

# Nurse Staffing Levels (Wales) Bill Explanatory Memorandum

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An Explanatory Memorandum on the Safe Nurse Staffing Levels (Wales) Bill was originally prepared by Kirsty Williams AM and laid before the National Assembly for Wales in accordance with Standing Order 26.6 in December 2014.

Following Stage 2 proceedings on the Bill (which was amended so that its short title became the Nurse Staffing Levels (Wales) Bill), this revised Memorandum has been prepared by Kirsty Williams AM in consultation with the Welsh Government. This is now laid before the National Assembly for Wales in accordance with Standing Order 26.28.

## **Declaration of Legislative Competence**

In December 2014, on the introduction of the Safe Nurse Staffing Levels (Wales) Bill, Kirsty Williams AM made the following 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**

**January 2016**

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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 and 26.28. 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 an overarching duty on Local Health Boards and NHS Trusts 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 Local Health Boards and NHS Trusts (where they provide nursing services) to designate persons to calculate safe, locally appropriate nurse staffing levels, and placing a duty on these organisations to maintain these staffing levels. There is provision for this duty to be extended to other healthcare settings at a future date;
  - requiring the Welsh Government to issue guidance to support NHS Wales organisations in calculating the appropriate nurse staffing levels;
  - ensuring that, when determining nurse staffing levels, factors such as the supervisory functions of staff, the qualifications, skills and experience of nurses and other staff providing care, and the ward environment are properly taken into account;

- placing a duty on Health Boards and NHS Trusts in Wales to report on their compliance with the nurse staffing requirements and on actions taken 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 Nurse Staffing Levels (Wales) Bill.

8. Regulation of health professionals is excepted under the heading to paragraph 9. None of the provisions in the 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)<sup>1</sup> 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 review<sup>2</sup> 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 safety<sup>3</sup> (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 Question<sup>4</sup>, 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<sup>5</sup> (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 Wales<sup>6</sup> (January 2014) highlighted 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*<sup>7</sup>, 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*<sup>8</sup> 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 mortality<sup>9</sup> 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 study<sup>10</sup> 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 study<sup>11</sup> 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 Aiken<sup>12</sup> (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 Wales<sup>13</sup> 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 safety<sup>14</sup> 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 2009<sup>15</sup> 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 study<sup>16</sup> 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 evaluation<sup>17</sup> 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.<sup>18</sup>

26. A 2011 study<sup>19</sup> 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 review<sup>20</sup> 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.<sup>21</sup>

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 care<sup>22</sup>.

### **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 guideline<sup>23</sup> 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 Nursing<sup>24</sup>, and in Wales the

Welsh Government's Chief Nursing Officer issued a set of principles to support the planning of safe nurse staffing levels. Again, this 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;
- 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 Boards<sup>25</sup> 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 2014<sup>26</sup>, 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, and has undergone a period of validation. 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 Local Health Boards and NHS trusts 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 Wales<sup>27</sup> 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.<sup>28</sup>

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, the Bill was introduced with the intention of strengthening 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).<sup>29</sup>

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.<sup>30</sup>

## What the Bill does and why

### Duty on NHS Wales organisations

44. Section 1(1) of the Bill inserts a new section 25A into the NHS (Wales) Act. Section 25A places an overarching duty on Local Health Boards and NHS Trusts in Wales (where they provide nursing services) so that when they are considering the extent of the provision of nursing services necessary to meet all reasonable requirements, they must have regard to the importance of providing sufficient nurses to allow nurses time to care for patients sensitively. This overarching duty applies when Local Health Boards and NHS Trusts in Wales provide care themselves and when Local Health Boards commission/fund care from third parties.

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 a safe and appropriate level of nurse staffing in all settings where NHS nursing care is provided, allowing nurses the time to care for patients sensitively. 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.<sup>31</sup>

## Calculating and maintaining nurse staffing levels

48. For adult acute medical and surgical wards, the Bill requires Local Health Boards/NHS Trusts to designate a person (or description of a person) to calculate the appropriate nurse staffing level to meet all reasonable nursing care requirements (referred to in the Bill as the 'nurse staffing level').
49. Health Boards/Trusts must take steps to maintain the nurse staffing level.
50. The Bill recognises that staffing levels need to take account of individual patients' needs and local circumstances, including for example the ward environment and the skills of nursing and other staff on shift.
51. It sets out a 'triangulated' approach to ensuring nurse staffing levels are sufficient to enable the provision of safe, effective nursing care that meets patients' needs. This approach includes the exercise of professional judgment, use of validated acuity/workforce planning tools, and reference to known indicators of safe nursing care.
52. Different nurse staffing levels may be calculated at different times to ensure that an appropriate level of nursing care, which reflects patients' needs and conditions on a ward, is always provided.
53. The Bill initially requires this triangulated approach to determining nurse staffing levels to be implemented in adult acute medical and surgical wards. 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 the duty to calculate and maintain nurse staffing levels to be applied to other settings as the evidence base for these areas develops.
54. 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'.

55. 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'<sup>32</sup>.
56. The 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, and seeks to ensure that all relevant information, tools and expertise are utilised when determining the appropriate numbers and skill mix of nursing staff for individual ward settings and shifts.
57. Under the Bill, Health Boards and NHS Trusts in Wales must also make arrangements to provide patients with information about the nurse staffing level.
58. 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.<sup>33</sup> Responses to the consultations on the draft 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. It is anticipated that this issue will be addressed in Welsh Government guidance to support the calculation of appropriate nurse staffing levels.

### Guidance

59. For adult acute medical and surgical wards, the Bill requires the Welsh Government to develop guidance to support Health Boards and NHS Trusts in complying with the duty to calculate and maintain nurse staffing levels which enable the provision of safe nursing care.
60. The guidance may set out a number of factors that should be taken into account when calculating the appropriate nurse staffing level, including the qualifications, competencies, skills and experience of nursing staff and other staff involved in providing care, the ward environment, and patient turnover. If nurses providing care are also required to undertake supervisory or administrative functions, this should also be considered as it will impact on their capacity to provide direct patient care.

