Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
12 February 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
Llinos Madeley
Committee Clerk
0300 200 6565
SeneddHealth@Assembly.Wales

Agenda – Supplementary Documents

Safe Nurse Staffing Levels (Wales) Bill: consultation responses

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

Safe Nurse Staffing Levels (Wales) Bill: consultation responses (Pages 1 - 168)

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Chartered Society of Physiotherapy – SNSL(Org) 01 /
Tystiolaeth gan Cymdeithas Siartredig Ffisiotherapi – SNSL(Org) 01

CSP Wales Office
1 Cathedral Road
Cardiff CF11 9SD
[redacted]
www.csp.org.uk

Health and Social Care Committee
National Assembly for Wales
Pierhead Street
Cardiff CF99 1NA

Dear Committee Members

Re: Safe Nurse Staffing Levels (Wales) Bill – Briefing from the CSP to inform scrutiny of the member in charge of the Bill

Introduction

The Chartered Society of Physiotherapy (CSP) welcomes the opportunity to provide a briefing to inform the scrutiny of the member in charge of the Bill. The profession will also be providing a further written contribution in response to the committee's terms of reference.

As highlighted in our response to the member in charge of the Bill, the CSP and our members are wholly committed to supporting the drive to improve the quality of care and outcomes for patients, and understand the spirit of the proposed Bill. However, we cannot support an approach to legislation that does not address staffing in a multidisciplinary way, does not focus on quality outcomes for patients, and risks a focus on numbers of nurses in isolation from the plethora of other factors that impact on patient outcomes and benefit.

Comments from the CSP

1. The CSP notes that the Bill seeks to address the issue of 'minimum' staffing levels and has been renamed the 'Safe' Nurse Staffing Levels (Wales) Bill. Also, that the Bill includes specific provision that any ratio is upwardly adjustable and must not be used as an upper limit by the health service body to which such a ratio applies. However, the profession considers that

ambiguity still remains around the intended meaning of 'safe', with this exacerbating the risk that the legislation will be misinterpreted and misapplied.

This is heightened by the interchangeable use of both words within the Bill. 'Safe' and 'minimum' are used without clarity of intention. Safe is used as the heading for Section 2 and is used at Section 2- insert Section 10a sub-section (1) paragraph (a). Minimum is used at Section 2 – insert Section 10A sub-section (1) paragraph (b), while Section 2 - insert Section 10A sub-section (5) paragraphs (b), (c) and (e) all refer to 'minimum ratios'. This latter term also leads to concern that a specific patient : nurse staff ratio will be defined, or be presumed to exist that can be applied to different patient care/service delivery contexts, regardless of variables relating to patient acuity, environment and wider staffing issues (including those relating to skill mix and the multi-disciplinary team).

2. The Society remains concerned that a 'minimum' staffing level does not necessarily mean a 'safe' staffing level. As there is no guarantee that implementing a set level of staffing achieves the delivery of safe care, there is a risk of the Bill misleading the public and failing to support a cohesive approach to staffing levels across services in ways that will contribute to safe and effective patient care. The CSP considers that any guidance from the Welsh Ministers should be fully transparent about the evidence-base for the positive correlation between staffing levels and quality of patient care.

3. The Society notes in the explanatory memorandum the assertion that the ratios should be maintained in adult in-patient wards in acute hospitals as this is where the majority of evidence exists. The profession wishes to reference very recent work undertaken by National Institute for Health and Care Excellence whose extensive review of the literature highlighted an explicit lack of evidence relating to nurse staffing levels linked to patient outcomes. (Detail in sections 2 and 3, document accessible via; http://www.nice.org.uk/Guidance/SG1)

   The Society is also concerned about the transferability of the limited observational studies that exist from outside of the UK to requirements for Wales.

   The CSP continues to question how it can be possible to provide an over-arching minimum staffing level when the level of care required by individuals or groups of patients (e.g. within a particular patient group, stage of a care pathway, or a care environment) may vary from hour to hour, day to day or from week to week. The intended longer-term of the legislation in terms of the patient care settings to which it should apply is also unclear, with it only being indicated in Section 2 – insert Section 10A sub-section (1) paragraph (b) that it is intended to relate specifically to staffing levels in adult inpatient wards in acute hospitals.

   Recognising the absence of robust evidence, the profession is further concerned about the suggestion of wider application of the minimum ratios to other settings and circumstances. It is essential that consideration of staffing levels in any area of service delivery takes account of the multiple variables

that impact on quality of patient care and outcomes. These variables relate to the three broad areas of patient acuity, service environment, and staffing factors (including those pertaining to skill mix and the integrated contributions of the multi-disciplinary team).

In addition, there is no reference to staffing levels that can help to ensure effective quality of care for patients. Wrapped up in the term ‘effective’, the profession would see care that is delivered with compassion, in partnership with patients to ensure that it is delivered in line with their individual needs and preferences, based on the best available evidence, and with due consideration to optimising outcomes for patients and optimising use of resources. This will include consideration of how staffing levels and configurations across the multi-disciplinary team can reduce individuals' need for hospital admission, their length of stay, and re-admission.

4. The CSP notes from the explanatory memorandum that the Bill seeks to address the risk that the legislation will have the consequence of service providers diverting resources from other areas and staffing groups in order to comply with mandated nurse staffing levels. However, given that section 2 – insert Section 10A sub-section (1) paragraph (a) relates only to nursing, the CSP considers there is still the risk that reductions will be made to staffing in other groups (such as Allied Health Professions (AHPs)), or that some services to patients will be terminated to meet the new, legally enforced nurse staffing levels requirements. The profession therefore remain strongly concerned that the legislation would have a perverse impact. The negative implications of the legislation could well be to reduce the safety, quality and effectiveness of care; lessen patient access to services that will have long-term benefits for their health and well-being; and compromise the delivery of cost-effective, affordable services in response to changing population and patient needs.

   The CSP is convinced that the need for patients to have services that are ‘safe’ and ‘effective’ requires ‘appropriate’ levels of staffing across the whole workforce including medical, nursing, AHPs such as physiotherapy and others. Staffing levels of the other staff groups do impact on high quality patient care. Addressing staffing needs within one profession is therefore insufficient for safeguarding and optimising the effectiveness of care for patients in totality.

5. The CSP notes in Section 2 – insert Section 10A sub-section (6) paragraph (a) a reference to the use of validated workforce planning tools, which are capable of being applied to calculations by reference to individual nursing shifts. We would urge that a focus on nurse input and tasks risks compromising the required focus on patient outcomes and benefit. Furthermore, we are aware that the recent NICE work on safe staffing in acute wards in acute hospitals failed to identify robust evidence on the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix. The value of this requirement within the Bill is therefore questionable.

6. We would also urge that an appropriate distinction in terminology is achieved between use of staffing level ratios and workforce planning activities, when these obviously reflect different aspects of services in terms of resourcing, design and delivery. The use of terms interchangeably is likely to cause confusion.

7. The CSP notes in section 2 – insert Section 10A sub section (6) paragraph (c) a reference to provision for the required nursing skill mix needed to reflect patient care needs and local circumstances. Greater clarity and definition is needed on what constitutes 'local circumstances' and a greater emphasis on ensuring that expectations reflect the significance of local factors relating to patient acuity, service environment and wider staffing issues.

8. The CSP welcomes, in section 2 – insert Section 10A sub-section (7) paragraph (c) the reference to time to undertake or participate in continuing professional development, including mentorship and supervision roles. However, once again, the CSP highlights that it is essential that these needs are recognised across the whole workforce, including for AHPs and support workers, with the risks of a focus on nurse staffing requirements mitigated.

9. The "range of matters" in section 3 sub-section (5) paragraphs (a) to (i) are noted to primarily relate to failures of care rather than positive aspects of quality of care and patient outcomes and as previously highlighted the evidence base for monitoring and reporting such elements requires further consideration.

Concluding comments

In conclusion, whilst supporting attention to enhance the quality of care and outcomes for patients, the CSP considers a more rounded and multi-factorial method is necessary to achieve safe and effective care delivered by appropriate staffing. The Society continues to hold the view that a number or ratio is not an indicator of good quality care delivered with compassion.

The profession is content for this evidence to be made available publicly.

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 52,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self-management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

Written evidence: Safe Nurse Staffing Levels (Wales) Bill

RCP (Wales) written evidence

Key points

- This Bill must be properly enforced to ensure it is effective.
- Detailed guidance on implementation must be issued to NHS bodies.
- Staffing data must be publicly available and easily accessible.
- Staffing numbers should be displayed in every ward.
- Outcomes from this Bill must be published in a transparent and accountable way to inform future service improvement.

For more information, please contact:

Lowri Jackson
Senior policy and public affairs adviser for Wales
[redacted]

Royal College of Physicians (Wales)
Regus House, Falcon Drive
Cardiff CF10 4RU
[redacted]
www.rcplondon.ac.uk/wales

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff CF99 1NA

SeneddHealth@Assembly.Wales

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
Dr Alan Rees MD FRCP
[redacted]

From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP
[redacted]

08 January 2015

Dear colleague,

Thank you for the opportunity to respond to your consultation on the general principles of the Safe Nurse Staffing Levels (Wales) Bill.

About us
The Royal College of Physicians (Wales) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing 30,000 fellows and members worldwide, including 800 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Our response
The Royal College of Physicians (RCP) strongly welcomes this Bill and its multi-disciplinary approach. The Bill and related guidance should consider a range of factors to ensure that staffing levels adapt to meet local need, including staff competencies, staff behaviours, patient load, relative and carer need, and sudden changes in workload. Patients should be fully involved in monitoring and evaluating this work. We welcome the stated purpose of this Bill, that is, that nurses should be deployed in sufficient numbers to enable the provision of safe nursing care to patients at all times; improve working conditions for nursing and other staff; and strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Below we have pulled out a number of specific areas for comment.

National Health Service (Wales) Act 2006, Section 10A (1) (a) and (b)
'Each health service body in Wales must in exercising its functions—
(a) have regard to the importance of ensuring that registered nurses are deployed in sufficient numbers to enable the provision of safe nursing care, allowing time to care for patients sensitively, efficiently and effectively; and (b) take all reasonable steps to maintain minimum registered nurse : patient ratios and minimum registered nurse : healthcare support workers ratios in adult inpatient wards in acute hospitals (in accordance with guidance under this section)'
In order to make any kind of impact, this Bill must be enforced. We would welcome more detail on how this is to be achieved. For example, hospitals could be required to shut beds without the required number of nursing staff present. This would be a drastic, but effective move, and it already happens in

some aspects of healthcare eg level 2 and 3 critical care. At present, it is doctors and nurses on the frontline who bear responsibility when things go wrong because of a shortage of staff, yet most have very little authority over staffing numbers. We would therefore support the implementation of corporate accountability for this legislation. We would also support the removal of the word 'reasonable' from this section. Health bodies should 'take all steps', or alternatively, 'all possible steps' to maintain safe staffing ratios.

National Health Service (Wales) Act 2006, Section 10A (3)
'The Welsh Ministers may by regulations make provision for the duty under subsection (1)(b) to extend to additional settings within the National Health Service in Wales.'
We strongly support this provision.

National Health Service (Wales) Act 2006, Section 10A (5) (a)
'The guidance must specify methods by which health service bodies may comply with the duty'
Changes in the acuity of patients can have a major impact on nursing resources. For example, patients in level one care can experience a deterioration in their condition which would require more intensive monitoring until the patient has stabilised. We would support the use of a 'red flag' system when assessing whether available nursing staff meet patients' nursing needs over a 24-hour period. The nurse in charge should be aware of all situations of risk on the ward and they should be able to decide whether additional nursing staff need to be allocated. For example, when nutritional assessments are carried out, there should always be subsequent weighing of the patient or appropriate diet ordered. The RCP would urge those drafting guidance to consider this aspect of nurse staffing levels very carefully. We are keen to be involved in developing these tools as this work progresses.

