondents specified that use of acuity/workforce planning tools alongside the ratios would help ensure that there is always an appropriate level of staffing to meet needs locally. The importance of professional judgment in assessing patient need was also strongly emphasised.

104. Responses described the importance of an appropriate skill mix ratio. Again, it was suggested that the appropriate mix may vary, and that professional judgment was needed to determine the required combination of nursing staff.

105. Some evidence suggested the need for a more holistic approach to ensuring safe, quality care, involving the whole healthcare team – ‘it is not just the domain of nursing staff.’ This was strongly voiced by the Chartered Society of Physiotherapy (CSP). The CSP's concerns largely centred around the lack of consideration given to other health professions in the proposed legislation, and the possible adverse effects on these staff of implementing staffing requirements/protections that apply only to nurses. This is discussed further in paragraphs 162–164 (unintended consequences).

106. A key theme throughout this consultation was the need for an emphasis on ‘safe’ staffing rather than on minimum levels. As a result, the draft Bill was renamed the Safe Nurse Staffing Levels (Wales) Bill, and within its scope is a wider duty on the Welsh NHS to ensure an appropriate level of nurse staffing in all settings, at all times. The draft Bill recognised the need for flexibility, and aims to facilitate a ‘triangulated’ approach to determining the right level of nurse staffing, using professional judgment and appropriate workforce planning tools. The minimum ratios are therefore only one element of this legislation to ensure safe staffing levels. To address the concern that the minimum ratios may be misinterpreted as a norm or target level, specific provision is included in the Bill to ensure that any ratio is upwardly adjustable and is not applied as an upper limit in practice.

Applicable settings

107. A strong theme that emerged from the consultation was that any action to ensure safe staffing should not be restricted to acute settings only, particularly given the current policy focus on shifting care from hospital to community settings. There was some concern that resources may be pulled from areas where minimum ratios are not in place to meet the requirements in settings where the legislation does apply.

108. The minimum ratios element of this legislation initially applies to adult acute hospital ward settings, which reflects the current evidence base. The Bill recognises the importance of having appropriate levels of staffing wherever nursing care is provided and, alongside the wider duty on the Welsh NHS to ensure appropriate levels of nursing staff in all settings, there is provision for minimum ratios to be prescribed for other areas at a future date, as the evidence base for these develops.

Ensuring nurse staffing levels meet local patient need

109. Responses highlighted that patient acuity is the main factor which may change from shift to shift, and supported the use of acuity/dependency tools and professional judgment to ensure an appropriate level of staffing. In some responses, the NICE safe staffing guideline was welcomed as a useful tool.

The staffing of hospital wards should be based around the needs of its patients and they must be able to be flexible around the ever-changing needs of their

patients. When difficult decisions need to be made, ward managers need to have the power to respond and alter their staff balance accordingly.⁴¹

110. It was noted that staffing requirements will vary between Health Boards, and will need to take account of demographics, population health, disease trends and the balance of acute and community service provision in an area.
111. Within Health Boards and hospitals, the hospital environment itself (ward layout for example) can impact on staffing needs – ‘no one size fits all’. Staff skills and competencies also need to be considered, and it was noted that nurse staffing should be considered in the context of the whole multi-disciplinary healthcare team.
112. As described earlier, the Bill requires the Welsh Government to issue guidance to health service bodies on compliance with the duties on safe staffing, which recognises the important role of acuity/workforce planning tools, the exercise of professional judgement, and the need for an appropriate skill mix among nursing staff.

Publication of nurse numbers

113. The consultation asked whether reports on nurse staffing levels should be publicly available. Respondents broadly welcomed the publication of information on staffing levels, but there was a clear view that simply publishing numbers would not in itself aid public understanding, and there would be a need to ensure that the published data is meaningful and provides sufficient context and explanation.
114. Responses from NHS organisations suggested that information relating to occasions where safe staffing might have been compromised, and the associated outcome, may be of greater value than a blanket publishing of numbers.
115. There was some support for information to be published in a number of different ways, for example from noticeboard displays at ward level to more detailed information being included in Health Board annual reports.
116. To facilitate openness and transparency, the guidance required by the Bill must set out a process for the publication to patients of information on the

numbers and roles of nursing staff on duty. It also requires each health service body in Wales to publish an annual report setting out the actions it is taking to comply with the safe staffing requirements, and which also records incidents of non-compliance.

Protections

117. The importance of education and continuing professional development was a key theme in consultation responses. The Chartered Society of Physiotherapy echoed this, but had concern about one health profession's training being protected but not another's.
118. It was noted that lifelong learning is a professional requirement for nurses, but that this wasn't necessarily facilitated by the NHS. A number of respondents described how staff are often unable to be released for training (even where this is compulsory training) because of low staffing levels. Some respondents described a significant element of good will, and reported staff attending training during their days off (this is borne out by the RCN's recent employment survey).
119. There was support for the Bill to ensure protected time off for staff training and development. There was a concern that, without this protection, adhering to required minimum levels could make it even more difficult for staff to be released.
120. It was noted by a small number of respondents that a requirement for protected time for staff training and development may carry an additional and significant cost.
121. The Bill includes provision to ensure that protection is afforded for certain activities and the status of particular roles when staffing levels are being determined. This includes time for training and continuing professional development (including induction periods for new staff), planned and unplanned absence, and the supernumerary status of particular roles. There was some concern from NHS organisations about a potential additional cost here. However, protected time for leave and training, as well as supernumerary status for senior nurses in charge, is already included in the Chief Nursing Officer's nurse staffing principles, issued in 2012. This

provision is included in the Bill to ensure this is consistently taken into account by NHS organisations in Wales.

Raising concerns

122. A small number of respondents suggested that existing provisions for staff and or patients to raise concerns are not sufficient, or may be too complex and act as a deterrent. The RCN indicated that some of its members had been actively discouraged from raising concerns about unsafe staffing.

123. There was a broader view that the correct mechanisms exist, but that there may be a wider cultural problem in that staff don't feel supported to raise concerns, that they may be fearful of repercussions, and that complaints/concerns may not receive appropriate priority. It was suggested that supporting people to use the current mechanisms would be preferable to further mechanisms being developed.

There are policies in place for both [for NHS staff and patients to raise concerns], perhaps its more about culture, responses and being held to account (MNS14 Cwm Taf University Health Board)

124. Whilst a small number of responses suggested that there should be specific protection in the Bill, the broader consensus was that legislating for safe staffing would, in itself, support staff and patients to challenge poor practice, and would help facilitate the cultural change needed. It was decided therefore, not to include any specific new requirement or process for raising concerns in the Bill.

Monitoring/compliance

125. There was some concern that the current arrangements for monitoring staffing levels may not be adequate, nor a consistent approach taken. There was a clear view that Health Boards should be held more accountable for safe staffing. Responses from some representatives of NHS organisations suggested that making safe staffing a Welsh Government tier 1 priority could be an effective way of achieving the desired outcomes.

126. A range of interventions were suggested in the event of non-compliance, including financial penalties. Some respondents emphasised that the focus of any action taken should be on improvement, rather than punishment.

127. To strengthen accountability, the Bill places a duty on NHS organisations in Wales to monitor compliance with safe nurse staffing requirements and take action where failings occur.

Evaluation/measuring of outcomes

128. Respondents agreed that there would be a need to evaluate the impact of this legislation. There was no real consensus about an appropriate timescale for evaluation, although there was a view that monitoring should be ongoing, with more formal evaluation at particular points (the most common suggestions here were every six months, annually or within five years).

129. A range of indicators to measure the impact of the Bill were suggested including:

- length of stay;
- number of adverse incidents;
- complaints;
- patient satisfaction;
- staff satisfaction;
- staff sickness absence (particularly for conditions such as work-related stress);
- HIW inspections;
- Number of 'rule 28s' (this involves cases where coroners are required to report circumstances in which further deaths could occur if action is not taken to prevent them).

130. The Bill includes a requirement for the Welsh Government to review the operation and effectiveness of the legislation at regular intervals, and measure the impact of the legislation by reference to a range of recognised safe staffing indicators.

Second consultation

131. 27 responses were received to the written consultation on the draft Bill. Again, these included a range of stakeholders, many of whom had also responded to the first consultation.
132. The vast majority of respondents welcomed the aims of the Bill and its changed focus to 'safe' rather than 'minimum' nurse staffing levels. There were some concerns around specific provisions and some suggested alterations to wording.
133. The Chartered Society of Physiotherapy remained opposed to the introduction of a safe nurse staffing levels bill, due to their concern that it does not address staffing in a multi-disciplinary way. A small number of respondents (representing NHS organisations) questioned whether the Bill is the only mechanism by which improved nurse staffing levels could be achieved.

Comments on specific provisions included the following:

Guidance on safe staffing

134. The British Medical Association suggested that the guidance may need to define what is meant by a 'safe staffing level'. There was some concern about interchangeable use of the terms 'safe' and 'minimum' in the draft Bill.
135. The Royal College of Physicians supports the use of a 'red flag' system when assessing whether available nursing staff meet patients' needs over a 24 hour period.

Nurse staffing ratios

136. There remains some concern over use of the word minimum. It was suggested that the word 'recommended' be used instead of, or as well as 'minimum'. The Royal College of Nursing suggested that 'safe nurse:patient ratios' be used instead, and suggested the need to make it clear where nurse means registered nurse.
137. Some evidence requested more clarification in the Bill as to what constitutes 'reasonable steps'. The Royal College of Physicians suggested

that the wording ‘all reasonable steps’ be changed to ‘all steps’ or ‘all possible steps’.