### Reports

61. The Bill also requires Health Boards and NHS Trusts in Wales to publish a report on compliance with the duty to calculate and maintain nurse staffing levels in adult acute wards, including the impact that any failure to maintain the appropriate levels has had on patient care (for example, an increase in incidents of harm caused by medication errors, falls, and pressure ulcers). Reports must also detail any action taken where nurse staffing levels have not been maintained.
62. Reports, which can form part of a wider report, must be submitted on a three-yearly basis.
63. The Older People's Commissioner for Wales' report, Dignified Care: Two Years On<sup>34</sup> stated that 'routine and public reporting about the adequacy of

staffing levels must be an immediate priority for the Welsh Government and the NHS’.

### Consultation

64. 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. The Bill specifies that consultees must include Local Health Boards, any NHS Trust which is required to have regard to the guidance, the independent health care and care home sectors. The Welsh Ministers must also consult with organisations which appear to them to represent the interests of persons likely to be affected by the guidance, and other persons likely to be affected by the guidance as they consider appropriate.
65. 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.

### Consultation

66. 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.
67. The Royal College of Nursing has provided advice and expertise throughout the development of this Bill.

### Initial consultation

68. 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.

69.29 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.

70. 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.

71. 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.

72. 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*

73. 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.

74. 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.<sup>35</sup>

75. 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.
76. 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.
77. 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 159–164 (unintended consequences).
78. 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 (retaining this name at introduction), and within its scope was 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 aimed to facilitate a ‘triangulated’ approach to determining the right level of nurse staffing, using professional judgment and appropriate workforce planning tools. The minimum ratios were 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 was included in the Bill to ensure that any ratio is upwardly adjustable and is not applied as an upper limit in practice.

79. During Stage 2 proceedings on the Bill, the Minister for Health and Social Services tabled amendments that removed the term 'safe' from the Bill, resulting in it being retitled the 'Nurse Staffing Levels (Wales) Bill.'

80. Advocating this change, the Minister stated that:

Trying to establish a legally secure definition of 'safe' or 'safely' in such terms would be impossible, I believe, as the concept would have to be relative to the setting in which it was being used.

81. The Member in Charge of the Bill disagreed, stating that:

the term 'safe' has... been used in numerous Measures and Acts in the National Assembly for Wales.

82. However, even with the removal of the term safe from the text of the Bill, the Member in Charge of the Bill considered that:

the Bill, subject to the Government amendments, will still result in actions that support the delivery of safe staffing levels.

83. The Minister agreed with these comments, stating that:

the impact of the Bill and the effect of the Bill are not affected by the use of a single word. We differ on whether it should be included or not, but we are of the same mind in relation to the impact that the Bill will have.

### *Applicable settings*

84. 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 the duty to calculate and maintain the appropriate nurse staffing level is not in place, to meet the requirements in settings where the legislation does apply.

85. The duty to calculate and maintain nurse staffing levels 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 Local Health Boards and NHS trusts in Wales (that provide nursing services) to have regard to the importance of providing sufficient nurses in all settings, there is provision for the duty to calculate and maintain nurse staffing levels 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*

86. 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.<sup>36</sup>

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 Local Health Boards and NHS trusts on compliance with the duties on nurse 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 Bill requires Health Boards/Trusts to make arrangements for the publication to patients of information on nurse staffing levels. It also requires Health Boards and Trusts to publish three-yearly reports on compliance with the staffing requirements, and which also record 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.

*The guidance required by the Bill may set out that the supervisory and administrative functions of nurses are taken into account when calculating the nurse staffing level. Raising concerns*

121. 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.

122. 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)

123. 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*

124. 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.

125. 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.

126. To strengthen accountability, the Bill places a duty on NHS organisations in Wales to monitor and report on compliance with safe nurse staffing requirements, including reporting on actions taken where failings occur.

#### *Evaluation/measuring of outcomes*

127. 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).

128. 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).

129. Under the Bill, Health Boards/Trusts will be required to report on the impact on patient care of failures to maintain the appropriate nurse staffing levels. This can be by reference to recognised indicators of nursing care quality such as medication errors, falls and pressure ulcers.

## Second consultation

130. 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.

131. The vast majority of respondents welcomed the aims of the draft 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.

132. 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 was the only mechanism by which improved nurse staffing levels could be achieved.

Comments on specific provisions included the following:

### *Guidance on safe staffing*

133. 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.

134. 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*

135. There remained 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.

136. Some evidence requested more clarification in the draft 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’.

137. 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.

138. 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.

139. 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*

140. 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.

141. 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*

142. One response suggested that greater clarity/definition is needed about what is meant by ‘local contexts’.

143. 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.

144. 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*

145. 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.

146. 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*

147. 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.

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

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

150. 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.
151. 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*

152. 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*

153. 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.
154. 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.
155. 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*

156. 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.
157. 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.

158. 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, prior to introduction**

Grateful consideration was given by the Member in Charge to all comments received during her consultation on the draft Bill. A number of changes were subsequently made to the Bill as introduced, reflecting the feedback received. These included more consistent use of terminology throughout the Bill, and amendments to wording to clarify or strengthen some provisions.

#### **Unintended consequences**

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

#### ***Negative impact on other staff groups***

160. As described above (paragraph 77) 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 draft Bill failed 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.<sup>37</sup>

161. Whilst very supportive of the draft Bill and the setting of minimum nurse staffing ratios, UNISON Cymru believed 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.

162. 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*

163. 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 as introduced required that staffing levels should be at all times safe, but did not itself prescribe the numbers of nursing staff needed. Similarly, following amendments at stage 2, Local Health Boards and NHS Trusts (where they provide nursing services) are under a duty to have regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively, but the Bill does not prescribe the numbers of nursing staff needed. It is expected that the nurse staffing level calculated for individual wards will be evidence-based and used to ensure that no service operates at an unsafe level.

164. 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.<sup>38</sup>

### **Power to make subordinate legislation**

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

166. Section 1(2) confers power on the Welsh Ministers to amend the settings to which the new duty to take steps to calculate and maintain nurse staffing levels under new Section 25B may apply. This provision is included in order that the duty can be extended to other settings, 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**

167. This Bill will apply only to Local Health Boards in Wales, and NHS Trusts (where they provide nursing services) in Wales.