National Health Service (Wales) Act 2006, Section 10A (5) (f)
'The guidance must be designed to ensure that the requirements of the duty are met on a shift-by-shift basis.'
We strongly support this provision.

National Health Service (Wales) Act 2006, Section 10A (5) (g)
'The guidance must include provision about the publication to patients, to the extent that Welsh Ministers consider it appropriate, of the numbers, roles and responsibilities of nursing staff on duty'
We are not convinced that the current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales are adequate and appropriate, or that this data is always strictly accurate. We strongly support making both medical and nursing staffing data publicly available and easily accessible, and displaying information about staffing numbers in every ward.

National Health Service (Wales) Act 2006, Section 10A (7) (a)
'The protections mentioned in subsection (5)(h) are protections for the supernumerary status of student staff and persons performing supervisory functions (such as Ward Sister or Charge Nurse)'
We support this. However, the guidance must ensure that all protected roles must maintain and develop their clinical skills. We need to ensure that this senior expertise is not lost from the clinical area.

Safe Nurse Staffing Levels (Wales) Act 2014, Section 3 (5)
'The Welsh Ministers must publish a report of the results of each review which gives details of the impact of this Act'
We are very supportive of this provision. We will be especially interested in finding out more about the impact of this legislation on mortality rates and overtime and sickness levels. The RCP is very supportive of the move towards a seven day service, believing that patients deserve the same high quality care in the evening and weekends as they receive during the week. We certainly see it as a priority to introduce a seven day service for acute and emergency care as we recognise that there is a discrepancy between

mortality rates during the week and those on the weekend. In addition, patients need continuity of care, but all too often hospitals 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. We therefore welcome moves to address the issue of unacceptable levels of temporary nursing staff on acute wards.

The RCP would also like to highlight the following areas of work to the Committee:

Future Hospital Programme

In September 2013, the Royal College of Physicians (RCP) launched the Future Hospital Commission report, *Caring for medical patients*.[1] This 214 page report focuses on the care of acutely ill medical patients, the organisation of medical services, and the role of physicians and trainees across the medical specialties in England and Wales. The model of care proposed is underpinned by the principle that hospitals must be designed around the needs of patients. The Future Hospital Programme (FHP) is now an agreed 2014-2017 organisational priority for the RCP. The purpose of this pan-college project is to develop and implement the RCP's vision for the future of medical care across hospital and community settings. In Wales, this work is being led by our vice president, Dr Alan Rees, a senior consultant physician with an interest in diabetes and endocrinology.

A growing medical workforce crisis

During the Future Hospital Commission, the RCP found increasing evidence to suggest that both trainee doctors and senior hospital doctors are struggling to cope with the increased demands being placed on the health service. A 2013 GMC study[2] found that a reduction in trainee doctors' hours enforced by the New Deal and the European Working Time Directive (EWTD) has increased the tension in an already over-stretched workforce. Later in 2013, the RCP published a short paper about the medical workforce crisis, *Fit for the future*[3], alongside a longer research document, *The medical registrar: empowering the unsung heroes of patient care*.[4] This report found that medical registrars are facing increasing challenges in their delivery of patient care in NHS hospitals.

Teams without walls

The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry[5] (the 'Francis report') makes stark reading, and it shows that if hospital teams are poorly staffed and/or managed, patient care can suffer with tragic results. Other recent reports, including the *Trusted to care* review[6] into standards of care at Abertawe Bro Morgannwg University Health Board, have highlighted issues of excessive mortality, poor care and the levels of nursing staff – these reports are of great concern to the RCP. Effective patient care can only be delivered by effective teams of doctors, nurses and other allied health professionals working together. This is why we firmly believe that these problems need to be seen as part of a bigger picture of failing holistic care.

The current crisis in hospital care is an impetus to rethink how non-medical professionals work to support medically trained staff. Close collaboration between all professional groups will be needed to reduce the problems seen recently. In 2008, the RCP published *Teams without walls*[7], which outlined an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local

[1] http://www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf
[2] http://www.gmc-uk.org/news/14414.asp
[3] http://www.rcplondon.ac.uk/projects/hospital-workforce-fit-future
[4] http://www.rcplondon.ac.uk/sites/default/files/future-medical-registrar_1.pdf
[5] http://www.midstaffspublicinquiry.com/
[6] http://wales.gov.uk/docs/dhss/publications/140512trustedtocareen.pdf
[7] https://www.rcplondon.ac.uk/sites/default/files/teams-without-walls-1_0.pdf

clinicians. The RCP believes that an urgent rethink is required about the provision of hospital care for acutely unwell medical patients to allow safe, high-quality care of patients.

Seven day working

The RCP is very supportive of the move towards a seven day service, believing that patients deserve the same high quality care in the evening and weekends as they receive during the week. We certainly see it as a priority to introduce a seven day service for acute and emergency care. However, we have warned that this will probably require extra resources. It is also key that support and diagnostic services operate over seven days to facilitate transfer out of the hospital setting, which will probably mean more investment in integrated health and social care. It is our hope that reconfiguration of the health service in Wales will enable rotas to be established to provide a seven day service (that is, five day working over a seven day week).

The balance between providing specialist and general care

The RCP believes that the entire hospital workforce must be reorganised to better meet the needs of frail elderly patients. The balance between specialist and generalist skills must be considered. This will still be necessary even if there is a considerable shift from hospital care to community care for older people. The Bill should address the need for a continuous presence of a member of the team, although this does not *always* have to be a registered nurse, as this will depend on the condition of the patient. For example, many patients present to acute medical units with cognitive impairment arising from dementia. Healthcare assistants are able to sit with them if their condition is relatively stable, but should their condition fluctuate then a registered nurse should be able to take over.

Other relevant material

National Institute for Health and Care Excellence (NICE) guidelines are available on safe staffing for nursing in adult inpatient wards in acute hospitals[8] as well as a toolkit for safe staffing[9] and an overview pathway[10]. NICE is also development safe staffing guidelines on a number of other areas in the NHS[11]. We would urge the Committee to consider these evidence-based tools as part of their scrutiny.

For more information

If you have any questions, please contact our colleague, Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted] or on [redacted].

With best wishes,

Dr Alan Rees
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

[8] http://www.nice.org.uk/guidance/SG1
[9] http://www.nice.org.uk/news/press-and-media/first-toolkit-endorsed-by-nice-for-safe-staffing
[10] http://pathways.nice.org.uk/pathways/safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals
[11] http://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/nice-safe-staffing-guidelines

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)

Briefing for:	National Assembly for Wales, Health and Social Care Committee.
Purpose:	The Welsh NHS Confederation response to the Inquiry into the general principles of the Safe Nurse Staffing Levels (Wales) Bill
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, Welsh NHS Confederation [redacted] Tel: [redacted]
Date created:	08 January 2015.

Evidence from The Welah NHS Confederation – SNSL(Org) 03 / Tystiolaeth gan Conffederasiwn GIG Cymru – SNSL(Org) 03

Introduction.

1. The Welsh NHS Confederation, on behalf of its members, wholeheartedly welcomes the opportunity to respond to the inquiry into the general principles of the Safe Nurse Staffing Levels (Wales) Bill.

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

Summary

5. As with our response to the earlier consultations on this Bill,[i] we feel it is important to highlight that the Welsh NHS Confederation wholeheartedly supports any initiative aimed at proactively improving patient safety. Our members are committed to delivering high quality care which results in the best possible outcomes for patients and their families. However, we must

emphasise that, while vital, nursing ratios and nurse staffing levels are one of many elements to consider - alongside technology, training, education, planning and good leadership - when it comes to patient safety.

6. It is also important to highlight the need for flexibility when it comes to staffing levels. The number of nurses required may vary depending on local need, the complexity of an individual patient's condition and the type of ward the patient is on. Any changes to nurse staffing should be evaluated on the basis of their impact on patient outcomes and patient experience.

7. Nurses, working as part of a wider multidisciplinary team, play a vital role in achieving the outcomes that we want for the NHS: an NHS that provides quality care and excellent outcomes for patients. Our vision for the NHS is that it meets the needs of the people it serves, and is ready to change to meet those needs in the future. This vision includes:

- Looking after patients as a 'whole person'. Patients are fully informed about their care and involved in decision-making.
- Supported self-care will be the norm for the 800,000[ii] people living in Wales with long-term conditions, with technology supporting choice, self-reporting, and monitoring.
- Everyone will receive fully integrated care, built around general practice and extended primary care teams alongside social care, the third sector and carers.
- Acute and elective episodes will be dealt with in a bed in hospital where necessary. Hospitals will be designed to be the most local they can be and be appropriately staffed and set up to be sustainable by working closely with local GPs, councils and community services.
- Specialist centres will be at the heart of delivering world class outcomes, leading the way in innovation, research and development and cutting edge medicine.
- There will be seven day urgent and emergency care because it shouldn't be the case that people are more likely to die in hospital on a Sunday than a Tuesday, or that when people fall in care homes the only place to take them is A&E.
- Nursing staff, along with other NHS staff should make every contact count, collaborating with individuals and the public in improving individual and population health outcomes.
- The effective commissioning of registered nurse training places will be key to meeting safe staffing targets in acute and community settings, thereby reducing the need for overseas recruitment.

8. To demonstrate that we have achieved our vision we must ensure:

- Positive outcomes for patients;
- A reduction in health inequalities;
- A passionate, highly-trained workforce; and
- Helping more people avoid hospital admission through improved community and social services.

9. Nurses play a vital component in this vision. However they are still only one part of a wider multidisciplinary team that can achieve this. We believe a more appropriate approach would be to ensure wards have both the right numbers of staff and skill mix to meet patients' needs, recruiting staff more on their values and better training for nurses to make sure all care is delivered in a safe and compassionate way.

Questions

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

10. Improving patient safety is the heart of the NHS in Wales but mandatory staffing levels cannot guarantee safe care. While it is absolutely the case that good nursing is vital if high quality care is to be delivered everywhere, it is too simplistic to say any issues with care can be resolved through increasing resources and safe nurse staffing levels. Overall we do not agree that introducing legislation that imposes a crude system of staffing ratios is the right way to tackle poor patient care, and inquiries, including the Mid Staffordshire Public Inquiry,[iii] found that minimum staffing levels do not necessarily improve patient outcomes.

11. The Mid Staffordshire Public Inquiry heard evidence from California, where minimum nurse to patient ratios were introduced in 2004. A research paper, presented by Leeds University professor Dawn Dowding, found no apparent difference in outcomes between California and other states that did not have minimum staffing levels. The report suggests that there are many other variables which have a high impact on the quality of patient care – such as quality of medical technology, culture, ongoing staff education and management practices.[iv]

12. Furthermore, when comparing the UK health systems with other countries in relation to equity and safe care, the UK ranks highly. The 2014 Commonwealth Fund report[v] compared the UK health system with the healthcare systems of eleven other countries (including Australia, Canada, Germany, Netherlands, New Zealand and USA), and the UK NHS was found to be the most impressive overall. The NHS in the UK was rated as the best system in terms of co-ordination, efficiency, effectiveness, safety and providing person-centred care.

13. There is the potential for safe nurse staffing levels to be further implemented through other ways rather than legislation. Safe staffing could become a Tier 1 standard/indicator that could be implemented with more speed than legislation. Further assessment of efficacy in delivering safe staffing levels could be introduced via the performance management mechanisms between Welsh Government and the Health Boards and Trusts**.**

14. Instead of introducing legislation, a better response could be ensuring we get the right staffing pattern and skill mix to meet patients' needs; to recruit staff more on their values; better training of nurses; the further commissioning of registered nurse training places and making sure all staff operate in organisations that value compassion and care.