138. The importance of appropriate skill mix was again emphasised, and the differentiation between nurse:patient and nurse:healthcare support worker ratios was welcomed. The important role played by healthcare support workers in supporting nurses was highlighted.
139. It was widely emphasised that setting staffing levels is only one element, and that this needs to be triangulated with use of acuity/workforce planning tools and professional judgment.
140. The potential for minimum ratios to be interpreted as a norm/target level was a significant concern raised by a number of respondents. The provision to ensure that this does not happen was welcomed, but there was some concern about how this would work in practice and how it would be monitored.

Applicable settings

141. The provision to extend to additional settings was generally welcomed, with community settings particularly highlighted. There was some concern that, as currently drafted, ‘additional settings within the National Health Service in Wales’ may not include care homes or other settings, such as people’s homes, where nursing care is provided.
142. There was a suggestion that the Bill should include provision to extend to other healthcare professionals, as well as other settings.

Ensuring nurse staffing levels meet local patient need

143. One response suggested that greater clarity/definition is needed about what is meant by ‘local contexts’.
144. Use of acuity/workforce planning tools was largely welcomed. Professor Dame Clark suggested that the word ‘dependency’ should be omitted, as this is often loosely used and not clearly understood. She also highlighted the need to include the concept/term ‘evidence-based’, and suggested the phrase ‘evidence-based and validated workforce planning tools’ be used instead of acuity and dependency tools.

145. Professional judgement was highlighted as being of key importance in ensuring flexibility and an appropriate level of staffing in response to demands on a ward. There was some concern that the focus on/setting of minimum staffing levels may lower the value of or reduce recognition of professional judgment.

Publication of nurse numbers

146. There was support for making staffing data publicly available, though again, no clear view about how this should be done. Hywel Dda University Health Board raised a concern about data alone not providing an accurate picture, and how this may undermine public confidence in a service.

147. The requirement for NHS organisations to publish an annual report on compliance with the safe staffing requirements was welcomed by some; it was emphasised that any such report must be accessible to and understandable by the wider public.

Protections

148. The provision for supernumerary status for senior nurses in charge was broadly welcomed, although two responses from Health Boards noted that this may involve a funding commitment. Hywel Dda University Health Board suggested the term 'supervisory' be used rather than 'supernumerary'. Whilst supporting the need for certain roles to be supernumerary, the Royal College of Physicians pointed out that these staff must still develop/maintain clinical skills. Other evidence also suggested that senior staff should still be able to provide assistance, for example, with wound dressings or drug rounds where needed. The Royal College of Nursing suggested that 'Ward Sister' would be more appropriate than 'Lead Sister', pointing out that Lead Sisters may not be ward-based, may cover a number of clinical areas and may already have supernumerary status.

149. It was also suggested that supernumerary status should be extended to include newly appointed staff.

150. Montgomeryshire Community Health Council and Brecknock and Radnor Community Health Council suggested that the provision for induction periods should also specify 'newly appointed staff'.

151. There was broad support for protected time for training and continuing professional development. Specific comments included that this should also specify 'statutory/mandatory training' and compliance with the new revalidation process being introduced by the Nursing and Midwifery Council.
152. The Older People's Commissioner questioned whether the protection for planned and unplanned leave would include suspended staff, as this would need to be taken into account when workforce/rota planning.

Consultation

153. One respondent requested more detail about whom the Welsh Government will be required to consult with in developing the guidance, noting that other professions are likely to be affected by the legislation.

Monitoring/compliance

154. Some responses suggested that this area may need to be strengthened, and that there is a lack of clarity as to how compliance will be measured and what action will be taken as a result.
155. Montgomeryshire Community Health Council proposed that hospitals failing to comply with the minimum nurse staffing requirements should be publicly censured and given a precise timescale to demonstrate that they have successfully taken action to achieve and sustain safe nurse staffing levels.
156. Brecknock and Radnor Community Health Council proposed that non-compliance should attract a fine, to be levied against the budget allocation for that body's executive director team/corporate board function.

Review

157. Some respondents felt this was an essential part of the legislation, although the Community Health Councils suggested that more detail as to how reviews will be carried out is needed.
158. The Older People's Commissioner suggested that indicators linked to the amount of time protected for training, and the number and severity of pressure sores should also be included.

159. Professor Dame Clark suggested that ‘agency and bank nursing’ may be a more appropriate term than ‘temporary nursing’, and should be included for clarity.

Subsequent changes made to the Bill

160. Grateful consideration has been given to all comments received during the consultation on the draft Bill. A number of changes have subsequently been made to the final version of the Bill, reflecting the feedback received. These include more consistent use of terminology throughout the Bill, amendments to wording to clarify or strengthen some provisions, and the inclusion of additional protections and safe nursing indicators.

Unintended consequences

161. Both consultations identified some concerns about potential unintended consequences of introducing this legislation. These have been considered in developing the Bill.

Negative impact on other staff groups

162. As described above (paragraph 105) a concern was raised that introducing legislation for one healthcare profession could have a negative impact on other professions involved in providing care, potentially by diverting resources from staff groups that are not ‘protected’ by the legislation. The Chartered Society for Physiotherapy were particularly concerned that the Bill fails to take a multidisciplinary approach to safe staffing.

The danger will be that, in order to meet legal requirements (and with no extra resources available), resources from staff groups other than nursing will be used to ensure the minimum nurse staffing levels are met. This would have detrimental effects to effective services for patients impacting on quality of care and length of stay.⁴²

163. Whilst very supportive of the Bill and the setting of minimum nurse staffing ratios, UNISON Cymru believes that these should be applied to all staff in every health setting, pointing out that having inadequate numbers of cleaning or clerical staff for example could risk adding non-clinical tasks to nurses’ workloads.

164. Mandatory minimum nurse staffing levels have been in place in Victoria, Australia since 2001. Discussions with the Australian Nursing and

Midwifery Federation (ANMF) have indicated that there is no evidence of a negative impact on other healthcare professions in Australia; the ANMF did not identify any reports or concerns raised by other staff groups. It was suggested that having safer staffing levels for nurses had in fact benefitted other members of the healthcare team and had a positive impact on their workloads. For example, through having more organised hospital discharges, occupational therapists and social workers are not called in at the last minute. Similarly, there is no reported evidence of a negative impact on other professions in California, where hospitals have been required to meet the established ratios since 2004.

Ward closures

165. A small number of respondents (including two NHS Wales' organisations) raised a concern about wards potentially being closed in order to comply with required staffing levels. The Bill however requires that staffing levels should be at all times safe, it does not itself prescribe the numbers of nursing staff needed. It is expected that any minimum staffing levels introduced will be evidence-based and used to ensure that no service operates at an unsafe level.

166. Similar fears existed in California prior to the implementation of mandatory minimum nurse staffing ratios there. However no hospitals or hospital units have been closed in California as a result of the ratios being introduced.⁴³

Power to make subordinate legislation

167. The Bill contains one provision which enables subordinate legislation to be made.

168. Section 2(1) which inserts section 10A(3) into the National Health Service (Wales) Act 2006 confers power on the Welsh Ministers to amend the settings to which the duty under new Section 10A(1)(b) may apply. This provision is included in order that the duty to take all reasonable steps to meet recommended minimum ratios can be extended to settings, other than adult inpatient wards in acute hospitals, should there be sufficient evidence that such an extension is necessary. Any regulations made by the Welsh Ministers will be by way affirmative procedure. This is considered

appropriate as the power extends the settings to which the new duty may apply.

Territorial application

169. This Bill will apply only to health service bodies in Wales.

Cross-border issues

170. As the Bill applies to health service bodies in Wales, there are no direct cross-border issues.

Part 2: Regulatory Impact Assessment

171. This Regulatory Impact Assessment (RIA) considers the options available in respect of the main provisions within the Bill, and analyses how far each of these would meet Kirsty Williams' policy objectives. In doing so, it considers the associated risks, costs and benefits of each option.
172. The RIA also explores the potential for unintended consequences and includes equality considerations (including a Children's Rights Impact Assessment).

Option 1: Do nothing: Maintain working towards current Chief Nursing Officer guidelines and acuity tool implementation

173. This is the baseline option; to continue with the current system. The status quo position assumes that the current Welsh Government policy of working towards non-statutory standards with associated funding commitments, as announced at the time of the Draft Budget 2015-16 are continued, as set out in the subsequent paragraphs. The nurse staffing position within the NHS is continually developing and it is therefore difficult to pin down the current, or latest, position in terms of staffing costs in acute wards.
174. Since 2012, the Welsh Government has worked with NHS organisations to make progress towards ensuring appropriate nursing establishments on adult acute medical and surgical wards. A national set of principles, issued by the Chief Nursing Officer, has been used, while an acuity and dependency workforce planning tool was chosen; this was implemented in adult acute ward settings in April 2014. 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 Welsh national principles also include a 1.1 WTE nurse per bed ratio and again the majority of wards now comply with this requirement. The principles include a head-room of 26.9%, to allow for planned and unplanned absence, staff training, continual professional development and the supernumerary status of particular roles.
175. The issue of nurse staffing levels is complex. It has to encompass skill levels, skill mix and patient acuity, as well as raw numbers. What is important is that Health Boards can achieve and maintain nurse staffing levels that are appropriate to patient needs, which is why the Bill will

support them to use a triangulated approach that includes use of an acuity tool, professional judgement and nurse sensitive patient outcome indicators.