### **Cross-border issues**

168. As the Bill only applies to Local Health Boards and NHS Trusts (where they provide nursing services) in Wales, there are no direct cross-border issues as the Bill places no obligations on providers outside Wales. However, Local Health Boards and NHS Trusts (where they provide nursing services) are responsible for commissioning services for persons who are usually resident in their area. The overarching duty in section 25A to have regard to the importance of providing sufficient nurses to allow the nurses time to care for patients sensitively will, for example, apply when Local Health Boards are commissioning services for their residents from providers across the border in England.

## Part 2: Regulatory Impact Assessment

169. 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.

170. 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**

171. 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 Budgets 2015-16 and 2016-17 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.

172. 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 introduced 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 numbers of patients per registered nurse should not exceed 7 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.

173. 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*

174. In [2013](#), according to StatsWales, there were over 28,000 full time equivalent nursing, midwifery and health visiting NHS staff.

175. 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.

176. To feed into the calculations relating to the impact of the Bill as originally introduced, 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.

177. 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.

178. 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.

179. At the time of drafting the original impact assessment for this Bill, [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.<sup>39</sup>

180. 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.

181. 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.”

182. 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.

183. 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 numbers are linked to bed numbers and changes in bed spaces will necessitate a change in nursing to serve a different bed capacity.

184. 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.*

185. 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.
186. However, the period of public sector austerity and cuts is anticipated to continue through the current UK Parliament and there will be a further National Assembly for Wales election in 2016. 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*

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

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

#### *Current administration and reporting*

188. 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.

189. 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.
190. Currently Directors of Nursing have a responsibility to assure the Health Boards that staffing numbers 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 numbers 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.
191. 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. Implementation of the Chief Nursing Officer's principles 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.

192. 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.**

193. Section 1(1) of the Bill inserts a new section 25A into the NHS (Wales) Act. Section 25A places an overarching duty on Local Health Boards and NHS Trusts in Wales (where they provide nursing services) so that when they are considering the extent of the provision of nursing services necessary to meet all reasonable requirements, they must have regard to the importance of providing sufficient nurses to allow nurses time to care for patients sensitively. This overarching duty applies when Local Health Boards and NHS Trusts in Wales provide care themselves and when Local Health Boards commission/fund care from third parties.

194. This impact assessment sets out the estimated costs of the Nurse Staffing Levels (Wales) Bill, as amended at Stage 2. 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](#),<sup>12</sup>

- Rafferty, A. et al, (2007) [Outcomes of variation in hospital nurse staffing in English hospitals: Cross-sectional analysis of survey data and discharge records](#),<sup>10</sup>
- [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](#).<sup>9</sup>

195. The calculation of nurse staffing levels, supported by appropriate guidance, as 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.

196. 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

197. Prior to introduction, 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.
198. 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 the duty to calculate/maintain nurse staffing levels, and the issuing of supporting 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*

199. The Bill places a number of duties related to nurse staffing levels upon Local Health Boards and NHS Trusts in Wales. 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*

200. The Bill requires Local Health Boards and NHS Trusts to designate a person (or description of a person) to calculate the appropriate nurse staffing level to meet all reasonable nursing care requirements (referred to in the Bill as the 'nurse staffing level'). Local Health Boards / Trusts must take steps to maintain the nurse staffing level.
201. The Bill recognises that staffing levels need to take account of individual patients' needs and local circumstances, including for example the ward environment and the skills of nursing and other staff on shift.
202. It sets out a 'triangulated' approach to ensuring there is an appropriate level of nurse staffing to meet patients' needs. This includes the exercise of professional judgment, use of validated acuity/workforce planning tools, and reference to known indicators of safe nursing care.

203. Different nurse staffing levels may be calculated at different times to ensure that an appropriate level of nursing care, which reflects patients' needs and conditions on a ward, is always provided.
204. The Bill initially requires this triangulated approach to determining nurse staffing levels to be implemented in adult acute medical and surgical wards. 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 the duty to calculate and maintain nurse staffing levels to be applied to other settings as the evidence base for these areas develops.
205. 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'.
206. 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'<sup>40</sup>.
207. The 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, and seeks to ensure that all relevant information, tools and expertise are utilised when determining appropriate nurse numbers for individual ward settings and shifts.
208. 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, the use of existing acuity tools and professional judgment that takes account of local circumstances and individual need.
209. Health Boards had £10 million recurrent allocated across Wales to enhance medical and surgical staffing levels for the financial year 2013–14 and maintained in future budgets.
210. Responses from Local Health Boards together with three year plans produced for the periods 2014–15 to 2016–17, and 2015–16 to 2017–18 further show that medium term plans and associated funding are in place to meet these standards by the end of this period. The announcement of an additional £425 million funding for the health service in 2014–15 and 2015–16, along with investment in the NHS in the 2016–17 Draft Budget 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.
211. 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.

212. 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.<sup>41</sup> 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.<sup>15</sup>
213. While progress is being made towards providing funding to meet the Chief Nursing Officer's principles, with 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 plans and funding projections**

#### *Monitoring and administrative costs*

214. Under the Bill, Health Boards and NHS Trusts in Wales must also make arrangements to provide patients with information about the nurse staffing level.
215. 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.<sup>42</sup> 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.

216. 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.**

217. 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. Welsh Government officials also subsequently raised the view that though the three indicators are already collected, adding the information on staffing levels at the time of collection is an additional cost which could be considered and that existing ICT systems may need further development in order for data to be 'pushed' into common reporting or collection systems. 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**.

218. 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.

219. 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).

#### *Reporting requirement and collection of performance information*

220. The Bill requires each Local Health Board in Wales, and any NHS trust to which the duty applies, to publish a report every three years on their compliance with the duty to calculate and maintain nurse staffing levels in adult acute wards. This must include the impact that any failure to maintain the appropriate levels has had on patient care (for example, an increase in incidents of harm caused by medication errors, falls, and pressure ulcers). Reports must also detail any action taken where+ nurse staffing levels have not been maintained.

221. The Bill is looking to minimise any unnecessary administrative burdens, reports which can form part of a wider report, must be submitted on a three-yearly basis.
222. 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. 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.
223. 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.
224. 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 the 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** every three years, or £3,020 annually. 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  $£31,630 * 7 * 9 * / 220 \text{ working days year} / 3 = £3,020$ .

225. It is not suggested that the results of this triennial 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*

226. 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 and Trusts. 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.

227. 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.