15. There are also concerns about the proliferation of documentation that frontline nurses are now expected to complete in response to a range of national developments and programmes. All of these have value, but an unintended consequence of this administrative workload can detract from their ability to provide patient focused care. Overall we believe that any initiative to improve patient safety, whether legislation or otherwise, must be based on evidence that demonstrates the best results for patients.

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

16. Section 1 of the Bill states that its purpose is to ensure nurses are deployed in "*sufficient numbers*" to enable "*provision of safe nursing care to all patients at all times*". However, there is no definition of what would be regarded as "*safe nursing care*" therefore it is unclear what the overall purpose of the Bill is and what patient outcome it is attempting to achieve in practice.

17. While NHS Nurse Director's in Wales support the setting of safe staffing levels, they would stress that there needs to be clear professional judgment applied to ensure that flexibility in staffing remains a critical part of meeting patient needs. The use of workload and acuity tools should help inform the setting of staffing levels.

18. Already in Wales, in response to the Francis Report,[vi] there is an assessment process to determine staffing levels on wards, based on the severity of patients' conditions (acuity) rather than solely patient numbers. The core principles, developed by the Chief Nursing Officer and issued to all Health Boards in Wales in 2012,[vii] include:

- the number of patients per registered nurse should not exceed seven by day;
- a night time ratio of one nurse to 11 patients;
- the skill mix of registered nurse to nursing support worker in acute areas should generally be 60:40.

19. In July 2013 the National Assembly for Wales Research Service produced a research note[viii] which highlighted that most Local Health Boards in Wales are meeting, or exceeding, these ratios.

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

20. One of the potential barriers to implementing the provisions of the Bill is that it takes little consideration for the workforce needed for the future and how it links with patient outcomes. When considering the best outcomes for patients, we need to help create a workforce that is fit for the future, including the nursing profession. The healthcare system must be redesigned around the service user, supporting people to maintain their own well-being and staying as healthy as possible and utilising community and local services rather than going to hospital or to a GP surgery.

21. The population of Wales is projected to increase by 4% to 3.19m by 2022[ix] and we have a rapidly ageing population, with the number of people over 65 in Wales set to rise to 26% of the total population by 2033.[x] The NHS will need to respond to significant future challenges in respect of high rates of chronic conditions, long-term limiting illness, obesity, poverty and health inequalities. Demand for services is set to increase significantly and the NHS workforce must be ready to change, respond and react to the challenges ahead.

22. The NHS will always need to treat people with high level, emergency, specialist and intensive care. However, there is a need for system-wide changes if models of care that are more community based are to be implemented.As the Welsh NHS Confederation discussion paper 'From Rhetoric to Reality - NHS Wales in 10 years' time'[xi] highlighted: "*With ongoing financial constraints, the previous growth in the workforce has ceased. Yet the future supply and availability of clinical staff is crucial to the quality, range, shape and organisation of health services as we seek to do more with fewer staff. Delivering more of the same through traditional roles and ways of delivering care will not be an option. NHS Wales and its staff will simply have to work differently to meet increasing demands, and to be responsive to needs at the same time as ensuring high quality, compassionate, effective care.*"

23. There is a need to think radically about the workforce of the future, the skills that NHS Wales will need and who will be the key decision makers in patient pathways, coupled with the need to design workforce models which are deliverable and the impact of 'prudent healthcare'. We need

help to build consensus around what a sustainable future workforce will look like and how it will be developed.

24. A workforce that is fit for the future must include people who can work effectively across professional and organisational boundaries - including across health and social care; and harness and promote innovation and technological development. The need to balance the development of generic skills required to provide care to an ageing population and recognition of the place of self-care in developing models will all impact on how we think about and plan the workforce. More generalist and less specialist competencies are needed throughout the workforce to support the increasing number of people with complex health and care needs.

25. Further information about the future workforce will be highlighted in a briefing produced by Welsh NHS Confederation, NHS Wales Employers and Workforce Education Development Services. The briefing is due to be published at the end of January and will provide a summary of the key issues facing the NHS Wales workforce based on the elements of Integrated Medium Term Plans produced by Health Boards and Trusts, together with a high level review of other UK and Wales data and information sources.

iv) Are there any unintended consequences arising from the Bill?

26. There is some concern from NHS Wales Nurse Directors that mandatory staffing levels may result in less flexibility, a lower value and reliance on professional judgment and may mean that staffing levels do not respond to changes in patient acuity and dependency.

27. Other unintended consequences arising from the Bill includes:

a) While Section 10 (A) (5) (e) states that the guidance to health service bodies in Wales *"must include provision for ensuring that the recommended minimum ratios are not applied as an upper limit in practice"* it is unclear what this provision will be and therefore minimum staffing levels could be interpreted as maximum which potentially puts additional stress into clinical areas regarding safe staffing levels.

b) Clear consideration needs to be given to circumstances where recruitment into posts is a key constraining factor. Already nurse supply and demand issues are proving challenging for a number of NHS organisations across the UK at present. Recently NHS Employers conducted a survey[xii] for Health Education England to gather robust and timely intelligence from employers in England about the current nurse workforce demand and their views on supply issues. Of the 90 organisations surveyed, 83% reported that they are experiencing qualified nursing workforce supply shortages, and of 49 organisations surveyed 45% had actively recruited from outside of the UK in the last 12 months to fill nursing vacancies.

c) Each NHS hospital and service has different demands on its services. Arbitrary ratios could limit organisations' ability to plan care in a way that is best for the patient and limits the way we use the skills of other staff like physiotherapists and occupational therapists.

d) There is potential for one part of the system, nurses in adult acute wards, to be prioritised in relation to staffing above others. One example is that community nursing could see reductions in staffing in order to comply with legislation in hospital settings.

e) The role of nurses could be adversely modified to take on broader roles which would not have ordinarily be seen as nursing, thus impacting on the time to care of registered nurses in particular. There is already some evidence that nurses are utilised for many differing roles

including, for example, bed management and patient flow, presenting a challenge to direct clinical care.

f) There is potential diversion of funds away from other members of the healthcare team that play an important role in patient care. Nurse numbers and ratios do not take into account the role of speech therapists, occupational therapists, physiotherapists, dieticians and others. Will vacancies be held in these staff groups to pay for more nurses? This would be significantly detrimental to holistic patient care and outcomes.

g) Any legislative framework is likely to become outdated over time. This may be more prominent in relation to staffing where models of health and social care are changing, as highlighted above in response to question iii.

h) Having more staff does not equate to a more productive service. As highlighted within a recent report by The King's Fund,[xiii] on the future financial sustainability of the NHS in Wales, increased funding over the last decade has allowed the Welsh NHS to employ more staff, and in general to produce more activity. However, productivity, measured by hospital activity per head of staff, has fallen among medical staff. While activity among medical staff has also fallen in England over the same period, the decrease has not been as great, and nursing productivity, which has remained stable in Wales, has increased across the border. Many of the most significant opportunities to improve productivity will come from focusing on clinical decision making and reducing variations in clinical practice across the NHS, and shifting the focus away from hospital-led, acute services. Reducing variations in clinical service delivery and improving safety and quality should be key priorities for providers.

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

28. Health Boards and Trusts presently take full responsibility for the quality of care provided to patients and for nurse staffing capacity and capability. Health Boards and Trusts ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day and night. This includes identified time set aside for nurses to have continued professional development.

29. The current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales is adequate and appropriate. Most areas are utilising rostering systems that support a focus on staffing levels to meet the requirements of individual wards and can be used for monitoring purposes (planned versus actual staffing). These also help to identify the level of additional/flexible staffing required such as bank or agency staff.

30. In addition, currently there are periodic but regular reports into Welsh Government in relation to the implementation against the Staffing Principles for acute medical and surgical wards.

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

31. As highlighted previously, it is essential that professional judgment and the use of acuity type tools help inform decisions locally regarding staffing levels. It's not just about numbers but the right staff with the right skills within the service.

vii) The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

32. There is clear evidence that staffing levels in acute medical and surgical settings impact upon care quality and patient outcomes. However, there is not as much evidence to support this in other settings.

33. Safe staffing levels should only be developed with the use of professional judgment and a risk balanced approach to settings other than acute medical and surgical wards. The development of community services will require, for example, sufficient numbers and skill of community nurses often within and as part of multi-professional and multiagency teams. Other settings include mental health, learning disabilities, health visiting and critical care settings for example. In some areas of practice Royal Colleges and other professional associations (such as neonatal) already produce guidance in relation to staffing and the use and emphasis on these could be more useful.

34. It is imperative that safe staffing plans are also developed for community hospital, community health, mental health and child health services.

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

35. It is important to emphasise that each hospital and service has different demands on its services and often it is down to professional judgement to make sure organisations have the ability to respond to these demands. Although section 10 (5) (b) says guidance would specify the minimum nurse to patient ratios, *"which individual health service bodies may adjust so as to increase the minimum numbers of nurses for their hospitals,"* mandatory staffing levels may result in less flexibility than the current system.

36. Section 10A (1) (6) (b) of the Bill says the guidance must *"allow for the exercise of professional judgement within the planning process."* However there is concern from Nurse Directors that the setting of staffing levels will lower the value of this professional judgement. As a result, staffing levels may not be able to respond to changes in patient acuity and dependency.

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

37. As highlighted previously it is important that when considering safe staffing it is important to involve the use of evidence-based and workforce planning tools, allow for the exercise of professional judgement within the planning process, makes provision for the required nursing skill-mix needed to reflect patient care needs and local circumstances. Many of these methods are already being implemented across health services in Wales.

38. Staffing agreements should be based on a triangulated approach, including professional judgement and an acuity tool. The acuity tool currently being tested has shown variable and some unexpected results; further validation would be welcome to demonstrate its reliability as a workforce tool. Until the acuity tool is finally validated nursing principles should remain in place.

x) Includes provision to ensure that the minimum ratios are not applied as an upper limit?

39. The setting of minimum nurse to patient ratios should not be read to mean 'maximum'. There is a concern that this Bill may have unintended consequences in that the minimum may well be applied as the maximum. Although section 10 A (1) (5) (e) says the guidance must include a provision for ensuring that the recommended minimum ratios are *"not applied as an upper limit in practice"* there are questions over how this will be monitored. Also, each ward should have flexibility depending on the needs of its patients. Many of the most significant opportunities to improve productivity will come from clinical decision making and reducing variation in clinical practice across the NHS, which will also improve safety and quality.

xi) Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?

40. NHS Wales has become more transparent and accountable and is further developing a culture of honesty and openness so the service can learn from mistakes and improve activities. Increased transparency is a key driver in improving quality across the NHS as a whole, highlighting both those areas where good practice is in place and those where there is scope for improvement. All Health Boards and Trusts are improving visibility and ease of access to information to ensure that patients and the public are informed. Adopting an approach where organisations volunteer such information as part of quality improvement should enable a clear move in the direction of full openness and transparency.

41. While we are in support of the publication of information, the value of publically available reports would not be in simply publishing how many staff are on duty, but rather the numbers of occasions where safe staffing could have been compromised and the outcome. This must engender a collective responsibility and consideration of the actions that brought about a 'shift of concern', sending a clear message to staff of the commitment to ensure staffing meets the patient needs on a risk balanced and professional judgment basis.

xii) Includes protections for certain activities and particular roles when staffing levels are being determined?

42. As highlighted previously, it would be difficult to protect certain activities and particular roles when staffing levels are being determined because each NHS hospital and service has different demands on its services and patients have different clinical needs.

xiii) The requirement for Welsh Ministers to consult before issuing guidance?