Progress towards meeting the Chief Nursing Officer's guidance

176. In [2013](#), according to StatsWales, there were over 28,000 full time equivalent nursing, midwifery and health visiting NHS staff.
177. In response to the Francis Inquiry, £10 million recurring funding was introduced in the 2013–14 financial year to support Health Boards to recruit additional nurses and help ensure nurse staffing levels were in line with the core national principles.
178. To feed into the calculations relating to the impact of this Bill, information was sought from Health Boards to gauge how much resource would be required to meet these staffing levels and also how much progress has been made to date. However, the information received was mixed and has had to be gathered from a number of different sources and at various different points in the year. Nevertheless, whilst it is not possible to accurately estimate an overall picture, a general view of the scale of investment needed and the direction of travel is apparent from the limited information available.
179. In response to a request for information Abertawe Bro Morgannwg University Health Board stated that:
- At February 2013, meeting Chief Nursing Officer's guidance relating to safe staffing expectations would cost £3.1 million.
 - Figures provided in the summer 2014 by the Health Board suggest that meeting these safe staffing expectations would cost £1.0 million.
180. The Health Board's 3 year plan highlights that the Board is working toward meeting the expectations with the following actions in terms of workforce:
- Systematically reviewing its nursing workforce numbers in acute ward areas against the All Wales Staffing Principles. (The Board stated that they had already targeted quality investments to improve nurse staffing levels on our medical and surgical wards).
 - Implementation of an all-Wales Acuity and Dependency Tool for all adult acute ward areas from 1st April 2014.
181. At the time of drafting this impact assessment, [Aneurin Bevan University Health Board](#) had not had a 3 year plan accepted by Welsh Government.

The Draft Plan of the Health Board included the following estimates in terms of implementing the All Wales Staffing Principles. Pages 64–65 state that:

The majority of our workforce and consequently the majority of care is provided by our nursing staff. We have reviewed ward staffing levels against the **All Wales Staffing Principles** and recognise the challenge that the University Health Board faces in relation to our existing ward establishments in some of our medical and surgical wards. The cost associated with the variance is £1.3m for medical wards and approximately £400k for surgical wards, which collectively is £1.8m. This has now been recognised and funded by the Welsh Government. Again, we must recognise that we need to roll out the broader nurse staffing principles to community hospitals and other units not covered by the above approach.⁴⁴

182. Betsi Cadwaladr University Health Board provided information that, as of June 2014, all acute medical and surgical wards were compliant with the All Wales staffing Principles, although it identified that £2.5 million was needed to meet 26.9% headroom uplift.
183. The 3 year plan from Cardiff and Vale University Health Board suggests that funding has been identified to ensure that the Board will meet the national staffing principles over the planning period. The plan states that the additional funding provided around the time of the Draft Budget 2014–15: “... recruitment of medical and surgical nurses, of which Cardiff and Vale UHB was allocated £1.4 million.” The plan goes on to state that “149 new WTE staff to be employed in 2014–15 due to service developments and increasing qualified nurses due to CNO standards – generally in Medical Clinical Board.”
184. Hywel Dda University Health Board stated that:
- At March 2013, meeting safe staffing expectations would cost £5.0 million, a shortfall of 144.5 staff.
 - At March 2014, meeting safe staffing expectations would cost £0.7 million, a shortfall of 21 staff.

185. Therefore, it is difficult to provide an overall cost of meeting the Chief Nursing Officer's guidance around safe staffing, as Health Boards are at varying stages of implementing the guidance, and information available is from different timeframes. However, it is clear that there has been considerable progress between March 2013 and April 2014. Also, those Local Health Board Plans which have been approved by the Welsh Government indicate that workforce planning is in place to meet these standards and funding has been identified within the plans. As services continue to be modernised, the number of staff required will change. For example, staff ratios are linked to bed numbers and changes in bed spaces will necessitate a change in nursing to serve a different bed capacity.
186. The following is taken from the NICE safe staffing guideline, relating to England, but providing a similar message, [FAQs](#):

How much will this cost?

The current national cost for nursing staff in acute wards is estimated at around £4 billion. Implementing the NICE guideline is unlikely to have significant financial impact in many trusts, as they may simply need to adapt their processes to work out where nursing staff should be at any given time. Nor will any financial impact be felt in a one year period. Many trusts are already rolling out planned staffing changes as a result of the Francis enquiry, which will spread the cost across a number of financial years. The expected increased training numbers for nursing staff will also see a gradual increase between now and 2017.

Precise estimates of the cost of the guideline nationally are very difficult to produce because of local variation and because changes are already being made. The important estimates are those that will be made by individual hospitals. In addition, over time, the savings from safer care will be significant and may even match or exceed the upfront cost. For instance, reducing the number of infections patients get after surgery could save up to £700 million a year alone. For every fall avoided because a nurse was available to help a patient to the bathroom another £1,400 is saved.

187. Since the information in these plans was published, the Welsh Government has announced additional funding for the NHS in Wales at the time of the Draft Budget 2015–16. This included a package of £425 million funding over two years, £200 million in 2014–15 and £225 million in 2015–16. The Minister stated that this funding is intended to ensure that NHS

organisations have sufficient funding to meet their agreed plans. As described above, this includes the requirement to meet the Chief Nursing Officer's guidance on staffing levels, the usage of acuity tools and professional judgement.

188. However, the period of public sector austerity and cuts is anticipated to continue into the next UK Parliament and there will be a further National Assembly for Wales election before plans to meet the existing safe staffing guidelines have been fully implemented. Therefore, without a statutory basis to safe staffing levels, there is a definite risk that momentum could be lost in the future and standards could deteriorate in the future.

Basic scenario costing of nursing requirements to be in place to meet Chief Nursing Officer standards

189. Due to the complexities in identifying the cost of meeting current staffing requirements in the NHS already highlighted, a simplistic calculation of staffing needs has been calculated to provide a constant baseline figures for comparison between the options considered. The following analysis in Table 3 was based on information provided by the RCN to show what the rough staffing costs of providing safe staffing levels in acute wards based on the latest available data, mainly relating to 2013–14. This makes a simple calculation to estimate the staffing cost, based on 2013–14. **The cost calculation is around £275 million per year, which falls on NHS organisations providing adult acute services.** Whilst these costs are only approximate they do correlate to the NICE estimates in England of the cost of nursing staff in acute wards per head mentioned earlier. Also, these estimates will be constant under the two options considered.

Table 3 Rough simple current safe staffing cost estimation

Factors	Numbers	How Calculated	Comment
Average Nursing Needs of patients per 24 hrs*	5.32 hrs	28 Bed Ward. calculation of the average nursing needs of patient treated on a sample ward over a 6 month period*	* Example Scenario: NICE guidelines SG1 (July2014)
Average bed occupancy	30	The average number of patients treated during 24 hr period was 30. On average all beds occupied, 2 discharges and 2 admissions per 24 hrs.*	
Additional workload per 24 hrs	5.6 hrs	*The additional workload was estimated using professional judgement to be 5.6 hrs. This was based on the additional activities and responsibilities of the nursing staff, other than direct care. Examples: supervision, coordination of work flow, plus allied healthcare work delegated to the nursing team.	
Total Nursing requirement per 24 hrs	165.2 hrs	Average nursing 5.32 x bed occupancy 30 + additional workload 5.6 = 165.2 nursing hours per 24 hrs	
Skill Mix	65% Registered Nurses	RCN guidelines for skill mix is 65 / 35	
Nursing staff required each day	14 RNs & 8 HCSW shifts	Based on 7.5 hour shift (taking all planned breaks into account) therefore 22 nursing shifts required per 24 hrs. Based on 65% RN requirement =14 HCSW = 8 per 24 hrs	
Number of hrs worked FTE RN & HCSW	1950 hrs per year	Full-time hours = 37.5 per week (@ 365) x 52 Total hrs per year = 1950	

Factors	Numbers	How Calculated	Comment
Ward nursing Staff Establishment (FTEs)	26 RNs & 14 HCSWs	<ul style="list-style-type: none"> Total nursing requirement 165.2 nursing hrs per 24 hrs $165.2 \times 365 = 60298$ hrs per year Each nurse = to 1950 hrs per year: $60298/1950 = 31$ nursing staff required. Add 26.9% FTE to account for sickness, leave and education/training = 39.4 nursing staff Skill mix 65 / 35 = 26 RNs & 14 HCSWs required for ward establishment. 	
Number of nursing staff required for Wales' acute patients	6,551 RNs & 3,528 HCSW	<ul style="list-style-type: none"> Number of acute patients per 24 hrs = 7674.3** Number of nursing staff per 30 patients = 39.4 Number of nursing staff for $7674.3 / 30 \times 39.4 = 10,079$ FTE per 24 hrs Skill mix 65 / 35 = 6,551 / 3,528 	**Stats Wales 2012-13
Cost Per year:	Cost of nursing acute patients safely: £274 million	<p>6,551 RNs @ £25.8K * 23% on-costs = £208M</p> <p>3,528 HCSW @ £15.5 * 21% on-costs = £ 66M</p>	<p>Agenda for Change</p> <p>*** Band 5 increment 6</p> <p>****Band 2 increment 4</p>

Rough [on cost calculations have been made using the University of Bath on cost calculator.](#)

Current administration and reporting

190. The Welsh Government currently has an established system for the monitoring and oversight arrangements of progress against the three year integrated plans and performance of the NHS in Wales in general. This is undertaken through a variety of means, such as: Monthly Chief Executive meetings; monthly and quarterly delivery meetings; joint executive meetings etc. There is also a recognised escalation and intervention