228. 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

229. The Welsh Government must issue guidance under sections 25B and 25C of the Bill. The Bill requires that this 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. The Bill specifies that consultees must include Local Health Boards/NHS Trusts (who will be required to have regard to the guidance) and the independent health care and care home sectors, as well as relevant organisations representing the interests of staff and patients. 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.

230. 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.

231. 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.

232. 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.

233. On this basis the estimated one off cost of developing, consulting and communicating the guidance would **not be expected to exceed £45,000**. This estimate is £5000 higher than the figure in the December 2014 impact assessment, to reflect the wider consultation requirements in the amended Bill. 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.

234. Performance in relation to implementation of the Chief Nursing Officer's nurse staffing principles 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

235. 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.

236. Powers of direction are set out in section 12 of the NHS (Wales) Act 2006 which enable the Welsh Ministers to give directions to Local Health Boards and NHS trusts about how they should exercise functions which have been delegated to them.

237. 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.

238. 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.**

239. 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 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.

240. 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

241. The amended Bill does not require the Welsh Government to review the operation and effectiveness of this legislation.

242. However, it would be prudent for the Welsh Government to conduct an in-depth study of the impact additional funding is having in wards. 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 such a review 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

243. 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.

244. 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.<sup>43</sup>
- Hospital nurses typically care for one patient less than nurses in other states, the lower caseload is significantly related to lower patient mortality.<sup>44</sup>

245. 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.<sup>45</sup> 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.<sup>46</sup>

246. 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.<sup>47</sup>
- 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.

247. 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 care<sup>48</sup>.

248. A 2011 study<sup>49</sup> 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 review<sup>50</sup> 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.
249. 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.
250. 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.<sup>51</sup> 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.
251. 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.<sup>52</sup>

### *Summary of costs*

252. 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 £15,100 costs over the following five years, shown in Table 5. In total this is a cost of approximately £65,000 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.

253. A detailed assessment of the Bill's impact on Agency and Bank is included at Annex A of this Explanatory Memorandum. This assessment was conducted in response to the Health and Social Care Committee's recommendation, in its stage 1 report, that the Member in Charge conduct further analysis of the potential cost increases on agency/bank nursing staff that could occur in the short term, as a consequence of the Bill's implementation. The assessment was completed in June 2015. This assessment concluded that the Safe Nurse Staffing Levels (Wales) Bill (as introduced) likewise requires that Health Boards take all reasonable steps to deliver a safe level of nurse staffing, determined through a triangulated approach. As such, the initial costs associated with setting safe staffing levels in Wales, as required by the Nurse Staffing Levels (Wales) Bill should be equivalent to those in Health Boards' forward looking three year plans.

**Table 4** One off costs

One off costs		£
Guidance		45,000
Communication		5,000
<b>Total</b>		<b>50,000</b>

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

On-going costs	Year 1 (£)	Year 2 (£)	Year 3 (£)	Year 4 (£)	Year 5 (£)	Year 6 (£)
Staffing, including CPD	275,000,000	275,000,000	275,000,000	275,000,000	275,000,000	1,375,000,000
Annual reporting	3,020	3,020	3,020	3,020	3,020	15,100
<b>Total</b>	<b>275,003,020</b>	<b>275,003,200</b>	<b>275,003,020</b>	<b>275,003,020</b>	<b>275,003,020</b>	<b>1,375,015,100</b>
<b>Additional costs of Bill</b>	<b>3,020</b>	<b>3,020</b>	<b>3,020</b>	<b>3,020</b>	<b>3,020</b>	<b>15,100</b>

**Table 6** Total costs, including staffing costs in Option 1

Overall costs						£
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Guidance	45,000	0	0	0	0	45,000
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
Annual reporting	3,020	3,020	3,020	3,020	3,020	15,100
<b>Total costs</b>	<b>275,053,020</b>	<b>275,003,020</b>	<b>275,003,020</b>	<b>275,003,020</b>	<b>275,003,020</b>	<b>1,375,065,100</b>
<b>Additional costs of Bill</b>	<b>53,020</b>	<b>3,020</b>	<b>3,020</b>	<b>3,020</b>	<b>3,020</b>	<b>65,100</b>

### *Unintended consequences*

254. Consultation responses 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.

255. 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.

256. Consultation responses 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.<sup>53</sup> It may also be noted that any argument for a status quo whereby wards are currently unsafely staffed is inherently flawed.

257. During development of this legislation we 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 would 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

258. This Children's Rights Impact Assessment (CRIA) considers the effect of the Nurse Staffing Levels (Wales) Bill on children in Wales and their rights under the United Nations Convention on the Rights of the Child (UNCRC).
259. 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.
260. 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.
261. 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.
262. 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

263. 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.
264. It places a duty on Local Health Boards and NHS Trusts to calculate and maintain nurse staffing levels for adult acute hospital wards. It also requires

the Welsh Government to issue statutory guidance to support NHS Wales organisations in determining nurse staffing levels that are locally appropriate and at all times safe.

265. Section 1(1) of the Bill inserts a new section 25A into the NHS (Wales) Act. Section 25A places an overarching duty on Local Health Boards and NHS Trusts in Wales (where they provide nursing services) so that when they are considering the extent of the provision of nursing services necessary to meet all reasonable requirements, they must have regard to the importance of providing sufficient nurses to allow nurses time to care for patients sensitively. This overarching duty applies when Local Health Boards and NHS Trusts in Wales provide care themselves and when Local Health Boards commission/fund care from third parties.

266. 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**

267. 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.

268. 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'.

269. 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.

270. 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.

271. 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.

272. Whilst the Bill requires nurse staffing levels to be calculated/maintained, and statutory guidance to be issued, for adult acute ward settings initially, it is acknowledged that a number of younger patients may spend time on adult wards.

273. 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.

274. 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?

275. 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.
276. 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.
277. 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.
278. 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 Bill requires a triangulated approach to determining the appropriate nurse staffing level, which includes the use of validated workforce planning tools, the exercise of professional judgment, and reference to known indicators of safe nursing care.
279. As noted above, the duty to calculate and maintain nurse staffing levels 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 Local Health Boards and NHS trusts 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 the duty to calculate and maintain nurse staffing levels to be prescribed for other areas at a future date, as the evidence base for these develops. It is considered that this duty and the safe staffing guidance required by the Bill should be extended to children's settings in due course.