43. It is important that the Welsh Minister consults with Local Health Boards and Trusts, and others who are likely to be affected by the guidance. Due to some uncertainties within the Bill, for example what is the definition of *"safe nurse staffing levels"* the guidance will be key to achieving the Bill's overall purpose.

xiv) The monitoring requirements set out in the Bill?

44. The current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales is adequate and appropriate.

xv) The requirement for each health service body to publish an annual report?

45. Section 10A (10) of the Bill highlights the need for information to be made public and for each health service body in Wales to publish an annual report. As highlighted previously, the NHS in Wales is committed to transparency in the interests of accountability and has worked hard to improve this. A wide range of information, including performance data, mortality rates and inspection reports are all published in the public domain.

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

46. In reference to some of the measures mentioned in the Bill under section 3 (5), there is concern about how these would be defined and monitored. For example, in terms of the number of falls on a ward, what would be the number that would be a cause for concern? Also in relation to mortality rates as a measure of hospital quality and safety, a number of reviews have highlighted that the measure is not always a meaningful measure of quality, and can be misleading.[xiv] There needs to be a multidimensional approach to measuring healthcare, given the complexity of this area. Furthermore, many of the measures listed in the Bill will depend on the kind of ward.

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

47. The existing guidance is effective and does have an impact on staffing levels. The Chief Nursing Officer (CNO) together with Nurse Directors have embarked on a programme of work aimed at collating evidence regarding staffing levels that improve patient/client outcomes; and the application of evidence in the form of tools for calculating and implementing staffing levels. This work preceded that being undertaken by NICE on acute wards staffing and will be largely in line with timetables for other areas of nursing practice.

48. Regular monitoring of progress against the Nurse Staffing Principles for acute medical and surgical wards has been taking place by Welsh Government (via the CNO Office). This does not currently however form part of the Tier 1 indicators and measures of Welsh Government.

xviii) Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

49. It is important that certain aspects of the Bill should be on the face of the Bill and not left to subordinate legislation and guidance, for example a clear definition of what is the "provision of safe nursing care" should be defined within the Bill and what it is attempting to achieve.

xix) Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

50. This can only be truly understood when the scope of the Bill is clearly articulated, including the publication of the subordinate legislation and guidance. Not taking account of the above unintended consequences, and ensuring an equitable application of safe staffing levels in all settings, is likely to incur considerable costs. This would include additional data collection, collation, validation and publication.

51. As highlighted in our response[xv] to the National Assembly for Wales Finance Committee inquiry into Welsh Government draft budget proposals for 2015-16 the demand on the health service is growing and the rising cost of providing the service means that the NHS faces a significant funding gap, at the same time as an understandable expectation of improving the quality and safety of services. This means that the NHS will not be able to continue to do all that it does now, and certainly not in the same way.

52. The key critical factor when considering the financial implications of the Bill is whether the outcomes desired by this Bill can be achieved by means other than legislation. The cost and complexity of this Bill may mean that there are more cost effective and more rapid means of achieving the same outcomes.

53. There must be appropriate funding to ensure that safe nurse staffing levels are not resourced through the depletion of other services. There would need to be a clear commitment by the government that legislated staffing levels are also fully funded if safe staffing principles were to be implemented within Wales.

xx) Do you have any other comments you wish to make about the Bill or specific sections within it?

The importance of multidisciplinary teams

54. As previously highlighted multidisciplinary teams are vital to ensure that patients receive quality of care and receive excellent outcomes.

55. International evidence suggests that mandated registered nurse to patient ratios can improve nurse staffing and lead to better recruitment, generate a more stable workforce, and more manageable workloads for staff. The impact on patient outcomes is less clear but there is evidence that the resultant lower caseloads are related to lower levels of patient mortality. However, if we are to resolve possible issues within the Welsh NHS and improve patient care, we need to take a broad and deep view that looks honestly and openly at all aspects of the NHS, not just one group of staff.

56. Staffing levels may well be an issue in some parts of some hospitals in Wales, but it is not the case that we need more nurses everywhere. A better response would be to ensure we get four things right - the right staffing pattern and skill mix for each service, recruitment of NHS staff based more on their values, better training for nurses at the ward leader level, and ensuring nurses operate in organisations that value compassion and care. It is critical that we empower senior clinicians and managers at a local level to take greater responsibility for setting high standards of care, including determining the right staffing pattern for delivering these standards for their patients.

57. Multidisciplinary working has the opportunity to significantly reduce the strain on our services in the future, alongside building and learning new skills, we must collaborate and support our partners in other sectors, including social services, housing, education, transport and the third sector. This collaboration "*between specialists and generalists, hospital and community, and*

mental and physical health workers"[xvi] will play a big part in making sure our services are sustainable for the future.

Engaging with the public

58. To ensure positive outcomes for patients we must engage with the public and consider their views about staffing issues and the impact that improved nurse staffing levels have on their individual care.

59. We know that the NHS in Wales must do more to involve the public and patients, staff and partner services in explaining and working through the choices that need to be made. In our discussion document 'From Rhetoric to Reality - NHS Wales in 10 years' time'[xvii] we referred to building a new understanding of how the NHS should be used, embodied by an agreement with the public that would represent a shared understanding: *"Involving the public is central to realising an NHS where patients and the public are key and valued partners, where they are seen as 'assets'. "*We highlighted the importance that as time progresses we must ensure we work with the public to co-produce services and reduce demand, releasing capacity in the system. While some people will not want to engage, all have the right to be given the opportunity to do so.

60. Although co-design and co-production are beginning to happen in some parts of the public sector, the prevailing mindset in many areas is still one in which citizens and service users are passive recipients of services. In order to move towards the kind of engagement needed there is a major cultural shift required to move away from the view of public services as delivery agents to passive populations, to a greater focus on localities in which everyone does their bit.

61. The future success of the NHS relies on us all taking a proactive approach to health and ensuring that we create the right conditions to enable people in Wales to live active and healthy lifestyles. The sustainability of the NHS and other public bodies is the responsibility of everyone in Wales, but there appears to be a real lack of understanding that this is the case.

Integration

62. In addition to the role multidisciplinary health teams play in providing quality care and excellent outcomes for people, it is important that the role of other sectors should also be considered in people's well-being and care.

63. Integration and multi-agency working is key for the Welsh NHS Confederation because to tackle the culture of ill health in Wales we must recognise that health is much more than health services. As 'From Rhetoric to Reality – NHS Wales in 10 years' time'[xviii] highlighted, better health is the responsibility of all sectors and engagement is necessary with all our public service colleagues, from social care to housing, education and transport, to take us all from an 'ill-health' service that puts unnecessary pressure on hospital services, to one that promotes healthy lives. In serving the public the NHS must consider its own success with regard not only to treating healthcare needs, but more importantly, in relation to the ability of other sectors to impact on the quality of life for individuals. As the paper highlights: "*Health and healthcare must be premised on how we best support people to maintain their health, with the aim of eliminating or reducing their potential to require NHS services, and we must work in an integrated way with all sectors across Wales*."

64. The NHS must build on how it might improve its ability to work and support partners and colleagues in other sectors to reflect the multi-disciplinary demands required to run public services in a holistic way. There is a need for wholesale change to ensure that there are positive outcomes for patients, a reduction in health inequalities and to help people avoid hospital admission through improved community and social services. To achieve these outcomes it is vital that health is not seen as a stand-alone issue and that integration is prioritised. All public bodies in Wales must build on how we might improve our ability to work together and support our partners and colleagues in other sectors to provide the best outcomes for the people of Wales.

65. The Welsh NHS Confederation is already working closely with ADSS Cymru on the 'Delivering Transformation', previously 'Strengthening the Connections', project to take the practical steps required for the integration of health and social care services. Our close work with this body, and other key partners, is ensuring that there is no compromise in the quality of the service and the ability to safeguard individuals from the services operated by our members.

Conclusion

66. The Welsh NHS Confederation welcomes the debate on safe nurse staffing levels, but there are a number of important questions to be answered in order to determine whether legislation is the most appropriate approach.

67. Improving patient safety is at the heart of the NHS in Wales but mandatory staffing levels cannot guarantee safe care. While it is absolutely the case that good nursing is vital if high quality care is to be delivered everywhere, it is too simplistic to say any possible issues with care can be resolved through increasing resources.

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[i] The Welsh NHS Confederation, June 2014. Response to the 'Minimum Nurse Staffing Levels (Wales) Bill' and the Welsh NHS Confederation, September 2014. Response to the 'Safe Nurse Staffing Levels (Wales) Bill'.
[ii] Wales Audit Office, March 2014. The Management of Chronic Conditions in Wales – An Update.
[iii] Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009.
[iv] The Mid Staffordshire NHS Foundation Trust Public Inquiry (2010) http://www.midstaffspublicinquiry.com/inquiry-seminars/nursing
[v] The Commonwealth Fund, June 2014.Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally
[vi] The Mid Staffordshire NHS Foundation Trust Public Inquiry
[vii] Welsh Government, April 2012. Chief Nursing Officers Guiding Principles for Nurse Staffing in Wales
[viii] National Assembly For Wales, July 2013, Nurse staffing levels on hospital wards
[ix] Nuffield Report, June 2014. A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26.
[x] National Assembly for Wales, 2011. Key issues for the Fourth Assembly.
[xi] The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.
[xii] NHS Employers, May 2014. NHS Qualified Nurse Supply and Demand Survey – Findings.
[xiii] The King's Fund, 2013. A review of the future financial sustainability of health care in Wales.
[xiv] Stephen Palmer, June 2014. A Report to the Welsh Government Minister for Health and Social Services to provide an independent review of the risk adjusted mortality data for Welsh hospitals, considering to what

extent these measures provide valid information, focusing initially on the six hospitals with a Welsh Risk Adjusted Mortality Index (RAMI) score of above 100 in the data published on Friday 21 March 2014.

[xv] The Welsh NHS Confederation, September 2014. National Assembly for Wales Finance Committeecall for information into Welsh Government draft budget proposals for 2015-16.

[xvi] Kings Fund, July 2013. NHS and social care workforce: meeting our needs now and in the future?

[xvii] The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.

[xviii] Ibid

Y Gymdeithas Feddygol Brydeinig
Pumed Llawr
2 Pentir Caspian
Ffordd Caspian
Bae Caerdydd
Caerdydd
CF10 4DQ

British Medical Association
Fifth Floor
2 Caspian Point
Caspian Way
Cardiff Bay
Cardiff
CF10 4DQ

Ffôn/Tel [redacted]
Ffacs/Fax [redacted]
Ebost/Email [redacted]

BMA

Cymru Wales

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from BMA Cymru Wales – SNSL(Org) 04 / Tystiolaeth gan BMA Cymru – SNSL(Org) 04

GENERAL PRINCIPLES OF THE SAFE NURSE STAFFING LEVELS (WALES) BILL

Consultation by the National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

14 January 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the National Assembly for Wales' Health and Social Care Committee on the general principles of the Safe Nurse Staffing Levels (Wales) Bill.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

BMA Cymru Wales offers the following responses to the specific questions posed by the Committee upon which we have a view:

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

In line with the comments provided in response to the two previous consultations, BMA Cymru Wales continues to express its support for the need for this legislation. The requirement for adequate staffing levels, particularly in acute hospital wards has been frequently underlined – such as in a recent study published in *The Lancet*[1] which highlighted the link between nurse staffing levels and patient outcomes, and the recent report by Professor June Andrews and Mark Butler[2] which outlined inadequacies in the care of older patients at the Princess of Wales and Neath Port Talbot Hospitals. We consider that until appropriate safeguards are implemented, such as those which would be put in place by this Bill, then local health boards in Wales will continue to deplete ward nursing establishments and run wards with unsafe nurse staffing levels.