- process which has been developed in conjunction with Health Inspectorate Wales and the Wales Audit Office. This involves sharing and reporting on the performance and progress on NHS organisations between each other.
191. Every Health Board has the responsibility to ensure that the governance arrangements for collecting and monitoring information is reported to the Board in a timely manner in order to assure the Board that safe care is maintained. The Directors of Workforce and Organisational Development are required to provide quarterly accounts/staff monitoring/sickness levels/mandated training and they are also required to produce annual reports for publication by the Health Board at AGMs. Therefore, the cost of collecting and monitoring performance information is already funded within Health Boards. Some hospital wards do not currently have e-rostering but have plans in place to implement it within the next 6 months on a priority need. All Health Boards have placed medical and surgical nursing domains as the priority and some Health Boards are well advanced in e-rostering.
192. Currently Directors of Nursing have a responsibility to assure the Health Boards that staffing ratios according to establishment figures are upheld. There is a hierarchical management structure from Ward Manager to Senior Nurse to Directorate Nurse to Divisional Nurse to Assistant Directors of Nursing. All of whom have, within their area of responsibility, monitoring systems to ensure staffing ratios are adhered to. Some Health Boards already demonstrate in each clinical domain pictorially the reporting chain and indeed have this at individual ward level for patients and their relatives to view. This is deemed to be best practice and was also recognised early on in the Saving 1,000 Lives campaign.
193. Sickness data is recorded via e-rostering and the Electronic Staff Record for all staff. This information and data on bank and agency utilisation is already reported to the Boards of Local Health Boards. The current guidance relating to safe staffing is being monitored and the Welsh Government would expect to keep this guidance under review and update when necessary. Therefore, the status quo position currently includes established processes and associated costs for monitoring, oversight and updating of guidance. Although it is not possible to quantify these costs, comparison can be made with how this baseline is proposed to change under Option 2.

194. Consideration was given to whether the desired outcome could be achieved without legislation, by raising safe nursing levels to a tier 1 priority. If such a policy were undertaken, staff costs would hold as in the two options considered in detail. Also, there would need to be some form of monitoring of performance and progress towards meeting these levels. The costs would therefore not be likely to be significantly less than those set out in Option 2, without achieving the desired impact. Current data on patient waiting times in Wales demonstrates that making an issue a tier 1 priority doesn't guarantee results. A future Welsh Government could reprioritise a tier 1 priority at any time, without there even being discussion in the Assembly. Therefore, it is considered that nurse staffing levels are too important to be addressed by temporarily raising their status to a tier 1 priority.

Option 2: Preferred option: Introduce Bill to ensure nurse staffing levels within the Welsh NHS are sufficient to provide safe, effective and quality nursing care to patients at all times.

195. This option places a duty on health service bodies in Wales to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided. For adult inpatient wards in acute hospitals, the Bill requires the Welsh Government to develop guidance on safe nurse staffing and sets out a process for monitoring, publishing and reviewing the implementation and outcomes of this legislation.

196. This impact assessment sets out the estimated costs of the Safe Nurse Staffing Levels (Wales) Bill, as introduced. This is the only option which would achieve the policy objectives behind the Bill. It is clear, from 2013–14 data, that the Chief Nursing Officer's guidance on safe staffing is not being met consistently across Health Boards. Therefore, it is time to give this issue statutory backing. There is a wealth of academic evidence to support the need for such legislation.

- Aiken, Linda et al (2002), [Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction](#),¹²
- Rafferty, A. et al, (2007) [Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records](#),¹⁰

- [Ball JE et al \(2013\)](#) 'Care left undone' during nursing shifts: associations with workload and perceived quality of care, [and](#)
- Aiken, Linda et al, (2014) [Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study.](#)⁹

197. The setting of minimum nurse staffing ratios and the guidance required by this Bill will initially be implemented for adult acute hospital ward settings. This is the area where the current evidence base supports the implementation of such safe nursing standards. The Welsh Government continues to engage in other clinical settings, and work is underway to develop evidence-based acuity tools for use in community settings (district nursing and health visiting teams) and mental health inpatient settings.

198. Current direction from the Welsh Government in terms of safe staffing is as follows:

- Professional judgement will be used throughout the planning process
- Nursing establishments on acute wards should not normally fall below 1.1 WTE/bed including a head-room of 26.9%
- For specialist areas and wards with tertiary services, professional standards, guidelines and national frameworks should be used to determine nurse staffing levels e.g. National Stroke Nurse Staffing Standards (2007), Quality Requirements for Adult Critical Care in Wales (2006)
- Numbers of patients per Registered Nurse should not exceed 7 by day
- The skill mix of Registered Nurse to Nursing 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
- Ward activity and demand will be considered when establishing staffing levels as well as the number of beds, environment and ward lay-out
- A night time ratio of 1 nurse to 11 patients

199. Consideration was given to setting out more prescriptive demands on the face of the Bill. It was decided that giving Local Health Boards and the Welsh Government flexibility would enable existing systems to be utilised, reduce unnecessary burdens and keep administrative costs to a minimum.

200. Based on the success of the legislation in this area and the gathering of an evidence base in other areas, there would be potential to extend the

application of minimum ratios and safe nurse staffing guidance to other areas. Although the intention of this Bill is not to do so at present, if this were to be considered in the future a costed business case would need to be put forward to evidence the value for money of such a changed approach.

Impact on NHS Bodies

201. The Bill requires health bodies to take reasonable steps towards having capacity to meet safe staffing levels. It is not anticipated that this will impact on current Health Board plans which are looking to meet standards over the current three year planning period. As stated in option 1, funding is agreed in current plans to enable Local Health Boards to work towards having these agreed safe staffing levels in place.

Additional staffing required

202. The Bill requires the setting of minimum ‘nurse to patient’ ratios and ‘nurse to healthcare support worker’ ratios for adult acute hospital ward settings. It places a duty on health service bodies in Wales to take reasonable steps to ensure that nurse staffing levels do not fall below these minimum levels. The ratios themselves are not included in the Bill, but will be set out in the statutory guidance following consultation with relevant stakeholders.

203. The Bill initially requires ratios to be set for adult acute wards as this reflects the initial focus of work carried out by the Chief Nursing Officer and NICE on nurse staffing levels, lessons learned from recent work such as the Francis report, the Keogh mortality review and the Berwick review into patient safety, and the evidence base demonstrating the link between nurse staffing levels and patient outcomes in these settings. The Royal College of Nursing’s guidance on safe nurse staffing levels in the UK highlights that most of the research evidence relates to hospital-based care, and there is currently a lack of equivalent research in primary and community care. The Bill includes provision for minimum ratios to be prescribed for other areas as the evidence base for these areas develops.

204. The minimum staffing ratios required by this Bill will set a baseline below which staffing levels must not fall, and will thus act as a warning signal that, where levels are below this baseline, patient care may be compromised.

205. Therefore the impact of the Bill will be dependent on the statutory guidance to be issued by the Welsh Government. The intention of the Bill is that a triangulated approach will be used to ensure that all relevant information and expertise is utilised when determining appropriate nurse numbers for individual ward settings and shifts. It is anticipated that the Chief Nursing Officer's guidance in this area would be taken forward as the basis for the statutory guidance required by the Bill, which would incorporate these suggested minimum standards, the use of existing acuity tools and professional judgment that takes account of local circumstances and individual need.
206. The CNO, through the Directors of Nursing, commissioned work to be undertaken to determine patient acuity tools in medical and surgical wards in Wales. The Assistant Directors of Nursing were the subject matter experts who produced an acuity tool and it was piloted in Abertawe Bro Morgannwg University Health Board. This acuity tool is now being rolled out across Wales. An acuity tool, when combined with professional judgement, should determine what the day-to-day capability and capacity is to deliver safe care. The capability in terms of resource and nursing structures, whereby registered nurses demonstrate sufficient knowledge and skills in line with experience to meet the clinical needs and dependencies of patients within their domain of care (this is in essence what an acuity tool and staffing level determine). However, professional judgement will also need to be considered because patients may have a variation in level of their own understanding of their condition and how much interface there needs to be with family members, who will need to be engaged along the patient pathway from the point of admission to discharge. Health Boards had £10 million allocated across Wales to enhance medical and surgical staffing levels. The acuity measurement tool is designed to be undertaken twice a year and all Local Health Boards have completed one cycle of this to date. Some Health Boards have indicated their historical underfunding. What this means in real terms is that they have not had sufficient funding to meet safe staffing levels and that their allocation from the £10 million provided the necessary financial resource to secure staffing levels commensurate with the CNO guidance.
207. Responses from Local Health Boards together with three year plans produced for the period 2014-15 to 2016-17 further show that medium

term plans and associated funding are in place to meet these standards by the end of this period. The recent announcement of an additional £425 million funding for the health service in 2014–15 and 2015–16 is intended to ensure that this is the case. The [Minister for Health and Social Services](#) set out that this funding would ensure that agreed plans would be fully underwritten.