280. 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. Should Welsh Ministers exercise their regulation making powers to extend the duty to calculate nurse staffing levels to children's settings, Welsh Ministers will be obliged to consult with organisations that are representative of the interests of child patients.

281. 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.**

282. 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.

283. 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.

284. 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, it is considered that the Bill respects the rights of young carers.

**Article 18 is respected under the Bill.**

285. 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**

286. The intentions and aspirations behind the 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.

287. 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.

288. The Bill seeks to address this concern by:

- including provision for the duty to calculate and maintain nurse staffing levels, and for supporting guidance, 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).

289. 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)

290. 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**

291. 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.

292. 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**

### **Part 3: Explanatory notes**

294. These Explanatory Notes relate to the Nurse Staffing Levels (Wales) Bill as amended at Stage 2 (having previously been laid before the National Assembly for Wales on 1 December 2014). The notes have been prepared by Kirsty Williams AM in consultation with the Department of [insert title] in the Welsh Government in order to assist the reader of the Bill.

295. 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: Nurse Staffing Levels**

296. Section 1 inserts new sections 25A to 25E into the National Health Service (Wales) Act 2006.

297. Section 25A imposes a new duty on Local Health Boards and NHS Trusts in Wales.

298. The effect of sub-sections 25A (1) and (2) is that when a Local Health Board is considering, for its area, the extent of provision of nursing services that are necessary to meet all reasonable requirements (which is one of a Local Health Board's existing duties), it has an overarching duty to have regard to the importance of providing sufficient registered nurses to allow the patients time to care for patients sensitively.

299. Subsection 25A (3) places a duty upon NHS Trusts in Wales that provide nursing services to provide such services to the extent that the Trust considers necessary to meet all reasonable requirements.

300. Subsection 25 (4) provides that where an NHS Trust is considering the extent of the nursing services that it provides, it has an overarching duty to have regard to the importance of providing sufficient nurses to allow nurses time to care for patients sensitively.

301. Section 25B introduces a duty for Local Health Boards and NHS trusts in Wales (where applicable) to designate a person or a description of person who must calculate the nurse staffing level, using the triangulated approach described in section 25C. Local Health Boards and NHS trusts in Wales must then take all

reasonable steps to maintain that level and make arrangements to inform patients of the nurse staffing level.

302. Subsection 25B(3) specifies the types of settings to which the duty to calculate a nurse staffing level applies. However, Welsh Ministers may expand the scope of the duty to cover other settings; for example to extend the duty to other types of ward. Such regulations are, by virtue of subsection 25E (2), subject to the affirmative procedure

303. Section 25C prescribes the triangulated approach which a designated person must use when calculating the nurse staffing level. The triangulated approach requires the designated person, when calculating the appropriate nurse staffing level, to exercise professional judgement; to consider the information generated by evidence-based workforce planning tools (such as an acuity tool), and to take into account the extent to which patients' well-being is known to be particularly sensitive to the provision of care by a nurse.

304. Subsection 25C(2) permits the designated person to calculate different nurse staffing levels at different times and depending on the conditions in which care is provided.

305. Section 25D places Welsh Ministers under a duty to issue guidance to Local Health Boards and NHS Trusts (where applicable) about the duties under sections 25B and 25C. It sets out a non-exhaustive list of the matters which may be included in the guidance and requires Welsh Ministers to consult with the persons specified in subsection 25D(3) about the guidance before issuing it.

306. Every Local Health Board and any NHS Trust to which those sections apply must have regard to the guidance when calculating nurse staffing levels in accordance with sections 25B and 25C.

307. Section 25E requires Local Health Boards, and any NHS Trusts in Wales to which the duty to calculate a nurse staffing level in section 25B applies, to submit a report to the Welsh Ministers, covering the specific criteria listed in subsection 25E(1)(a) to (c). Reports must be submitted within three years of Section 25E's coming into force and every three years afterwards. The Welsh Ministers must lay these reports before the National Assembly for Wales.

## **Section 2: Commencement**

308. This section provides that the provisions of the Act will come into force on Royal Assent, except for Section 2, which will be commenced by order.

## **Section 3: Short title**

309. This section describes the short title of the Bill. Once the Bill receives Royal Assent, it will be known as the Nurse Staffing Levels (Wales) Act 2016.

## Annex A: June 2015 analysis of the short term impact of the Nurse Staffing Levels (Wales) Bill on Agency and Bank nursing costs

### Introduction

1. It is widely accepted that to ensure the optimum balance between nursing productivity and flexibility, there is a need to invest in nursing bank resource whilst minimising the use of agency staff, especially from high cost nursing agencies. However, there is very limited information in the public domain in terms of current and future bank and agency costs in Wales.

2. As previously stated in the Explanatory Memorandum accompanying the Staffing Levels (Wales) Bill, all Health Boards are planning to use a triangulated approach to safe nurse staffing levels in adult acute hospital settings: the Chief Nursing Officers principles; the acuity tool; and professional judgement. There is continuing evidence that whilst progress is being made, further investment is needed to ensure that these standards are met. Further research also confirms that some Health Boards are experiencing increases in temporary staffing costs, and are implementing plans to reverse these increases and in particular focussing on reducing usage of high cost agencies.

3. The original Explanatory Memorandum reported Royal College of Nursing (RCN) research showing that the overall cost of agency, bank and overtime staff for the three years 2010-11 to 2012-13, had been £132.5 million, or in the region of £44 million a year (this goes beyond the use of such staff in adult acute hospital wards, which is the focus of the Bill).

4. Since the Explanatory Memorandum was produced the following information has been produced:

- The Welsh Government commissioned Cardiff University to undertake a study *Research into nurse staffing levels in Wales*, which was published in May 2015. This study does provide an estimate of 2013-14 temporary staffing costs on surgical and medical wards, but does not look at historic trends or make future projections.
- All Health Boards have provided draft three year plans to the Welsh Government, setting out financial plans over the three year period from 2015-16 to 2017-18, although not all of these plans have been officially approved.
- We understand that, as part of the Integrated Medium Term Planning process, Local Health Boards will have provided the Welsh

Government with financial proformas showing staffing plans, including the use of temporary staff and locums going forward over the 3 year planning period.

- We understand that, the Chief Nursing Officer is leading nursing workforce projections for the Welsh Government.