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

We would support the provisions of the Bill in the manner they have been set out in Section 1 of the Bill as it has been introduced. However, we have some concerns as to how these provisions are then further taken forward within Section 2.

Specifically we have concerns that in securing appropriate staffing levels in adult inpatient wards in acute hospitals, the legislation as currently drafted might lead to nursing levels inadvertently being depleted in other inpatient settings such as in community hospitals.

We feel that additional safeguards may therefore need to be added in to this this legislation to ensure that a minimum nurse staffing level is delivered in all inpatient settings. This might be achieved, for instance, by requiring that there should be at least two qualified nurses present on an inpatient ward at all times – with sufficient cover from a third nurse also being provided in cases where there would otherwise only be two nurses present, in order for them to be able to take breaks.

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

We envisage that health boards might cite potential difficulties in being able to recruit sufficient nurses, including qualified nurses, and may state that they already experience difficulties in many instances in even recruiting agency nurses to fill gaps in rotas. Our members note that many nursing staff may regularly undertake additional shifts to ensure adequate staffing cover can be provided. There may, however, also have to be an acceptance from more senior nurses in managerial roles that they may at times also have to assist with direct patient care to ensure the provisions of this Bill can be fulfilled.

Are there any unintended consequences arising from the Bill?

We would reiterate our concern that requiring minimum ratios in specific defined inpatient settings could inadvertently lead to a depletion of nurse staffing levels in other inpatient settings. Amendments to the Bill may therefore be required to ensure this could not be the case.

Do you have a view on the duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided?

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[1] L H Aitken et al (2014) *Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study.* The Lancet. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/fulltext

[2] http://wales.gov.uk/topics/health/publications/health/reports/care/?lang=en

We support this duty, subject to the concerns we have raised above being addressed regarding the need to mitigate against the possibility of inadvertent adverse impacts on nurse staffing levels in other inpatient settings. However, we would note that the key to the success of this proposed duty may be derived from any accompanying powers that may be required to ensure that it is in fact fulfilled by health boards. We would hope that a statutory duty would in itself provide greater leverage to ensure that health boards do meet such obligations in relation to providing safe nurse staffing levels, whilst noting that current non-statutory obligations are often ineffective. We would therefore seek assurance that either having a statutory duty in itself will provide sufficient incentive to ensure safe nurse staffing levels are delivered, or else that sufficient additional measures and/or sanctions are also agreed to ensure that this will be the case.

An alternative approach that some of our members have suggested, might be to empower sisters and charge nurses to close wards down in cases where they feel they have a nurse staffing level that is inadequate for them to safely care for the patients in their charge. This might be a more effective approach than simply placing the duty to comply with this legislation on health boards themselves.

The Bill could also give consideration to how individual members of staff, and not specifically just nurses, would be able to raise concerns regarding unsafe nurse staffing levels without any fear of reprisal. In our view, it is vitally important that all staff can be fully protected in raising such concerns – and indeed the system in place should ensure they are actively encouraged to do so when they perceive safe nurse staffing levels are not in place, in order to maximise the effectiveness of this legislation.

Do you have a view on the duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios, which will apply initially in adult inpatient wards in acute hospitals?

The view of BMA Cymru Wales is that what would be regarded as 'reasonable' may require clearer definition, as it leaves it open to interpretation what steps might be seen as reasonable and what steps might therefore be seen as unreasonable. We feel it may be preferable for this duty to instead require all 'possible' steps, as we consider this might be more likely to lead to the intentions of the Bill being delivered.

Do you have a view on the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

We would again reiterate the concerns we have already expressed that this may lead to inadvertent adverse impacts on nurse staffing levels in other inpatient settings, such as in community hospitals. The Bill may therefore require to be amended to ensure such a concern is mitigated against.

Do you have a view on the requirement for the Welsh Government to issue guidance in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:

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

We consider that the guidance which will be required to define what particular minimum ratios should be in place in different specific circumstances must clearly define what is meant by a safe staffing level in a way that also takes into account the provision of an appropriate skill mix (e.g. between nurses and healthcare workers) in order for this to be achieved.

This guidance should recognise that the individual needs of patients may have to be taken into account in order to determine what the appropriate minimum ratio might be in a particular situation. For instance, some patients on acute psychiatric wards may require a designated member of staff to sit with them continually. The needs of individual patients within a ward may therefore need to be taken into account

in determining what the appropriate minimum ratio might be at a specific time on a specific ward, and not just the type of ward and the number of patients currently present.

We feel it could be helpful for what is described as 'additional settings' to which the provisions of the Bill could also apply to be defined so that it is clearer what might be intended.

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

Whilst we accept this might happen in circumstances where there is insufficient funding available, or where there are particular challenges in recruiting nursing staff, we also believe that the benefits of such a requirement in preventing wards from being run with unsafe nurse staffing levels would significantly outweigh the disadvantages of this potentially being the case.

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

We consider this is important if we want to ensure that excellent care is delivered to patients by motivated staff.

Do you have a view on the requirement for each health service body to publish an annual report?

This would appear to us to be an appropriate requirement. We would suggest that an appropriate standardised format is developed for these annual reports which also includes explicit requirements to provide detailed information concerning breaches of the provisions of this Bill, as well as of any action plans being implemented to prevent such breaches from reoccurring.

Do you have a view on the requirement for Welsh Ministers to review the operation and effectiveness of the Act as set out in section 3?

We support this requirement. Whilst it would be hoped that this legislation would be effective in achieving its aims from the date of its implementation, it would seem only sensible to include a provision for Welsh Ministers to subsequently review its operation and effectiveness in the way that has been outlined.

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

In the experience of our members, current guidance does not appear to have had a noticeable effect in preventing what they would perceive as unsafe nurse staffing levels. As such, we would reiterate our support for this Bill.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Royal College of Nursing – SNSL(Org) 05 / Tystiolaeth gan Coleg Nursio Brenhinol – SNSL(Org) 05

Coleg Nyrsio Brenhinol
Cymru
Royal College of Nursing
Wales

Inquiry into the Safe Nurse Staffing Levels Bill (Wales)
January 2015

Submission from the Royal College of Nursing, Wales
Presented to the National Assembly for Wales Health & Social Care Committee

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors, nursing students and healthcare support workers, with over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Written Evidence of the Royal College of Nursing in Wales in Response to the National Assembly for Wales Health and Social Care Committee Consultation on Safe Nurse Staffing Levels (Wales) Bill

1. The Royal College of Nursing is the world's largest professional organisation of nurses. It represents over 420,000 nurses, midwives, health visitors, nursing students and healthcare support workers. In Wales the Royal College has over 24,000 members. The majority of our members work in the NHS. The Royal College of Nursing works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession.

The Royal College of Nursing is a UK-wide organisation with its own National Board in Wales. It is a major contributor to nursing practice; standards of care and public policy as it affect health and nursing.

The Royal College of Nursing represents nurses and nursing, promotes excellence in nursing practice and care and shapes health policies.

The Royal College of Nursing welcomes the opportunity to respond to the Health and Social Care Committee's consultation on the Safe Nurse Staffing Levels (Wales) Bill.

Response to General Consultation Questions

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

2. The Royal College of Nursing in Wales believes that there is a need for legislation to make provision about Safe Nurse Staffing Levels.

International research clearly demonstrates that that the number of registered nurses and nursing staff on a ward makes a significant difference to successful patient outcomes including morbidity and mortality. In 2006 Professor Rafferty CBE surveyed nearly four thousand nurses and looked at 118,752 patient episodes of care in 30 hospital trusts in England. Her research found that wards with lower nurse to patient ratios had a 26% higher patient mortality rate. An international meta study in 2007 estimated that each additional full time nurse per patient day saved five lives per 1,000 medical patients, and six per 1,000 surgical patients (Kane et al 2007). Another study found that when

a nurse is charged with more than seven patients per day the risk of the patient dying within 30 days increases by 7 per cent (Aiken et al, 2014).

Poor outcomes also associated with low levels of nursing care include adverse events after surgery; increased accident rates and that patient injuries; increased cross-infection rates; and higher rates of pneumonia.

3. Despite these principles being well known within the nursing profession there has not been a commitment in the NHS to seeing Safe Nursing numbers in practice in wards. Paragraphs 10 to 12 of the Explanatory Memorandum reference the Francis Report (2013), the Keogh review (2013), the Berwick review (2013) and the Andrews Report (2014), all of which have drawn attention to the repeated failure of the NHS to sufficiently prioritise patient safety and the quality of care by safeguarding nursing numbers.

4. In Wales even the All Wales Nurse Staffing Principles Guidance issued by the Chief Nursing Officer (CNO) in 2012 has failed to make a sufficient impact. Trusted To Care (2014) the independent review of the Princess of Wales Hospital and the Neath Port Talbot Hospital specifically refers to *'lack of suitably qualified, educated and motivated staff particularly at night'* and comments: '*The Review Team were also concerned about the way staffing levels in the medical wards were determined as this seemed unconnected to the level of dependency and need on a ward at a specific time.'* The report of the Older People's Commissioner for Wales 'Dignified Care: Two Years On' (2013) states that '*there is a clear link between staffing levels and the safety and quality of care on hospital wards.*' As a result, the Royal College of Nursing believes that legislation is the only way to ensure Safe Nurse Staffing Levels on adult in-patient wards.

5. The figures below are from a Royal College of Nursing Survey carried out in 2013. This was an online survey sent out to a stratified random sample of the Royal College membership. The survey achieved a total of 9,754 usable responses across the UK, with 1,365 usable responses from nurses working in Wales. It shows the patient to nurse ratios reported by members in Wales:

	Patients per registered nurse
All	8.5
Older people	10.9
Mental health	8.2
Children and young people	4.4

Acute and urgent care	8.4

6. The Royal College of Nursing also undertook a Freedom of Information request (table below) which asked the Local Health Boards (LHBs) about the number of patients per registered nurse per day and night and the Ratio of Registered Nurses to Healthcare Support Workers. Their responses show that with the exception of Cwm Taf UHB all the other LHBs are failing to follow this guidance.

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)

7. The Royal College of Nursing believes that legislation by the National Assembly is necessary and will ensure that Health Boards place a greater priority on ensuring safe nursing levels on wards.

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

8. The Royal College of Nursing believes the provisions laid out in the Bill are the best way of achieving the Bill's purpose.

9. The duty on Health Boards to have regard to safe nurse staffing levels will ensure a Corporate level of accountability for the first time and increase the significance of the advice of the Nurse Director to the Board. Too often Board and Executive teams have consciously or unconsciously focused on financial and other strategic priorities at the expense of this key indicator of patient safety.

10. The requirement on Health Boards to publish information demonstrating how they have met the guidance will allow effective scrutiny, evidence of impact and also increase accountability.

11. In seeking to achieve the purpose of safe nursing levels the Bill does not set actual numbers but instead refers to the use to evidenced based and validated workforce planning tools, standards and guidelines of professional organisations and the role of professional judgment. The Royal College of Nursing views this as the sensible and sustainable approach

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

12. The Royal College of Nursing does not believe there are potential barriers to implementing the Bill. All LHBs currently undertake workforce planning and have the tools available to them to ensure that this legislation can be implemented without delay. This Bill simply places a duty upon the LHBs to consider Safe Nurse Staffing when planning their workforce.

Are there any unintended consequences arising from the Bill?

13. The Royal College of Nursing does not believe there will be any detrimental unintended consequences that can arise from this Bill. The experience of similar legislation in Victoria, Australia and California has been very positive (Serratt, 2013).

14. The Royal College of Nursing has previously been asked whether this Bill might result in a sudden increased demand for nurses might cause instability in another sector. This has not been the experience elsewhere. Indeed there was an increase in the number of nurses wishing to return to practice in Australia. If there was an increased demand this could be dealt with by an increase in the number of student nurses places commissioned.