208. Guidance required by the Bill will need to take into account the implications of any increasing in the demand for nursing staff. It will be important to ensure that sufficient time is incorporated to allow additional staff to be trained, otherwise there could be adverse impacts as Health Boards would potentially be competing for limited staff. There are options that the Welsh Government could consider, such as incentivising new staff to stay in Wales by offering an initial placement on completion of training.
209. Evidence from the '[perfectly resourced ward](#)' pilot conducted by Aneurin Bevan Health Board at the end of 2012 provided useful evidence around the financial impact of implementing safe staffing levels. Two wards were chosen to pilot a three month scheme where investment was made in the ward establishment and costs and outcomes were monitored. Over the three month period of the pilot, although nursing establishment costs were 6% higher than the preceding period, the considerable reductions in the costs of agency and bank staff more than outweighed these increases. At the end of the three month period, the combined staffing costs of the two wards had not increased (it was marginally lower than the preceding period). The key quality indicators show that there was a positive impact in terms of lower staff sickness, reduction in clinical incidents and higher patient satisfaction.⁴⁵ This is echoed by in-depth studies such as the by Dall et al in 2009. This report showed that investment in nursing offers clear cost savings and efficiencies, as increasing the number of registered nurses per patient improves productivity in terms of the number of deaths avoided and by helping patients to recover more quickly. It reduces medical costs by reducing the length of stay, preventing complications and thereby reducing demand for certain physician services.¹⁵
210. While progress is being made towards providing funding to meet the Chief Nursing Officer's principles, with a further UK election taking place in 2015 and an Assembly election in 2016, it is crucial that legislation is put in place to ensure that these plans are carried out. It is therefore considered

that the Bill as currently intended **should not lead to additional costs for NHS bodies compared to current funding projections and expectations on the NHS.**

Education and professional development

211. The Chief Nursing Officer guidance does address training and professional development and the need for headroom to allow for this. Evidence from Health Boards shows different levels of progress in terms of meeting requirements in this area.
212. The Bill includes provision to ensure that protection is afforded for certain activities and the status of particular roles when staffing levels are being determined (when establishment-setting and when ensuring the adequacy of day to day staffing). This includes time for training and continuing professional development (including induction periods for newly appointed, agency and bank staff), planned and unplanned absence, and the supernumerary status of particular roles, such as senior nurses in charge and student staff.
213. Protection for the supernumerary status of ward sisters/charge nurses is already set out in the core principles issued by the Chief Nursing Officer in 2012. The principles also identify the need for a 'head-room' of 26.9 per cent to allow for staff absence, leave and training needs. The protections included in the Bill therefore are not new requirements on health service bodies in Wales. While evidence from Health Boards shows different levels of progress in terms of meeting requirements in this area and that this principle is not consistently applied in practice, responses from agreed three year plans of Local Health Boards suggest that commitments and funding is in place to ensure these standards are met by the end of the financial year 2016-17. Assurances were given by the Minister for Health and Social Services that such funding is now available following the announcement of additional funding for the health service at the time of the Welsh Government 2015-16 Draft Budget.
214. We have consulted with a number of Health Boards in Wales who confirm that Health Boards have already incorporated a headroom equating to 26.9% to allow for staff leave and training needs. Some questions have been raised as to whether or not, if a clinical area had registered nurses

calling in sick at short notice, this would constitute a breach in safe staffing levels. There is sufficient latitude within the Bill under the professional judgement, to determine the minimum period upon which the patient/staff ratio set out in CNO's guidelines can be managed safely, based on the acuity levels of the patients in an area at any one time. There is also existing escalation policies within each LHB using the Datex system when breaches occur and this should already be part of the governance monitoring systems in place.

215. Therefore it is **not considered that this requirement will have any additional financial impact on Health Boards compared to current plans.**

Monitoring and administrative costs

216. To facilitate openness and transparency, the guidance required by this Bill must set out a process for the publication to patients of information on the numbers and roles of nursing staff on duty. This must aim to provide patients and visitors with an understanding of the level of staffing on a ward. It will be for those developing the guidance to set out the ways in which nurse numbers should be published.

217. The Bill itself does not set out a process for the publication of nurse staffing information. This will be included within the statutory guidance in order to ensure that it is aligned with, and reflects, the relevant processes/mechanisms for ensuring safe staffing, which are to be brought together in the guidance.

218. Health Boards will already be running electronic bed management systems which will monitor the workforce, patients and acuity to manage inpatients and waiting lists coming into wards. Every Health Board has the responsibility to ensure that the governance arrangements for collecting and monitoring information is reported to the Board in a timely manner in order to assure the Board that safe care is maintained. The Directors of Workforce and Organisational Development are required to provide quarterly accounts/staff monitoring/sickness levels/mandated training and they are also required to produce annual reports for publication by the Health Board at AGMs. So, Health Boards already have a system to collect, monitor and make available the relevant information. There are **not expected to be any additional changes needed to existing / planned**

processes, therefore there are estimated to be no additional costs in terms of collecting and making this information available.

219. The precise administrative requirements will need to be set out in guidance produced by the Welsh Government. The aim of any such requirements should be to ensure that these do not add any additional administrative burdens on NHS organisations, whilst ensuring that sufficient information is available on a shift basis and that relevant acuity tools are effectively used for longer term planning.
220. Responses to the consultation provided a mixed picture in terms of the potential costs of administration to implement the Bill. One concern was raised relating to the implied ICT investment. Further study was conducted to ascertain whether Health Boards currently have the current e-rostering systems to implement the Bill. The RCN provided evidence that while ICT systems in Health Boards will not be identical, all Health Boards currently have, or plan to have by the time the Bill is implemented, electronic systems to manage electronic rostering, manage the bank nursing, sickness, incidence monitoring and to measure against workforce planning. Therefore, ICT systems would not be required to change so **there would not be any additional costs in terms of ICT administration to implement this Bill**. Also, as records are electronic, records of staffing levels would be easily available from the date of Bill implementation, so **there would be no additional costs in terms of storing administrative data in the future**.
221. If an organisation did not consider that the electronic systems were in place to manage their workforce as set out in this Bill, this would raise questions as to the efficiency and internal communication within that organisation. It is vital in the modern NHS that comparisons can be made between the electronic data held, such as incidence; complaints; staffing and sickness levels.
222. As described in the Adult Acute Nursing Acuity and Dependency Tool governance framework, NHS organisations in Wales are required to establish their own escalation policy to provide guidance and clarity to staff when raising a concern around staffing levels. Such an escalation policy should set out actions to be taken, identify those who should be involved in the decision-making process, and outline any contingency arrangements

where staffing capacity issues cannot be resolved. It is not considered that this escalation framework need be changed, so there would **not be additional costs in relation to this** (please see enforcement section for more details).

Annual reporting requirement and collection of performance information

223. The Bill requires each health service body in Wales to publish an annual report setting out the actions it is taking to comply with the safe staffing requirements, and which records the number of occasions when nurse staffing may have fallen below the specified minimum levels. Safe staffing should not be considered as a standalone aspect of care and therefore it would not be expected that there would necessarily need to be a separate report relating to safe staffing legislation. The Bill is looking to minimise any unnecessary administrative burdens. This information may be published as part of a wider report, such as the annual quality statement which NHS Wales organisations are already required to produce.
224. A number of key priority areas, identified by the Welsh Government, are currently monitored in accordance with the NHS delivery framework⁴⁶. It is anticipated that such a framework would provide the mechanism for monitoring NHS organisations' performance against the Bill's safe nurse staffing requirements. In relation to tier 1 and statutory delivery requirements, the current delivery framework states that delivery assurance will be provided via Quality and Delivery Meetings (QDM).
225. There are a number of recognised safe nurse staffing indicators which should be monitored by NHS organisations on an ongoing basis and used to inform local staffing requirements. The Bill requires that the Welsh Government publishes a report of each review which demonstrates the impact of the legislation by reference to a range of these indicators, including: mortality rates; readmissions; healthcare associated infection rates; medication errors; falls; pressure ulcers; patient/relative satisfaction; protected training time; staff overtime; sickness absence, and; use of temporary nursing staff. These indicators reflect those identified by the Chief Nursing Officer and the NICE safe staffing guidance, as well as responses to our consultations. There will be limited additional costs here, but it is assumed that most of the performance information required will

already be collected. Information relating to the number of occasions where nurse staffing falls below expected levels would need to be extracted from electronic rostering systems.

226. There are currently monthly meetings, where Health Boards are required to make presentations to the Welsh Government. Compliance with meeting the Bill and progress in terms of outputs such as; mortality, length of stay, complaints, errors, sickness, agency costs and negligence claims could be included as part of such presentations with no additional cost.

If we were to assume that it would take 9 days of staff time, at £31,630 per annum including on-costs, to collect together existing performance information, collate and process this through the system for each of the 7 Health Boards in Wales, the combined costs for these health boards in Wales would be **£9,058** each year. These calculations are based on a typical administrative role and would include flexibility to incorporate time for sign off by senior management. We have consulted with several Health Boards who have said the above estimate would provide more than adequate resource.

Calculation $£31,630 * 7 * 9 / 220$ working days in year = £9,058.

227. It is not suggested that the results of this annual reporting requirement be separately audited by an organisation such as the Wales Audit Office, but would be available for public scrutiny and also review by the Welsh Government.

Welsh Government costs

Cost of communicating changes in law

228. The Welsh Government would incur direct costs in relation to communicating the changes to the law and new duties that would fall upon Local Health Boards. It is considered that this could be incorporated with ongoing publicity work and dialogue that the Welsh Government has with the NHS. The Welsh Government considered that the communications costs associated with the NHS Finances Wales Act would include media relations activities estimated to be £500.