### **Research into nurse staffing levels in Wales report**

5. The brief of the *Research into nurse staffing levels in Wales* project included the analysis of findings related to developing a better understanding of the availability and accessibility of nurse staffing data in medical and surgical hospital wards in Wales.

6. The report did find that:

“there is a worrying variety in terms of attempts at comparability and consistency of systems, processes and software packages used to capture and hold staffing information at the organizational level. The only way to access nurse staffing data at ward level is via ad-hoc requests made directly to individual Health Boards.”<sup>1</sup>

7. The study, which started in October 2014 and was published at the end of May 2015, included data from 181 medical and surgical ward areas from six Health Boards. This was time consuming for the project team and:

“no staffing data appear to be triangulated with patient safety outcomes or other related quality outcome metrics such as patient length of stay.”<sup>1</sup>

8. The report highlights that the data request template used combined agency and bank staffing, so it was not possible to represent the differences between the two types of staff. The report also found there to be a:

“marked variation in temporary staffing usage on wards that are similarly staffed and face similar demands such as unfilled vacancies, patient acuity and turnover.”<sup>1</sup>

9. The report recommends that further studies should be initiated to better understand this.

10. Based on returns from around 90% of wards in Wales, the study estimated that **annual temporary nurse staffing costs totalled £13.5 million for bank and £5.5 million for agency staff in 2013-14.**

## Costs going forward

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11. There is clearly evidence that temporary staffing costs have been increasing in recent years. There is no simple explanation for these increases which are due to a complex interaction of factors. Whilst historic efforts towards safe staffing levels have undoubtedly led to an increasing demand for nurses, the supply of nurses has also been impacted upon by flow of staff both into and out of the NHS.

### Health Board Plans 2015-16 to 2017-18

12. The updated three year financial plans that have been submitted to the Welsh Government this year are likely to provide the best idea in terms of a forward look. These plans should include commentary on how Health Boards are planning to address pressures and growing costs in these areas. We understand that Local Health Boards were also required to provide financial proformas which should show projected temporary staffing costs for each financial year 2015-16 to 2017-18.

13. On 22 May 2015 Kirsty Williams asked the Minister for Health and Social Services in written correspondence whether it would be possible for her officials to have sight of the relevant parts of these three year financial plans. Unfortunately, on 1 June, the Minister advised that the plans “would not be available in time for your purpose.” However, in further correspondence, dated 20 June, the Minister noted that a limited number of plans (Cardiff and Vale UHB, Cwm Taf UHB and Powys) had been publically considered in draft, and as such these draft versions of plans were publicly accessible. However, the detailed financial proformas that should accompany the plans for the relevant health boards do not appear to be in the public domain. Even where plans have not been approved as yet, these proformas would constitute the best estimates of LHB temporary staffing intentions going forward. With access to a summary of this information it would be possible to undertake more robust modelling of plans for future temporary staffing costs. Unfortunately, as yet, the Minister’s office has not been able to provide the information requested.

14. Cardiff and Vale UHB’s last two financial plans have set out temporary staffing costs. The overall variable pay bill includes: agency, nursing bank, nursing overtime, non-nursing overtime, locum medical and dental, waiting time initiative – medical and on-call. The total variable pay bill was almost £27 million or 5.46% of fixed pay bill in 2012-13, this fell to £23 million in

2013-14, or 4.68% of the total bill, in the first 6 months the proportion of total fixed pay bill was back up to 6.2%.

15. Of these costs, it is possible to show agency and nursing bank costs separately and compare how these have changed. We have combined information from the last year's plan, a draft for this year from Cardiff and the Vale UHB and made a simplistic calculation of annual temporary staffing costs based on the first 6 months of 2014-15 (this takes no account of how demand may fluctuate over a typical year).

Table 1: Temporary agency and bank staffing costs – Cardiff and Vale UHB

	Full Year		6 month period	6 month figures doubled		
	2012-13	2013-14	Apr - Sep 2014	2014-15	increase on 2013-14	increase on 2012-13
Pay Bill – Agency	£5,655,170	£3,660,691	£1,792,982	£3,585,964	-2.0%	-36.6%
Pay Bill – Nursing Bank	£8,381,253	£8,226,028	£5,250,382	£10,500,764	27.7%	25.3%
<b>Combined</b>	<b>£14,036,423</b>	<b>£11,886,719</b>	<b>£7,043,364</b>	<b>£14,086,728</b>	<b>18.5%</b>	<b>0.4%</b>

Source: [Cardiff and Vale UHB plans](#) and National Assembly for Wales Research Service calculations

16. Cwm Taf UHB estimate that their usage of temporary staff is higher, accounting for around 8% of the pay bill. As with the Cardiff and Vale UHB, the proportion is highest in the medical workforce compared to nursing and midwifery. Cwm Taf did not provide a breakdown of agency costs for 2013-14 and 2014-15.

17. Officials supporting Kirsty Williams AM in originally developing the Nurse Staffing Levels (Wales) Bill have not been able to access plans of the other Health Boards with large numbers of acute beds, Betsi Cadwaladr, Abertawe Bro Morgannwg and Aneurin Bevan. Nor has any of the information included in financial proformas relating to temporary staffing projections for health boards, with significant acute services, been provided at an individual or overall level for Wales.

### How Health Boards are looking to reduce temporary staffing costs

18. Cardiff and Vale UHB along with other Health Boards are implementing strategies to reduce the cost of temporary staffing and in particular agency staffing costs. It can be seen that there has been some success in reducing

agency costs, but nursing bank has risen considerably over the first 6 months of 2014-15.

19. Of the draft Health Board plans officials have been able to locate for 2015-16, a key policy in terms of reducing the use of agency staff has been the investment in internal staff. For example, Cardiff and Vale UHB are undertaking:

“A high level assessment and consideration is also being given to over-recruiting Band 5 nurses so that the UHB is ahead of any natural turnover occurring, any future need for extra capacity and almost eliminate the use of bank and agency.”<sup>1</sup>

20. Cwm Taf UHB are:

“continuing to realign the nursing workforce to meet the agreed establishments to meet the safer nursing recommendations. This involves the rebalancing of the nursing workforce across our wards and hospitals and an associated reduction in bank and agency usage.”<sup>1</sup>

21. The Cwm Taf UHB plan also states that:

“... In order to improve the consistency of patient care in the acute hospital wards a different, more innovative workforce strategy is being employed. Rather than relying totally on bank and /or agency staff to cover gaps in the rotas, a decision has been taken to appoint externally to a pool of 8 WTE qualified nurses that could be deployed to different wards on a longer term basis than the usual bank cover in order to cover more long term absences, e.g. long term sickness and maternity leave.”<sup>1</sup>

22. The original Explanatory Memorandum stressed the importance and value of the planned implementation of e-rostering systems to improve the efficiency of workforce management. The Cardiff University study also noted that e-rostering and sickness management was an important development.