15. A second fear expressed to us has been that costs could escalate as a result of employing more nurses. More detailed information and analysis is provided to the Committee in the

Explanatory Memorandum but a summary of the Royal College's response to this would be that *expenditure on nursing demonstrates the most effective impact on patient outcomes* (Bray et al, 2014)

16. The regulatory Impact section of the Explanatory Memorandum references findings from the 'perfectly resourced ward' pilot conducted by Aneurin Bevan Health Board at the end of 2012. 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 more than outweighed these increases. At the end of the three month period, the combined staffing costs of the two wards had not increased and in fact was marginally lower than the preceding period.

17. The Welsh Government has not published figures for spending on agency nursing in 2014 but the Royal College of Nursing is aware that agency costs to the NHS have increased 43% compared to 2013 and is at its highest level for four years. The Royal College of Nursing would estimate the cost of non-medical agency payments as between £20 and £30m in 2014.

A 2011 study (Hurst, 2011) 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.

18. Much research has also shown the financial benefit of safe nurse staffing levels. For example in 2009 US research quantified benefits per additional nurse at $60,000 with an additional $10,300 for reduced patient mortality, and $1800 from faster recovery. In the UK in 2009 Dr Foster Intelligence published research showing shorter hospital stays in acute Trusts that had more nurses per bed.

19. A final concern that has been raised with us is that other healthcare professions may feel disadvantaged by not being explicitly mentioned in this Bill.

20. The Royal College of Nursing has been delighted to receive support from BMA, RCP, the Diabetes National Specialist Advisory Group and UNISON Cymru.

21. Healthcare requires a multidisciplinary team approach to achieve the best outcome for the patient. At different moments in the journey of the patient they may require care from a surgeon, a pharmacist, a speech and language therapist, a physiotherapist etc.

The weight of academic evidence demonstrating the significance of the nursing impact is not a testimony to the superiority of the nursing profession but merely a testimony to that fact that the nature of nursing is a 24/7 caring role by the side of patient encompassing the very fundamentals of care including nutrition, hydration, alleviating pain etc. A core part of the nursing role is continuous assessment of the acuity of the patient, as the patients' needs change or escalate, nurses are responsible for referring onwards to other healthcare professionals.

Nurses make up the largest staff group in the NHS because they are
needed by patient *at all times* – and their absence has a significant negative impact.

Response to Consultation Question on Provisions in the Bill

View on the fact that, in the first instance, the duty applies to adult in-patient wards in acute hospitals only?

22. The vast majority of academic research demonstrating the value of safe nurse staffing levels has been carried out in adult in-patient wards in acute hospitals. Certainly, based on the information that we have provided in Paragraphs 3 to 5, the Royal College of Nursing believe that by starting on adult in-patient wards in acute hospitals this piece of legislation is aiming to focus where there is the most need.

23. The Royal College of Nursing welcomes the provision that Welsh Ministers may make provision for the duty to be extended to additional settings within the NHS in Wales ensuring that Registered Nurses have time to care in such a way that ensures the dignity of the patient as well as clinical effectiveness. The Royal College of Nursing believes the nursing in the community needs legal safeguards relating to Safe Nurse Staffing too. Staffing levels are mandatory in care homes and other settings and the Royal College of Nursing would welcome the opportunity to work with regulatory and inspection agencies and with the Welsh Government to develop effective workforce tools for the community.

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

which NHS organisations should use to ensure there is an appropriate level of safe staffing

24. The Royal College of Nursing welcomes the requirement on the Welsh Government to issue guidance which sets out the methods which NHS organisations should use to ensure there is an appropriate level of safe staffing. There needs to be a consistent and professional appropriate approach across Wales. Through this mechanism the Welsh Government would achieve this.

25. The Royal College of Nursing believes that Nurses must be able to meet patients fundamental care needs and efficaciously play their part in the delivery of complex treatments and therapies. The description of the potential guidance in the Bill is extremely helpful as it strikes an appropriate balance between the need of the individual nurse to use, and have respected, her professional judgment on the needs the patients, along with organisational support in the form of professionally recognised workforce planning tools and corporate accountability for patient safety.

Views on Welsh Government guidance including provision to ensure minimum ratios are not applied as upper limit?

26. The Royal College of Nursing strongly prefers to use the term 'safe'. The ratios evidenced by academics and cited by the CNO in Wales are because they are deemed as the 'safe ratio'. That is, if the ratios on the wards fall below this number, the wards themselves become unsafe and mortality and morbidity rates increase. These numbers are evidenced based.

27. However common sense and professional judgment both dictate that if the needs of patients are greater than normal then the safe number of nurses in duty will be higher. Professional standards and the nature of medicine itself can change safe practice. The Royal College of Nursing is pleased that the approach to guidance in this Bill recognises and allows for this.

28. As the committee will be aware, similar legislation has also been enacted in other parts of the world and there is no evidence of minimum becoming a maximum/standard number.

Views on Welsh Government guidance setting out process of providing information to patients on the numbers and roles of the staff on duty?

29. The Royal College of Nursing believes that this legislation will strengthen the accountability of relevant service planners and managers for the safety, quality and efficacy of their workforce planning and workforce management. We believe that Nurse Staffing information should be published at all levels of the healthcare system. This might include: placing information at ward level on notice boards for public consumption, in the LHBs annual report; during quarterly reviews between the Chief Executive of NHS Wales and in annual reports the this committee. The information for Wales/LHBs could also be placed on StatsWales for a LHB/LHB comparison.

Views on Welsh Government guidance including protections for certain activities and particular roles when staffing levels are being determined

30. The Royal College of Nursing believes that when decisions on Safe Nurse Staffing Levels are being made, some roles such as that of Ward Sister/Charge Nurse should be supernumerary. The Nurses in these roles should not be considered when determining Safe Nurse Staffing Levels because their roles provide oversight for the ward and other members of the nursing team on the ward must be able to refer to their clinical judgment when necessary. This was a clear recommendation of the Welsh Government Free to lead Free to Care strategy (2008) to improve patient care by empowering the ward sister and yet is still remains unachieved.

Student Nurses should also be considered to be supernumerary. Student Nurses are still undergoing training and should not be required to take the place of a Registered Nurse until they have completed their training and are then registered with the NMC. Including Student Nurses when workforce planning is unacceptable; puts patients at risk and places the Student Nurses in an unjust position.

Views on the requirement of the Welsh Government to consult before issuing guidance

31. The Royal College of Nursing believes this is a sensible and appropriate requirement allowing for professional organisations and other stakeholders to comment.

Views on the requirement for Welsh Minister's to review the operation and effectiveness of the Act

32. With regards to Section 3 of the Bill the Royal College of Nursing agrees that Welsh Ministers should be required to review

the operation and effectiveness of the Act once it has been enacted. The only way the effectiveness of the Act can be discovered is via a reporting mechanism and as the Welsh Ministers are responsible for the NHS in Wales this appears to be an appropriate mechanism. The first report would allow the Royal College as well as this Committee the opportunity to compare mortality rates and other indicators pre-legislation to those in the first year of the Act.

Views on the effectiveness and impact of the existing guidance

33. As mentioned above, the Royal College of Nursing believes that the All Wales Nurse Staffing Principles Guidance issued by the CNO in 2012 has failed to have the desired impact and will continue to do so. We believe that the guidance lacks the 'teeth' that legislation and statutory instruments provide. This legislation can be compared to the legislation to ban smoking in public and the ensure wearing of seatbelts in cars. In both of these cases knowledge about the benefits of not smoking and of wearing a seatbelt was widespread but the existence of legislation improved both the behaviour of individuals and that of organisations. This legislation will impact positively on public wellbeing and the patient experience.

View on balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance

34. The Royal College of Nursing feels that the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance is appropriate. By excluding specific numbers from the Primary legislation, Welsh Ministers are given the flexibility to increase the scope of the legislation, by making it applicable to more areas and to update the ratios if academic evidence shows the need for them to change. This flexibility will save time and money and ensure that Wales is able to provide the Safe Nurse Staffing that patients in Wales deserve.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Unison Cymru Wales – SNSL(Org) 06 / Tystiolaeth gan Unison Cymru Wales – SNSL(Org) 06

Safe Nursing Staffing Levels Bill
UNISON Cymru Wales written evidence (January 2015)

Introduction

UNISON is the UK's largest healthcare union with over 400,000 members working in the NHS. In Wales, UNISON represents 35,000 members providing NHS services. Our health members are nurses, student nurses, midwives, health visitors, healthcare assistants, paramedics, community care workers, cleaners, porters, catering staff, medical secretaries, clerical and administration staff and scientific and technical staff.

Unless there is a mandatory minimum, quality patient care will suffer. Over 90% of respondents in UNISON's 2013 staffing levels survey said they support mandatory minimum staffing levels, but it has to be acknowledged that quality is more important than quantity; staff numbers are only part of the problem. We believe that compassionate care would not only benefit the patient but also the working lives of our members.

General

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

UNISON believes that there should be a legally enforceable minimum nurse to patient ratio. We support and recognise the role which workforce planning tools have to play in helping organisations identify the right levels, but the use of these must be mandatory and, in the absence of this, the default position should be a legal minimum.

UNISON Cymru Wales has extensively sought the opinions of our members about the Bill, as we believe ongoing consultation with staff on the ground is crucial. Our Welsh members are overwhelmingly in favour of mandatory minimum nurse staffing ratios as they believe that this is the only way to provide a better quality of service for patients, increase staff morale and increase satisfaction in the workplace. For example, some of our members have

described scenarios where they have had to oversee 26 patients in acute areas at one time. This is not only clinically for patients, but also a dangerous working environment for staff.

Our UNISON survey in 2013 found that an alarming 45% of nurses were caring for eight or more patients on their shifts which highlights the need for a safe staffing levels bill. Validated workforce planning is effective in producing safe staffing levels as it is predictive, rather than retrospective and takes into account the fluctuations among the Local Health Boards. It is known that hospitals are the busiest at the weekends and on Mondays, when they are dealing with the backlog of pressures from the weekend's admittances. A workforce planning tool would take into account these issues and therefore could weigh staffing levels differently at the weekend to during the week. On the other hand a legislated ratio is static and does not take these factors into account. UNISON welcomes the reference to validated workforce planning tools in the Bill under Clause (6), but argues that further work needs to be undertaken to decide whether they can be used further.

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

As highlighted in our original consultation response UNISON believe that, as the proposed application of safe staffing levels doesn't apply to all staff in every health care setting, it detracts from the overall impact and purpose. From our perspective, this is a signification omission and we are disappointed that the Bill does not develop the point further. Extending application to all healthcare staff would allow our dedicated and hardworking members, in all pay bands and in all clinical areas, the time to provide the high level of care they desire, in a safe environment that engenders compassion.

We welcome that the Bill does make reference to healthcare support workers but this definition needs to be tightened up in several regards. The application of ratios of health care workers, other than nurses, should be applied to safe staffing levels in adult care in acute hospitals and beyond. Our members have described situations in which nursing staff are drawn away from clinical duties to undertake basic cleaning duties. Similarly, if inadequate numbers of clerical staff in medical records or wards are employed, nurses end up being diverted from their clinical tasks to clerical duties.

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

The chief barrier to successful implementation of the Bill and consequential improvements in the Welsh health care system would be the adoption of unrealistic nurse staffing ratios.

UNISON advocates a 1:4 nurse to patient ratio as we believe this will provide the best quality patient care at all times. Studies have shown that there are better clinical outcomes with a ratio of 1:6 or lower and that harm starts to occur when nurses are caring for 8 patients or more, although, clearly, "one size does not fit all". Therefore, each ward/clinical

area must be assessed for its particular appropriate staffing levels both in the day and at night.