229. This Bill will involve slightly more complexity in terms of communicating changes in the law than was the case with the NHS Finance (Wales) Act (with

some limited additional requirements to make information available to the public). However, it is not envisaged that there will be a need for an extensive public campaign, such as was the case with the Human Transplantation (Wales) Act, as the requirements to display information relating to staffing levels and publish annual reports will ensure members of the public are provided with information on nurse staffing.

230. There would need to be a letter sent to chief executives of NHS bodies. NHS organisations would need to provide bilingual information in a standard section on their website explaining the Bill and how it will work in practice, as well as including a paragraph in their complaints policies. It would be good practice for the Welsh Government to communicate changes to the law to other interested groups / related bodies such as community health councils, regulators and inspectorates, this could be achieved electronically. To reflect the slightly higher complexity of communicating information compared to the NHS Finance (Wales) Bill, **we would expect that communicating changes in the law would not be in excess of £5,000.** These would be one-off costs falling in the first year following implementation of the Bill. Estimates of the costs of amalgamating and producing guidance would have its own communication costs which would be included within published estimates.

Guidance

231. The Welsh Government must issue guidance, which must be consulted upon with experts and those organisations that will be impacted upon by this guidance. 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. Therefore, this would mainly be a matter of putting existing guidance and tools on a legislative footing, so we would not envisage costs being significant.
232. The NHS Finance (Wales) Act estimated that the Welsh Government would also revise and issue guidance to Local Health Boards, setting out the new duty, which is estimated to be around £2,000.
233. While the majority of guidance is anticipated to be made up of existing resources, there will be a need for some specific work in terms of guidance to set out a process for the publication to patients of information on the

- numbers and roles of nursing staff on duty. The guidance would need to also cover how compliance is to be monitored and reported.
234. This would lead to one off costs for the Welsh Government and the Chief Nursing Officer. As stated above, the majority of this guidance is already in existence. However there would be a need to draw together guidance based on best practice in terms of ensuring information is available to the public and produce guidance on the monitoring and reporting of compliance. This would be best approached on a project basis over three months and would require an anticipated maximum input of the following staff:
- 80% of a Grade 6.
 - 10% of 10 grade 6/7s.
235. On this basis the estimated one off cost of developing, consulting and communicating the guidance would **not be expected to exceed £40,000**. These costs are assumed to fall on the Welsh Government in the first year following implementation of the Bill. An allowance for the input of senior directors who will need to have an overview and steering role as part of this exercise is included in these opportunity cost figures. These staff have been assumed to be existing Welsh Government officials for the purposes of this estimate, however the Welsh Government may wish to second or utilise the resource of staff from other health sector organisations to substitute for the above resource.
236. Performance in relation to meeting the Welsh Government's current guidance and acuity tool under Option 1 is being continually monitored, with a view to updating guidance and requirements in the future when necessary. The information reported in terms of meeting the requirements of this Bill will provide a more robust evidence base but not necessarily make any future revisions of guidance more likely. Therefore, this Bill will not introduce any additional future burdens in terms of updating guidance compared to the status quo position.

Enforcement

237. As described earlier in this impact assessment, the Adult Acute Nursing Acuity and Dependency Tool governance framework requires NHS organisations in Wales to establish their own escalation policy to provide guidance and clarity to staff when raising a concern around staffing levels.

238. Powers of direction are set out in section 12 of the NHS (Wales) Act 2006 which enable the Welsh Ministers to give directions to health service bodies about how they should exercise functions which have been delegated to them.
239. Intervention powers are also available to the Welsh Ministers through sections 26–28. These powers can be utilised if a Health Board is considered to be failing to perform one or more of its functions and can, in certain circumstances, be applied to suspend or remove powers and functions.
240. As there is already an escalation and intervention process in place, **no additional costs should arise in terms of producing guidance around escalation policies and their enforcement.**
241. A person could already make a claim in negligence if they could show the nursing care fell below a reasonable standard but they would have this claim irrespective of the Bill. Clinical negligence claims in Wales are increasing annually as shown by the 13.7% increase to in year settlement claims from the Welsh Risk Pool in 2013–14. While there are a number of drivers leading to these annual increases, this legislation would lead to an environment where the risk of clinical errors is reduced.
242. The escalation process is designed so that issues are dealt with as they arise. In the hypothetical situation where a health board were to, for example, persistently disregard the importance of deploying sufficient nurses when taking budgetary decisions, this could give rise to a judicial review claim being brought against that health board. However, the potential lower risk of negligence claims that the increasing standards of care safeguarded by this Bill would bring mitigates against any such risk and claims alleging clinical negligence based on a failure to provide a reasonable standard of care could be made irrespective of the duty established by the Bill. Therefore, there would **not be an anticipated increase in legal costs or costs resulting from litigation for either the Welsh Government or Health Boards.**

Cost of reviewing legislation

243. The Bill will require the Welsh Government to review the operation and effectiveness of this legislation at regular intervals, initially after one year, thereafter at least every two years. The level of such monitoring could

range from an overview of indicators to more in-depth studies of the impact the Bill is having in wards.

244. The Bill requires that the Welsh Government publishes a report of each review which demonstrates the impact of the legislation by reference to a range of these indicators. As stated earlier, an overview of the impact of the legislation can be provided on a monthly basis through existing reporting arrangements. It is envisaged that the current three year rolling financial plans of local health boards should continue to provide assurance around planning to meet safe staffing standards, as is currently the case. It would also be prudent for these plans to provide evidence around how implementation is progressing and also outputs and outcomes, which would include performance indicators and other evidence around the impact that is being seen within the organisation and on patients. This could form part of the annual reporting that Health Boards will be expected to provide. The availability of such information will make the process of reviewing information and the subsequent cost far more modest.
245. The NHS Finances (Wales) Bill estimated one-off costs in terms of external capacity to review and support of the integration of medium term plans at £62,500. It would be expected that reviewing this legislation would utilise well under a fifth of the resource to review and support the integration of medium terms plans, with an allowance of additional costs in the first year to enable the process to become embedded. Therefore we have assumed a generous figure of in the region of **£15,000 to £20,000 in after one year and £10,000 to £15,000 every two years subsequently.**
246. This reporting requirement will give a benchmark of information to ascertain the impact of the Bill. This information would also highlight issues that the Welsh Government may wish to investigate in more detail. It would be prudent to conduct a more in-depth study of the impact additional funding is having in wards, although we would anticipate this would form part of existing work by the Welsh Government around the impact of additional funding provided around the time of the Draft Budget 2015-16, such an in-depth study, in isolation to other work, could cost in the region of £50,000 to £75,000. **Such costs are not included in the estimated cost of the Bill as it would be recommended that this would be incorporated into the programme of more wide ranging research the Welsh Government will already be undertaking.** The outcomes of these reviews

could be used to highlight issues that the Chief Nursing Officer may wish to consider to keep existing guidance up to date with emerging technology and delivery.

Benefits

247. Hospitals in Europe have been a target for spending constraint despite concerns about the adverse outcomes for quality and safety of health care. Health system reforms have shifted resources to provide more care in community settings while shortening hospital length of stay and reducing inpatient beds, resulting in increased care intensity for inpatients. Cost containment in hospitals results in higher intensity of services delivered in less time and more rapid patient throughput from admission to discharge. These changes require more nurses per patient, not fewer, to prevent deterioration in care quality and safety that can harm patients and lead to higher costs if expensive complications such as infections result.
248. There is a growing consensus, supported by several high quality systematic reviews, that the number of nurses available for patient care improves patient outcomes in acute medical and surgical wards. As well as tried and tested legislation in California and the State of Victoria in Australia, this is reflected by guidance produced by NICE and the Chief Nursing Officer recommending the implementation of safe staffing levels in such wards. In California, United States of America, ratios were set in 1999 (eg. 1:5 on medical and surgical wards). To date fifteen states in the US have legislation aimed at addressing safe nurse staffing but California is the only state to have specific ratios applying to each speciality in all hospitals. Evidence of reported impact in California includes:
- No evidence that ratios have increased costs.⁴⁷
 - Hospital nurses typically care for one patient less than nurses in other states, the lower caseload is significantly related to lower patient mortality.⁴⁸
249. In Victoria, Australia minimum nurse to patient ratios were legally mandated in the public sector in 2001 (1:4, plus one in charge on medical/surgical wards). In 2004 the way in which the registered nurse to patient ratio was expressed was changed to 5:20, to give more flexibility on registered nurse deployment across the ward.⁴⁹ The Australian Nursing Federation (ANF) reports that ratios have led to:
- Better recruitment and retention of nurses and greater workforce stability.
 - Adequate numbers of nurses rostered six weeks in advance.
 - Directors of Nursing having fully funded budgets to provide safe staffing levels, and a reduced reliance on agency staff.

- Better patient care; beds are not kept open unless there are sufficient staffing levels.
- More manageable nursing workloads.
- Increased job satisfaction for nurses, more workplace stability, and reduced stress.⁵⁰

250. In terms of the UK and Welsh context, safer care has the potential to significantly reduce costs to the NHS in the long term. The main benefits are listed below:

- Reduced risk of healthcare acquired infections: the cost to the NHS of surgical site infections is estimated to be around £700 million a year.
- Potential reduction in mortality rates.
- Improved patient experience: potential reduction in adverse events and associated costs.
- Reduced risk of litigation claims due to poor care: the average cost of a claim classed by the NHSLA under the 'nursing' category was £75,000 plus the claim excess and legal advice costs. [Dr Goodall, Director General, Health and Social Services, Welsh Government stated](#) the impact within any individual financial year within the Welsh risk pool is around £70 million a year.
- Potential reduced incidence of IV fluid-associated complications by better management of fluids: patients with complications appeared to spend an additional 2.5 days in hospital compared with patients without complications.⁵¹
- Reduced levels of falls, with a saving of approximately £1,400 per fall avoided.
- Potential reduction in bed days due to providing more effective care: potential resources released as a result of a reduced hospital length of stay have been estimated at £236 per bed day (national tariff, 2014–15).
- Reduction in readmissions within 30 days.
- Number of pressure ulcers: total costs in the UK were estimated as being £1.4 – £2.1 billion or around 4% of total NHS expenditure in 2004. This level will have reduced over the interceding period because of the

focus on preventing pressure ulcers. However, this can still be reduced considerably, thereby improving patient care and a decrease in costs associated with their management.