23. This is reflected in the Health Board plans that we have been able to view, Cwm Taf UHB has developed a workforce tracker which will be implemented as part of the policy to improve workforce management and reduce the need for temporary staff.

“This tracker enables the Health Board to rebalance the ward back to the establishment by turnover, retirements and also monitor the impact this should have on nurse bank spend. The Health Board can then make an informed decision regarding moving qualified staff if the workforce plan doesn’t show the movement needed. The tracker and that for Facilities are used to inform decisions by the Vacancy Control Panel.”<sup>1</sup>

24. Coupled with review to rebalance nursing and health care support staff where there was previously either over or under staffing:

“It is expected there will be a reduction in bank/agency usage and this will be monitored through the workforce tracker and finance.”<sup>1</sup>

25. Cwm Taf’s second phase of e-rostering was to be implemented in June 2015, meaning that adult acute hospital wards will be online by then. Cardiff and Vale’s implementation of e-rostering is well underway.

26. The 2014 report by London School of Economics, [\*NHS Safe Staffing: Not just a number\*](#) highlighted the considerable benefits that e-rostering aligned with workforce management can have on temporary staff costs.

27. Following the implementation of an e-Rostering system, Basildon and Thurrock University Hospitals NHS Foundation Trust:

“is benefitting from recurrent annual savings of £100,000 through reduced input time, errors and corrections. The more efficient use of permanent staff, has brought about a reduction in the use of temporary staff that was saving £670,000 per month, which included a 37% (£5.8 million) reduction in total temporary nursing spend... On the basis of the savings claimed at Basildon and Thurrock, this would suggest that across England the potential gains to the NHS in a transition from basic e-rostering to a fully electronic rostering and timekeeping system could be up to £41 million annually. The robust data provided by such a system would also allow the use of resources to be carefully managed within a proactive system of activity analysis and workforce planning, rather than with a reactive system for managing shortages.”<sup>1</sup>

28. Though they have few acute beds, Powys UHB state in their three year plan that:

“It is anticipated that there will be an increase in staff in post during the first two quarters of the year as vacancies are filled when compared with the 31st January 2015. As a result, there may be a reduced requirement for the use of temporary staffing, although for the purposes of this plan, we are assuming that current usage will continue. The budgeted projection of 1333.88 FTE projected for the duration of this plan will never be fully realised through staff in post as this includes headroom for the use of temporary staff. The effective use of temporary staffing will be continued and currently represents 7% of the total workforce.”<sup>1</sup>

29. Powys UHB also include multi-professional education commissioning numbers as an annex to their plan. This shows, for example, the academic intake of nurses and other staff and when they will complete training. This links into the recommendations in the Cardiff University *Research into nurse staffing levels in Wales report*.

### **Vacancies, turnover and recruitment**

30. In correspondence, the Minister provided a snapshot of the number of nursing vacancies handled by the NHS Wales Shared Services Partnership. This showed that, overall, there were 2,610 nursing vacancies and 744 healthcare support worker vacancies in Wales in January 2015. Average staff turnover nationally was 8.3% amongst nurses and 8.6% amongst healthcare support workers. A rough estimate therefore could be that there would be around 1,000 nursing vacancies in acute, elderly and general wards and in the region of 400-500 healthcare support worker vacancies.

31. The average time from advertising a post to filling a post was 69 working days in February 2015. It takes 37 days to advertise and interview for the post and 32 days from accepting the post to starting, including various security and qualification checks.

32. With all Health Boards there is a need to ensure that there is a supply of qualified nurses to meet the need.

There are factors that are needed to ensure that this happens. While information on average time to fill nursing posts indicates that nursing posts are being filled relatively quickly, there is anecdotal evidence provided in three year plans that some Health Boards are finding it more difficult to fill all their nursing vacancies than had been the case in the past. Although this is not within the remit of the Bill, there are a number of actions that are underway and need to be implemented to ensure that there is a sufficient

supply of nurses to meet the demand in the future. Some of these are set out below:

- The Welsh Government is [investing in extra training and education places for health professionals, including nurses](#). The number of training places for nurses in 2015-16 will increase by more than a fifth (22%).
- The Welsh Government is also providing [further investment for professional development for existing staff](#). There is potential to enhance the career prospects of experienced health support workers wishing to progress to being qualified nurses( wording and link to funding / report).
- By raising standards within adult acute and medical wards the Nurse Staffing Levels (Wales) Bill will reduce the disincentive to leave the NHS in Wales and will increase the incentive for nurses who have left the NHS in Wales to return. This will also make Wales a more attractive destination for nurses from outside the NHS.
- The investment and career progression opportunities mentioned above will also further enhance the incentive for current staff to remain in the Welsh NHS.
- The Cardiff University study highlighted a need for more understanding of why staff leave the NHS to join agencies. By offering flexibility along with the certainty of employment, training and other benefits of NHS employment, Health Boards can reduce the incentives for such staff to leave the Welsh NHS.
- The Cardiff University study also highlighted how better workforce planning could make better use of existing staff. The use of e-rostering can lead to far more efficient deployment of existing nursing staff and could improve down sickness rates. Also, it was felt that there was both overstaffing and understaffing on wards which was not explained by the data collected. More efficient workforce planning could inform and utilise staff more effectively.
- Better workforce planning: the Cardiff University study also highlighted a lack of data and planning within Health Boards considering the age of staff, leaving intentions or tracking of future graduates coming through the system.

### **How do bank and agency costs vary?**

33. Three year plans available in the public domain highlight the importance of getting the best value from their use of temporary staff. In general, this will involve using bank staff where possible and avoiding using the highest cost agencies.