Moreover, by only applying a safe staffing ratio to nurses the Bill does not adequately consider the pressure on nurses' duties that are the consequence of inadequate numbers of other healthcare workers, e.g. domestic and clerical staff as previously stated.

The Safe Staffing Alliance, of which UNISON is a member, recommends that nurses must at all times be supported by a sufficient number of healthcare assistants. Yet, the Bills' priorities remain solely focussed on the employment of qualified nurses, often at the expense of Healthcare Assistants. Whilst UNISON welcomed the additional £10 million given by Welsh Government to Health Boards for the employment of additional nursing staff, we have seen examples of Health Boards in Wales downgrading Healthcare Assistants' posts to pay for additional qualified nurses. This is not acceptable and means that qualified nurses are not getting the appropriate level of support to enable them to undertake their duties effectively.

Q: Are there any unintended consequences arising from the Bill?

On no account should the Bill lead to a 'plug gap' situation where staff are robbed from one unit and moved into the inpatient adult acute sector.

The majority of our members believe that there should be a requirement in the legislation for "protected time", for staff training and development built into nurse staffing ratios. Currently there are too many incidences when staff are pulled off mandatory training days to cover sickness on the ward, leaving those staff without the training they need. It should not be an unintended consequence that the Bill increases such situations.

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

UNISON agrees with Clause 2.5 (b) 'allow for the exercise of professional judgement' as NHS employees are often in the best position to know when systems in the Service are working efficiently and therefore when an appropriate level of nurse staffing is provided.

Education is a crucial force in the protection of both the patient and the worker. Aiken et al. 2004 found that a 10% increase in employment of degree-level educated nurses led to a 7% reduction of an inpatient dying. Increased staffing levels would also alleviate the pressures on practice placement settings, which would make it easier for nurses to dedicate time to support students. This would also benefit the health community at large.

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

It is important that there is a duty on health service bodies in Wales to take all steps to maintain these recommended nurse to patient ratios.

Q: The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

We understand that the duty will first apply to adult inpatient wards in acute hospitals because this is where the main body of evidence lies, however UNISON believes that agreed ratios should not only be restricted to adult care in acute hospitals. UNISON believes that in order for patients to receive the highest possible quality of care, the agreed ratios should be applied and extended to all clinical areas, including Community settings. Applying the duty only to acute hospitals will not sufficiently meet the standards required across the NHS. We understand that in order to extend the ratio there needs to be robust data collection methods and results in place. For this to occur, data collection in other healthcare setting should commence as soon as possible in order to identify reasonable staffing levels.

3 Ibid- the requirement for the Welsh Government to issue guidance 4 in respect of the duty set out in section 10A (1) (b) inserted by section 2(1) of the Bill which: sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing (including methods set out in section 10A(6) inserted by section 2(1) of the Bill)?

We welcome the use of validated workforce planning tools and the exercise of professional judgment within the planning process as methods. However, we believe there should be further consultation and agreement with all interested stakeholders, including employee representative organisations on the tools and methods to be used in establishing staff ratios.

Includes provision to ensure that the minimum ratios are not applied as an upper limit?

UNISON believes that the Bill highlights the importance that minimum ratios are not applied as an upper limit in Clause (5) of the guidance and Clause 6 (b). Safe staffing levels should represent a high quality of staffing levels, and agreed ratios should reflect requirements and circumstances in each hospital. Hospitals should be monitored to ensure that the agreed ratios are not regarded as upper limits, instead ensuring that the applied ratios mean they can deliver a high quality level of care. It is important that NHS organisations regard the agreed ratios as an absolute minimum, and broadly view these minimum ratios as “a level of care below which standards do not fall”.

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

The Francis Report was clear about the positive role that information sharing can play. We believe that transparency of staffing levels is an important driver of patient confidence, and patient awareness of roles. Detailing responsibilities and numbers of staff on duty will aid this process.

UNISON agree that information on the numbers and roles of nursing staff on duty should be published in areas accessible to patients and their families, but it is essential that the recording, monitoring and reporting process is streamlined. This view has been echoed in both the Francis Report and the Berwick Review which both found that there needs to be a systematic and responsive approach to determining nurse staffing levels. There are too many examples where nurses, and other health care workers have been caught up in bureaucratic systems which force them to take time away from the patient. NHS staff are already over-worked so any process for reporting data must not increase this burden. The streamlining of the process will not only improve administration for nurses and ward clerks and other staff, but will ensure the clarity required for an accurate system of monitoring.

Publication of such figures is meaningless unless the standards are clearly set and allow for the fluctuations of patient acuity and dependency.

Includes protections for certain activities and particular roles when staffing levels are being determined:

- the requirement for Welsh Ministers to consult before issuing Guidance?

UNISON strongly welcomes the requirement for Welsh Ministers to consult before issuing Guidance.

- the monitoring requirements set out in the Bill?

We suggest that the monitoring requirements set out in the Bill are extended to first include collecting data on whether a nurse's break was taken at an appropriate time, for example if a healthcare worker is working a long day and doesn't receive a break until 8 hours into their shift. Secondly, we believe that indicator 3.1 (h) should be expanded to include staff wellbeing alongside nursing overtime and sickness levels. Thirdly, an additional monitoring requirement that should be included is 'care undone'. In UNISON's report 'Running on Empty: NHS Staff Stretched to the limit', 55% of our members said that due resource constraints care was left undone, even though many of them had not taken their breaks and had worked overtime.

- the requirement for each health service body to publish an annual report?

We welcome the requirement for each health service body to publish an annual report and that it can be published as part of a wider report.

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

UNISON would suggest that for the first year, internal reviews in operation and effectiveness of the Act should be taken on alternative months to confirm that the staffing levels are appropriate. This would increase after the first year of the organisation. In conjunction, we agree that a first whole system review must be carried out as soon as practicable after the end of the one year period beginning with the date when the Act comes into force. We do not agree that subsequent reviews should be carried out at intervals of no more than 2 years. This has the potential to leave long periods of where harm could have occurred, this is especially true for the second review. The monitoring of the Act should be built in to the annual review to ensure that there is continuity across the processes.

We also believe that success of the Bill would be demonstrable improvements in the measures of healthcare as set out in 3(5), including for example, the measures should also include a monitoring of reductions in length of stay in hospital.

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

UNISON supported both the 2012 All Wales Nurse Staffing Principle Guidance and the 2014 NICE guidelines on 'Safe staffing for nursing in adult inpatient wards in acute hospitals'. The All Wales Nurse Staffing Principle Guidance was based on acuity rather than solely patient numbers and many of the Local Health Boards defined a range of safe staffing nurse's levels rather than a single defined figure. The 2012 guidance issued to the Health Boards in Wales recommended that the number of patients per registered nurse should not exceed 7 by day, which although is a move in the right direction, is still too high to provide a safe level of care. The guidance also lacked effective implementation as it was not a statutory requirement. The 2014 NICE guidelines are more similar to the proposed Bill and share similar issues such as 'plugging the gap' and the lack of reference to 'care undone' (where a number of staff reported that care was left undone).

Q: Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

The ability to extend the bill to additional healthcare settings that is currently subordinate legislation is welcomed and should not be disregarded.

<u>Financial implications</u>

Q: Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

Costs are always a concern and how the upfront costs impact the Welsh Public Health service is extremely important. However, findings by Bray et al. 2004 suggest that there is no evidence of overall cost increases, as the increase in funding for more nurses balances out with reduced costs associated with the length of stay of a patient and fewer infections. We would like a commitment from the Government that upfront costs will not be cut to the disadvantage of the Welsh Healthcare worker.

Q: Do you have any other comments you wish to make about the Bill or specific sections within it?

This Bill, if enacted properly, should lead to a marked improvement in the standards of healthcare in Wales. The 2009 Boorman Review into NHS Health and Wellbeing established solid links between understaffing, stress, job satisfaction and patient care.

While safe staffing levels are a positive move we believe that this should be applied to the whole health care system. To be a truly first class health care system the Welsh Government need to improve staffing ratios for all healthcare workers.

UNISON welcome further consultation throughout this process and look forward to speaking to the Committee in due course.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Chartered Society of Physiotherapy – SNSL(Org) 07 / Tystiolaeth gan Cymdeithas Siartredig Ffisiotherapi – SNSL(Org) 07

CSP Wales Office
1 Cathedral Road
Cardiff CF11 9SD
[redacted]
www.csp.org.uk

Health and Social Care Committee
National Assembly for Wales
Pierhead Street
Cardiff CF99 1NA

9th of January 2015

Dear Committee Members

Re: Safe Nurse Staffing Levels (Wales) Bill – Written Evidence from the Chartered Society of Physiotherapy

Introduction

The Chartered Society of Physiotherapy (CSP) welcomes the opportunity to provide written evidence to the committee. As far as possible we have attempted to answer the questions the committee has posed.

As highlighted in our response to the member in charge of the Bill, the CSP and our members are wholly committed to supporting the drive to improve the quality of care and outcomes for patients, and understand the spirit of the proposed Bill. However, we cannot support an approach to legislation that does not address staffing in a multidisciplinary way, does not focus on quality outcomes for patients, and risks a focus on numbers of nurses in isolation from the plethora of other factors that impact on patient outcomes and benefit.

Response to the consultation questions

1. General

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

The Chartered Society of Physiotherapy (CSP) is highly committed to ensuring the delivery of high-quality patient care and supporting, leading and contributing to initiatives focused on improving service delivery and ensuring patients receive safe, compassionate, person-centred care that is accessible, timely and effective. Delivery of care has to respond to the needs of an ageing population and increasing numbers of patients with long-term and multiple conditions, while achieving a stronger shift to health promotion, illness prevention and patient self-management. This commitment underpins our feedback to this consultation. All our points should therefore be seen and taken within this context.

In terms of proposed legislation on nurse staffing levels, we are concerned that this is not a solution to ensuring the delivery of high-quality, compassionate care and that it will not achieve its intended aims. We have concerns for a number of reasons (which we expand on in our response to subsequent questions). These are broadly as follows:

- The legislation risks diverting attention away from achieving quality of outcomes for patients (including long-term benefits, the fulfilment of personal treatment goals, and the promotion of self-management) and focusing narrowly on specific service input and delivery issues (rather than on initiatives designed to achieve service improvements within a context of financial constraint)

- It risks nurse staffing numbers becoming a focus that is addressed in isolation from the many other factors that affect quality outcomes and experience for patients (relating to broader factors to do with staffing – including skill mix and the contribution of the whole multi-disciplinary team; patient need, including in relation to acuity and dependency; and service delivery models, context and improvements)

- It risks creating unintended consequences that will impact negatively on the quality of patient care, thereby having the opposite effect from its intended purpose (please see our response to 1.4).

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

As indicated above, we have concerns about whether the proposed legislation and the proposed provisions within the Bill can form an effective way of achieving their

intended purpose. In line with our response to 1.1, our concerns centre on the following:

- The lack of the provisions' focus on the quality of patient experience and outcomes

- Confusion in the definition and use of terminology within the draft legislation, which creates ambiguity in its intended meaning and raises questions about how it is likely to be interpreted and implemented (for example, 'safe', 'sufficient' and 'minimum' are all used as descriptors in relation to staffing levels, apparently inter-changeably and without clarity on their intended distinctions)

- The practicalities of Government Ministers producing guidance on the detail of the legislation's implementation (including in ways that are sensitive to factors relating to patient need, staffing and service delivery context and that can be sufficiently premised on available evidence and established tools and resources; (see http://www.nice.org.uk/guidance/sg1/chapter/3-gaps-in-the-evidence)

- The risks and likely unintended consequences of the legislation, including through its focus on one type of setting for the delivery of care to one (if broad) group of patients and the planned formulation and potential uniform application of a minimum recommended nurse: patient ratio that would apply regardless of patient dependency and need.