251. It has also been shown that inadequate staffing levels can lead to a reliance on overtime and temporary (agency and bank) staffing, which can be costly and inefficient. Some responses to our consultations described high levels of temporary staffing on hospital wards.

Patients need continuity of care, but all too often wards rely upon agency staff for the delivery of care, which brings about increased risk to patients of having members of staff unfamiliar with local processes and procedures, as well as impacting upon the patient experience of care⁵².

252. A 2011 study⁵³ found that hospital wards with temporary staff had poorer staffing levels, higher workloads, more sickness absence and lower ward quality scores than wards that were staffed by permanent nurses only. The Keogh mortality review⁵⁴ in 2013 found an over-reliance on temporary nursing staff in the hospital trusts it looked into, noting that there were often restrictions in place on the clinical tasks temporary staff could undertake.

253. The perfectly staffed ward pilot in Aneurin Bevan in 2012, whilst a small study, showed a reduction of 64% in bank and agency staffing costs over the pilot period, compared to the previous 6 months.

254. The Royal College of Nursing, published a publication, Time to Care – Update in February 2014, which looked to estimate the cost to the NHS of agency/bank staff and overtime.⁵⁵ According to research undertaken by the RCN, Health Boards in Wales have spent approximately £132.5 million on agency/bank staff and overtime during the three previous years.

255. In terms of mortality, a study of nurse staffing and education and the impact on hospital mortality in nine European countries concluded the following. An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% (odds ratio 1.068, 95% CI 1.031–1.106), and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7% (0.929, 0.886–0.973). These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an

average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients.⁵⁶

Summary of costs

256. The majority of these costs would be opportunity costs, relating to staffing time to produce guidance, review legislation and produce information to feed into annual reports. Staffing costs will be the same under both Options: £275 million. Table 4 estimates that there will be around £50,000 in one off costs in the first year following introduction, followed by an additional £83,000 costs over the following five years, shown in Table 5. In total this is a cost of £133,000 over five years directly related to the Bill, shown in Table 6. Although, it would be prudent to include a more in-depth study into the impact of the Bill with a cost in the region of £50,000 to £75,000 potentially in Year 3.

Table 4 One of costs

One off costs		£
Guidance	40,000	
Communication	5,000	
Review legislation	5,000	
Total	50,000	

Table 5 On-going costs, including staffing costs in Option 1

On-going costs						£
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Staffing, including CPD	275,000,000	275,000,000	275,000,000	275,000,000	275,000,000	1,375,000,000
Review legislation	12,500	0	12,500	0	12,500	37,500
Annual reporting	9,058	9,058	9,058	9,058	9,058	45,288
Total	275,021,558	275,009,058	275,021,558	275,009,058	275,021,558	1,375,082,788
Additional costs of Bill	21,558	9,058	21,558	9,058	21,558	82,788

Table 6 Total costs, including staffing costs in Option 1

Overall costs	Year 1	Year 2	Year 3	Year 4	Year 5	Total	£
Guidance	40,000	0	0	0	0	40,000	
Communication	5,000	0	0	0	0	5,000	
Staffing, including CPD	275,000,000	275,000,000	275,000,000	275,000,000	275,000,000	1,375,000,000	
Review legislation	17,500	0	12,500	0	12,500	42,500	
Annual reporting	9,058	9,058	9,058	9,058	9,058	45,288	
Total costs	275,071,558	275,009,058	275,021,558	275,009,058	275,021,558	1,375,132,788	
Additional costs of Bill	71,558	9,058	21,558	9,058	21,558	132,788	

Unintended consequences

257. Consultation responses have highlighted concerns that staff could be taken out of areas that are not covered by the legislation which could potentially have an adverse impact on other areas. This is a natural concern, however, there is no evidence that this has happened in other areas of the world where similar legislation has been put in place.

258. If staffing levels were expected to rise too quickly, there could be negative impacts relating to a shortage of nurses to fill posts. This in turn could distort the market and lead to nurses leaving the NHS to seek higher pay through agency work. By only requiring gradual and sustainable increases in staffing levels and incentivising newly trained staff to remain in Wales, such a risk can be eluded. The increase in morale proven in pilots and other countries where minimum staffing has been in place would also lead to staff being more likely to remain within the NHS staffing establishment.

259. Consultation responses have also raised a concern that bed numbers could be reduced so that existing staff establishment meets ratios. It is important that the investment planned by the Welsh Government is maintained. The Welsh Government's current allocations and Local Health Board three year plans currently are sufficient to meet the Chief Nursing Officer's guidance. Similar fears existed in California prior to the implementation of mandatory minimum nurse staffing ratios there. However no hospitals or hospital units have been closed in California as a result of the ratios being introduced.⁵⁷ It may also be noted that any

argument for a status quo whereby wards are currently unsafely staffed is inherently flawed.

260. During development of this legislation we have considered the risk that minimum standards could be treated as a maximum. To ensure this is not an unintended consequence, guidance would be clear that the approach to workload planning should be triangulated using the Chief Nursing Officer's guidance, acuity tools and professional judgement, rather than a simple adherence to minimum ratios.

Children's Rights Impact Assessment (CRIA)

Introduction

261. This Children's Rights Impact Assessment (CRIA) considers the effect of the Safe Nurse Staffing Levels (Wales) Bill on children in Wales and their rights under the United Nations Convention on the Rights of the Child (UNCRC).
262. The UNCRC is an international human rights treaty that applies to all children and young people up to the age of 18. It was ratified by the UK in December 1991 and came into force in the UK in January 1992.
263. The Welsh Government adopted the Convention as the basis for policy making for children and young people in Wales in 2004. Children's rights in Wales are further protected by the Rights of Children and Young Persons (Wales) Measure 2011 which requires Welsh Ministers to have due regard to the substantive rights and obligations within the UNCRC and its optional protocols.
264. CRIAs are a key mechanism for implementing the UNCRC. The Welsh Government has committed to undertaking them as a means of ensuring that due regard is given to children's rights when introducing legislation or exercising Ministerial functions.
265. Whilst these obligations are on Welsh Ministers when bringing forward legislation, it is also important for Private Member Bills to fully take into account the UNCRC. This CRIA has been undertaken to inform the proposals in the Bill, by considering the potential consequences for children and young people of introducing the legislation, as well as identifying opportunities to further implement the Convention. Although some individual Articles of the UNCRC may appear particularly relevant, it is important to take a holistic view of the impact of the legislation across all Articles of the Convention.

The purpose of the Bill

266. The Bill aims to ensure that nurse staffing levels within the Welsh NHS are sufficient to enable the provision of safe, effective and quality nursing care to patients at all times.
267. It places a duty on health service bodies to take steps to ensure that nurse staffing levels on adult acute hospital wards do not fall below certain levels (minimum ratios will be prescribed), and requires the Welsh Government to

issue statutory guidance setting out the methods/processes by which NHS organisations will be expected to determine nurse staffing levels that are locally appropriate and at all times safe.

268. It also places a wider duty on health service bodies in Wales to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided.

269. The need for the Bill is covered in detail within the Explanatory Memorandum and not all of the arguments put forward are replicated within this CRIA.

Analysing the Bill's impact on children and their rights under the UNCRC

270. In preparing the Bill, consideration has been given to whether children and particular groups of children may be affected. This has informed the analysis of how the Bill impacts on the Articles of the Convention.

271. Two consultations have been undertaken on this proposed legislation. No concerns were raised specifically in relation to children and young people, although some wider concerns were raised which could have a potential impact on children's rights. These are discussed in the section 'Unintended consequences and risks'.

272. The Bill is relevant to the overarching principle of keeping children and young people safe from harm, and to a number of specific Articles within the UNCRC.

273. The most relevant Articles that have been identified are Articles 24, 6, 23, 12 and 13:

- Article 24 gives children the right to good quality health care and to clean water, nutritious food and a clean environment so that they will stay healthy.
- Article 6 gives all children the right of life and states governments should ensure that children survive and develop healthily.
- Under Article 23, children who have any kind of disability should have special care and support so that they can lead full and independent lives.

- Under Article 12, children have the right to say what they think should happen, when adults are making decisions that affect them, and to have their opinions taken into account.
- Article 13 gives children the right to freedom of expression, including receiving and sharing information.

274. Children and young people will be amongst those who benefit from the changes that would be made under the Bill. Nurses work in every kind of healthcare setting and clinical practice area, and provide care for people from birth through to death. As such, nurses are uniquely positioned to have a significant impact on the health and wellbeing of the whole population.

275. Whilst the Bill requires minimum staffing ratios and statutory guidance to be implemented in adult acute ward settings initially, it is acknowledged that a number of younger patients may spend time on adult wards.