34. Bank staff, as a rule, are generally paid their usual salary if they also have a substantive post. If they work for the bank only, they are paid from various points in the NHS pay scales.

35. Hourly rates for agency nurses for 19 companies who are part of the All-Wales 2015-16 contract were provided by the Welsh Government. The most expensive company charges almost 50% (48.4%) more for nurses in the same band as the cheapest company would, for working on the same shift. This variance holds for all midweek or unsocial hours shifts.

36. On occasion, Health Boards may need to use employment agencies which are not part of the all-Wales contract. The Welsh Government provided evidence that the range of costs will be even wider for these non-contract agency staff.

37. There are therefore savings to be made not only in terms of reducing the use of agencies, but also making sure that when agency staff are utilised, Health Boards use companies offering the best value for money for the given circumstances.

## Conclusions

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38. Although the Minister did not provide Kirsty Williams' Bill team with access to the latest Health Board plans, the Minister did state that:

“it is expected that HBs will use the triangulated approach to set staffing levels in these areas and therefore a narrative about the three elements of the methodology will be required to confirm compliance.”

39. The Nurse Staffing Levels (Wales) Bill (as introduced) likewise requires that Health Boards take all reasonable steps to deliver a safe level of nurse staffing, determined through a triangulated approach. As such, the initial costs associated with setting safe staffing levels in Wales, as required by the Nurse Staffing Levels (Wales) Bill should be equivalent to those in Health Boards' forward looking three year plans.

40. Health Boards are all implementing plans to reduce the use of temporary staffing, especially agency costs, and the Welsh Government is providing additional investment in nurse training and professional development. As such, even a cautious estimate of costs can assume that while the rate of increase shown in bank nursing costs in the first half of 2014-15 may continue into 2015-16, it will plateau in 2016-17 and start to decrease in 2017-18.

41. This fits in with the statements of direction in both the Cardiff and Vale and Cwm Taf UHB plans. It should be acknowledged that it is difficult to draw assumptions from a limited set of figures, as the Cardiff University report highlighted that there is considerable variation between wards and Health Boards. However, these are the only figures which are already in the public domain. We have assumed that the move away from high cost agency staffing will continue to see modest 5% reductions each year, to reflect the strong focus on reducing these costs in Health Board plans and build on the reductions shown in the Cardiff and Vale UHB's performance in 2013-14 and 2014-15. We have assumed that bank staffing costs continues to rise from 2013-14 through to 2016 and start falling towards the end of the 2016-17 financial year, as ongoing investment to increase the supply of nurses will take time.

42. The Nurse Staffing (Wales) Bill would reinforce the triangulated approach using the Chief Nursing Officers Guidelines, incorporating the acuity tool and professional judgement. Implementation is assumed to take

place from 2016-17, with guidance being agreed to potentially be implemented for the financial year 2017-18.

43. This would mean that if implemented for the start of the 2016-17 financial year- until further headline data from Local Health Board financial proformas is made available by the Welsh Government- the best rough estimate is that **the £19 million bank and agency costs in 2013-14 would have risen to almost £25 million in 2016-17 and around £65 million for the three years post implementation.**

44. Given the limited information available, we have deliberately erred towards overestimating the potential increases in bank nursing costs. The Health Board plans we had access to notably have policies in place to work towards eliminating agency costs by 2017-18.

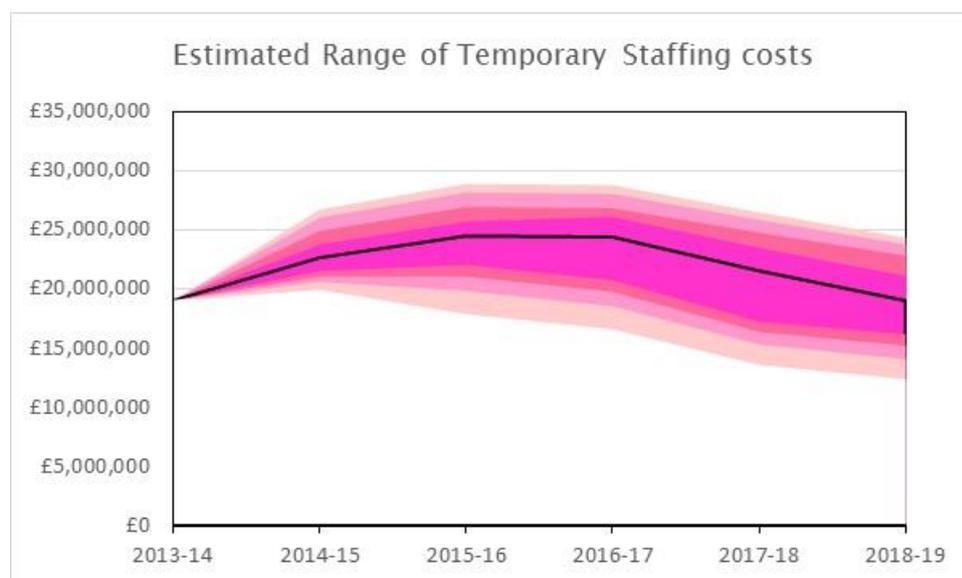
Table 2 Extrapolation of adult acute agency costs in 2013–14 (using limited data from three year financial plans)

	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Wales - adult acute						
Pay Bill – Agency	£5,500,000	£5,390,000	£4,850,000	£4,360,000	£3,930,000	£3,530,000
Pay Bill – Nursing Bank	£13,500,000	£17,230,000	£19,620,000	£20,010,000	£17,590,000	£15,460,000
<b>Combined</b>	<b>£19,000,000</b>	<b>£22,620,000</b>	<b>£24,460,000</b>	<b>£24,370,000</b>	<b>£21,510,000</b>	<b>£18,990,000</b>

Source: Cardiff University report, publicly available Health Board plans and Research Service calculations

Note: Figures are rounded to the nearest £10,000 so may not add to totals

**Chart 1 Estimated range of temporary staffing costs**



45. These estimates are set in a scenario based on current Welsh Government funding intentions for the NHS. This assumes that Health Board plans are implemented and the Welsh Government continues to provide at least as much funding as already agreed for these three year plans. These costs form part of the estimated costs of nurse staffing highlighted in the original Explanatory Memorandum that accompanied the Safe Nurse Staffing Levels (Wales) Bill on introduction.

## Annex B: References

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