276. The 2002 Carlile Review of safeguards for children and young people treated and cared for by the NHS in Wales found that nursing and other staff on adult wards may have no expertise in the care of children, and will not have gone through the appropriate employment checks or training in child protection. The Review recommended that sick children should be placed in children's wards whenever possible and that, while on an adult ward, children should have the same access to parents, qualified staff and facilities that they should have on a children's ward.

277. It is important that where children are being treated on adult wards, the needs of these younger patients are fully considered when determining an appropriate level of staffing. This includes taking a holistic view of their needs and rights, rather than focussing solely on their medical treatment. For example, children's educational needs should be taken into account – if a child is in hospital for a period of time and is well enough to do schoolwork, is this facilitated by the hospital environment and by staff? Where there may be a child protection issue, are staff adequately engaging in the safeguarding process?

278. It is also important that children and young people should be seen as individuals and be involved in discussions and decisions about their health and treatment. Having the time to talk to their young patients in hospital

should be a fundamental part of the role of nursing staff. Staffing levels should reflect the time needed to communicate with children and young people and ensure that they, as patients in their own right, are provided with appropriate information and given the opportunity to ask questions and voice any concerns.

279. There may be cultural issues connected with particular groups of children which may impact on staffing needs. These could include for example gypsies and travellers (where staff may have to work with the patient's family to gain their trust), looked after children (who may not always be accompanied by an adult), children with disabilities, and black and minority ethnic groups.
280. Therefore, in order to support children and young people in hospital in a holistic and child-centred way, liaising with other agencies where necessary, nursing staff may need additional time and access to relevant knowledge and training. This should be factored in when considering nurse staffing requirements for all settings.
281. In developing the Bill, it was considered of paramount importance that there be a flexible approach to nurse staffing which takes account of individual patients' needs and local circumstances. The minimum nurse staffing ratios are therefore only one element of this legislation to ensure safe staffing levels. The guidance required by the Bill must set out the methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing to meet patients' needs on a day to day/shift by shift basis. This includes the use of validated workforce planning tools, the exercise of professional judgment, and the application of relevant standards/guidelines developed by professional groups.
282. The Bill also recognises the need for nursing staff to have the necessary and up to date skills to carry out their tasks safely, effectively and sensitively. It includes provision to ensure that protection is afforded for training and continuing professional development when staffing levels are being determined.
283. As noted above, the minimum ratios element of this legislation initially applies to adult acute hospital ward settings, as this reflects the current evidence base. However the Bill recognises the importance of having appropriate levels of staffing in all settings, including children's health services, and so places a duty on health service bodies in Wales to have

regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided. Alongside this wider duty on the Welsh NHS, there is provision for minimum ratios to be prescribed for other areas at a future date, as the evidence base for these develops. It is considered that the minimum nurse staffing ratios and the safe staffing guidance required by the Bill should be extended to children's settings in due course.

284. Under Article 12, children have the right to say what they think should happen when adults are making decisions that affect them, and to have their opinions taken into account. The Bill requires the Welsh Government to develop guidance on safe nurse staffing following consultation with stakeholders. In order to ensure that the guidance is robust, expertly-informed and evidence-based, it is expected that groups representing the interests of all patients, including younger age groups, will be consulted.

285. Developing any further guidance about hospital services and staffing should provide an opportunity to give consideration to creating child-friendly spaces in all ward settings – both where children are patients themselves, and where they may be visiting others.

Articles 24, 6, 23, 12 and 13 are given effect under the Bill.

286. Under Article 18, both parents share responsibility for bringing up their children, and should always consider what is best for each child. Governments should help parents by providing services to support them, especially if both parents work.

287. We acknowledge that a proportion of adults undergoing treatment in hospital will have caring responsibilities; by helping to ensure improved outcomes for those patients, it is anticipated that this section of the Bill will also benefit those children and young people for whom patients have responsibility.

288. It is also recognised that some children and young people visiting adults in hospital may themselves perform a carer's role. It is important that nursing staff recognise the needs of young carers, as noted in the Welsh Government's Carers Strategy for Wales which identified that 'All health professionals need information and training on how they can identify and engage with young carers.' By ensuring that staffing levels will allow nurses the time to care for patients sensitively, efficiently and effectively, and by

protecting time for nurse training and professional development, it is considered that the Bill respects the rights of young carers.

Article 18 is respected under the Bill.

289. Articles 1–5 and 42 contain general principles of the Convention in relation to who is protected, an affirmation that all relevant organisations should work towards the best interests of children, parental freedom, applicability of these rights to all children and awareness of the Convention itself.

Articles 1–5 and 42 are respected under the Bill.

Unintended consequences and risks

290. The intentions and aspirations behind the Safe Nurse Staffing Levels (Wales) Bill are that children and young people will benefit and that their rights under the UNCRC will be complemented and progressed. However, any proposed legislation must be mindful of any unintended consequences and risks that outcomes may not be completely as planned. It has therefore been important to consider such issues when developing the Bill.

291. As stated above, no concerns were raised specifically in relation to children and young people during the two consultations that have been undertaken on this proposed legislation. However, there was a broader concern that the focus on adult acute settings may have a negative impact on other settings, in that resources may be diverted from these areas in order to meet the staffing requirements in adult wards.

292. The Bill seeks to address this concern by:

- including provision for ratios to be extended to other settings in the future, as the evidence base for these areas develops, and
- placing a duty on NHS organisations in Wales to have regard to the importance of ensuring safe staffing in all settings (this would therefore include community services, people’s homes etc. as well as all inpatient settings).

293. Additionally, it has been considered that a range of strategies/guidance are already in place for children’s health services including for example:

- The National Service Framework for Children, Young People and Maternity Services
- All Wales Neonatal Standards

- Royal College of Nursing guidance on staffing levels for children and young people's services
 - Flying Start (targeted early years programme)
294. The Welsh Government's seven core aims for children and young people, which summarise the UNCRC, are intended to form the basis for decisions on strategy and service provision:
1. have a flying start in life
 2. have a comprehensive range of education and learning opportunities
 3. enjoy the best possible health and are free from abuse, victimisation and exploitation
 4. have access to play, leisure, sporting and cultural activities
 5. are listened to, treated with respect, and have their race and cultural identity recognised
 6. have a safe home and a community which supports physical and emotional wellbeing
 7. are not disadvantaged by poverty.

Summary of the Bill's impact on children's rights

295. In summary, the Bill is considered complementary to the United Nations Convention on the Rights of the Child. Due regard of children's rights has been taken during the development of the Bill.
296. The impact on particular groups has been considered and, where necessary, proposals have been adapted to ensure that the Bill has as positive impact as possible without causing detriment to any particular groups. Potential risks and unintended consequences have been considered, which has had an influence on the content of the Bill.

Part 3: Explanatory notes

These Explanatory Notes relate to the Safe Nurse Staffing Levels (Wales) Bill as laid before the National Assembly for Wales on 1 December 2014.

They have been prepared by Kirsty Williams AM in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the National Assembly for Wales.

The Explanatory Notes should be read in conjunction with the Bill. They are not meant to be a comprehensive description of the Bill. Where an individual section of the Bill does not seem to require any explanation or comment, none is given.

Section 1: Purpose

Section 1 states the purpose of the Bill. It sets out what the Bill is intended to achieve. The effect of the purpose section is that it requires the remaining provisions of the Bill to be interpreted or read in light of it.

Section 2: Safe nurse staffing levels

This section inserts section 10A into the National Health Service (Wales) Act 2006.

Section 10A(1) imposes two new duties on health service bodies in Wales.

Firstly, it requires health service bodies, in all decisions that they take, to consider whether they are deploying a sufficient number of nurses to provide safe care. The duty will apply to all settings within the NHS in Wales, to include community settings and will apply to all functions that a health service body undertakes, for example budget setting, commissioning services, employing staff etc.

Secondly, it requires health service bodies to take reasonable steps to maintain minimum nurse: patient and nurse: healthcare support workers in acute settings, in accordance with guidance issued by Welsh Ministers under Section 10A (4). What are 'reasonable steps' will be determined taking into account all the individual circumstances of a case. The duty will however mean that in practice, health service bodies will need to justify a decision to provide fewer nurses than the number recommended by the guidance. In addition, they will need to accurately record the reasons for any such decision.

Section 10A(3) provides the Welsh Ministers with the power to make regulations, to extend the duty under section 10A(1)(b) (“the minimum recommended ratios duty”) to other settings within the National Health Service in Wales. This could for example include GP practices, community settings etc. Any regulations made by the Welsh Ministers under this section would be subject to the affirmative procedure.

Section 10A(9) imposes a duty on health service bodies to monitor the minimum recommended ratios duty and any action to prevent recurrence in accordance with a document issued by the Welsh Ministers setting out processes in place to monitor progress. It is anticipated that the NHS delivery framework will provide a suitable document for monitoring progress. This provision does not however limit the Welsh Ministers discretion to provide for a different monitoring process.

Section 3: Review

Section 3 provides for a review of the operation and effectiveness of the Act to be carried out by the Welsh Ministers as soon as practicable after the end of the year following the Act coming into force. Thereafter such reviews must be carried out on a biennial basis.

Following the review, the Welsh Ministers must publish and lay before the Assembly a report which provides further details, and in particular assesses the impact of the report on a range of matters which appear to them to constitute safe nursing indicators. Section 3 (a) – (j) sets out a list of safe nursing indicators. These are intended to give examples. This section does not prevent the Welsh Ministers from taking into account any other matters which appear to them to constitute safe nursing indicators.

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