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

In line with our response above, we see the following as potential barriers to the effective implementation of the legislation and its achieving its intended aims and purpose:

- Lack of clarity about the intended focus of the provisions; in particular, this relates to our points about ambiguities in the terminology used and an apparent conflation of issues and approaches to staffing levels as being the same as those to do with workforce planning

- Significant questions about the practicalities of implementing the provisions, including due to the conflation of issues and the assumptions that underpin them; for example, it is misplaced to assume that recommended minimum staffing levels would necessarily reduce a reliance on temporary and agency nursing staff

- The unintended consequences of the provisions that could detract from achieving their intended purpose, including through undermining the overall quality and outcomes of patient care; in particular, this could arise through the legislation leading to a depletion of staffing resource and capacity among the professions,

staff groups, patient groups and care delivery settings that are not covered by the proposed legislation - aside from undermining quality of care and service improvements, this could have a negative impact on the working conditions of other staff groups, when one of the express purposes of the proposed legislation is to improve working conditions for nurses.

1.4 Are there any unintended consequences arising from the Bill?

As indicated elsewhere, we see a range of unintended consequences arising from the Bill. These include the legislation producing the following risks and issues:

- Its creating a narrow focus on numbers of staff within nursing (registered and non-registered) to the detriment of looking at all the factors that contribute to ensuring patient safety through the delivery of timely, high-quality care
- Its leading to a diversion of resources to ensure the fulfilment of minimum patient: nursing staff ratios at the expense of sufficient, safe and effective staff resourcing within other service delivery areas and within other staff groups (and not necessarily in ways that would ensure sustainable service delivery models or adherence to good employment practice)
- Related to the above, its conferring a pre-eminence to ensuring time and support are factored into nursing capacity and resources for clinical leadership, continuing professional development (CPD) and student supervision when these elements are equally important for sustainable, high-quality care across all staff groups
- Its creating a distracting, bureaucratic focus on fulfilling and demonstrating fulfilment of minimum requirements at the expense of ensuring a focus on achieving and maintaining high-quality care, experience and outcomes for all patients (across all population and patient groups and all service delivery settings)
- Its leading to a focus on and adherence to a minimum nurse:patient ratio, regardless of assertions that this is not the intention.

2 <u>Provisions in the Bill</u>

What is the CSP's view on:

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

The CSP believes that health service bodies should be accountable to the Welsh Government for ensuring safe and effective staffing across all staff groups. How this accountability is implemented needs careful consideration. We question the value and appropriateness of a prescriptive, legislative approach to one staff group that encourages a focus on nurse:patient ratios in isolation from all the other factors affecting the quality of patient care. This risks forming a distraction from enacting a meaningful approach to strengthened accountability. We believe that there are other ways of achieving this that take a genuinely holistic approach, are appropriately inclusive of all factors and variables, and encourage a focus on outcomes for patients.

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

There would need to be detail and definition as to what is considered to be 'all reasonable steps'. A process would be needed to develop guidance on what those reasonable steps should be, with detailed consideration given to the development of appropriate mechanisms for organisations to use to demonstrate compliance with the legislation. Protocols and clear arrangements would also need to be in place to track, monitor and deal with failures to meet the duties under the legislation (as highlighted in our answer to 2.6).

In line with our broader concerns, we have reservations about the value of processes that would need to be in place and the risks that these would detract from broader initiatives to improve services and optimise the quality of patient care (including face-to-face contacts with patients).

2.3 The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

As indicated above, we have concerns about the proposal that the legislation will only apply to adult in-patient wards in acute hospitals. While we have fundamental concerns about legislating for safe staffing levels as an approach, we have specific concerns that this limitation will have unintended consequences in terms of impacting negatively on staffing levels for other patient groups, in other care settings and for other staff groups through resources being diverted to meet legislative requirements for this specific care environment and this specific staff group.
The ultimate result of the legislation could therefore be that the overall quality of patient care, experience and outcomes will be reduced as a result, in direct opposition to its intended purpose.

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

- **Sets out methods which NHS organisations should use to ensure there is an appropriate levels of nursing staffing (including methods set out in section !0A(6) inserted by section 2(1) of the Bill?**
- **Includes provision to ensure that the minimum ratios are not applied as an upper limit?**
- **Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?**
- **Includes protections for certain activities and particular roles when staffing levels are being determined?**

We have concerns about the planned requirement for the Welsh Government to issue guidance. This is for a range of reasons, in line with the points we raise above, centred on the following:

- We question the appropriateness and feasibility of the Welsh Government mandating specific methods and implementation of the legislation to the level of detail implied

- We question the extent of the resources, tools and evidence on which the Welsh Government could draw to produce such detailed guidance (see http://www.nice.org.uk/guidance/sg1/chapter/3-gaps-in-the-evidence)

- We are concerned that the current ambiguities in the draft legislation create risks for how detailed guidance could be produced in a meaningful way

- We are concerned about the appropriateness and feasibility of producing guidance that risks increasing prescription on issues that require a sensitivity to a wide range of local variables and factors (to do with patient need, staffing and service environment)

- We are concerned about the unintended consequences of producing detailed guidance in this way; for example, a particular focus on protecting 'certain activities and particular roles' would risk other activities and roles that sit outside the planned legislation being unprotected, with depletion in resourcing occurring as a result – in turn, this would be likely to impact negatively on patients' quality of care, experience and outcomes.

2.5 The requirement for Welsh Ministers to consult before issuing guidance?

For all the reasons outlined, we would see it as imperative that Welsh Ministers would consult before issuing guidance. This consultation process should be wide-ranging and inclusive, ensuring a full and robust scrutiny of the potential implications, risks and unintended consequences of the guidance and its potential interpretation and implementation.

2.6 The monitoring requirements set out in the Bill?

We would see the development of a process for comprehensive monitoring as an important component. Clear guidance would be required from the Welsh Government and monitoring may well require gaining data that is not collected currently. This would need to be considered and identified within costing for implementing the Bill.

We would want to be assured that the monitoring process was wide enough in its focus to consider and evaluate issues impacting on the quality of patients' experience and outcomes, as well as effective and efficient service delivery (including in relation to hospital admissions, readmissions and discharge; increased attendance at A&E departments; delays in the formulation of care packages for patients at home; and impact on social service costs). As part of this, the process should also capture information on issues affecting other professions and staff groups, not just nursing. This would be essential for ensuring that due account is taken of the kinds of unintended consequences identified elsewhere in our response.

2.7 The requirement for each health service body to publish an annual report?

We would see the production of regular reviews of the adherence and impact of the planned legislation as an important component. However, we would be concerned that annual reporting requirements achieved a balance in the following areas:

- Were sufficiently streamlined to avoid creating an unnecessary and counter-productive administrative burden on service providers
- Were sufficiently inclusive and wide-ranging to ensure a focus on the quality of patient care, experience and outcomes, including the potential for the legislation to have unintended consequences (for example, a negative impact on patient care, a diversion of staffing resource, and a depletion of capacity from other areas of care and service delivery in order to ensure legislative requirements can be met)
- Were sufficiently searching in terms of evaluative feedback on the challenges of implementing the legislation and its real value and impact in fulfilling its intended purpose.

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

We would see the requirement for review by Welsh Ministers of the operation and effectiveness of the Act as an important component. However, we would want to ensure that the Welsh Government also addresses the potential for the legislation to have unintended consequences. It would be important that full consideration was given to the relevance of factors and variables across different services, and the significance of these for the effectiveness of the Act. Indicators of success should also include a focus on the positive aspects of quality care and patient outcomes, and not just the prevalence of the negative measures identified in the legislation that point to failures in care.

3 Impact of existing guidance

Guidance exists in England and Wales that aims to ensure safe staffing levels. This includes the 'All Wales Nurse Staffing Principles Guidance' issued by the Chief Nursing Officer in 2012 and the 2014 NICE safe staffing guidelines for 'Adult in-patient wards in acute hospitals in England.

3.1 Does the CSP have a view on the effectiveness and impact of the existing guidance?

The CSP considers that the 'All Wales Nurse Staffing Principles Guidance' issued by the Chief Nursing Officer in 2012 has been an important tool within the NHS in Wales, but notes that adherence to its recommendation has not appeared within tier 1 of the NHS performance management framework. Rather than resorting to the use of legislation, work is required to determine the reasons why the guidance has not been adhered to in the ways intended. It would also be helpful for NHS Wales to consider safe, effective and appropriate staffing across the whole workforce to ensure quality outcomes for patients.

4 Powers to make subordinate legislation and guidance

The Bill contains one provision which enables subordinate legislation to be made (section 10A(3) inserted by section 2(1)). This provision would confer powers on Welsh Ministers to amend the settings to which minimum staffing ratios will apply to extend it to settings other than adult inpatients wards in acute hospitals.

4.1 Does the CSP have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

We have concerns about the proposed legislation being premised on one health care setting, with the prospect of detail and the future coverage of other areas being progressed through subordinate legislation and guidance. These are linked strongly

to our concerns about how the legislation is framed, including its narrow focus and current ambiguities in terminology.

5 Financial implications

5.1 Does the CSP have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

We have concerns that the consideration of the financial implications of the Bill does not take sufficient account of the unintended consequences of its implementation. In particular, we have concerns that a focus on nurse staffing levels for one health care setting/patient group will lead to resources being diverted away from other staff groups and patient needs/service delivery areas in order that compliance with legislative requirements is affordable.

Aside from compromising the quality of patient care and working conditions, this risks a false impression being gained of the Bill's financial implications. It also risks decisions being made about how resources are deployed that are not necessarily in line with patients' best interests, optimising the scope for innovations in service design and delivery, or managing the development and provision of affordable services within a context of financial constraint.

6 Other comments

6.1 Does the CSP have any other comments to make about the Bill or specific sections within it?

We are currently undertaking project work, funded by the CSP Charitable Trust, to develop a robust approach to formulating safe and effective staffing levels (SESL) for UK physiotherapy. The profession is fully committed to being part of the solution to assure the safety, experience and quality outcomes for service users across the health and social care landscape.

The approach in development will have applicability across the UK, taking account of each country's health and social care structures and policies, and aims to reflect the breadth of specialisms/patient pathways, settings, sectors and service delivery models in and through which physiotherapy is provided.

The project outputs will be an online tool with supporting guidance. The approach will be founded on the available evidence base and will be focused on achieving and upholding high-quality compassionate care for patients within affordable service delivery models.

Through our SESL project, we are seeking to achieve the following outcomes:

- Strengthened support to our members in identifying and articulating the physiotherapy staffing resources required to deliver a particular service to uphold and enhance the quality of patient care, while demonstrating cost-effectiveness

- An evidence-based approach to formulating and articulating SESL, grounded in available research literature and current and projected policy (across the UK)

- An approach that upholds and enhances quality in patient care, both in terms of patient experience and outcomes and achieving short- and long-term benefits

- A strengthened CSP contribution to national policy-making and implementation on a key issue relating to the quality of patient care and service design and delivery within increasingly constrained resources and rising expectation.

Concluding comments

In conclusion, whilst supporting attention to enhance the quality of care and outcomes for patients, the CSP considers a more rounded and multi-factorial method is necessary to achieve safe and effective care delivered by appropriate staffing. The Society continues to hold the view that a number or ratio is not an indicator of good quality care delivered with compassion.

The CSP is content for this evidence to be made available publicly.

Submitted by:

Dr Sally Gosling – Assistant Director of Practice and Development at the Chartered Society of Physiotherapy

Philippa Ford MBE MCSP – Public Affairs and Policy Manager for the Chartered Society of Physiotherapy in Wales

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 52,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self-management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving

scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Age Cymru – SNSL(Org) 08 / Tystiolaeth gan Age Cymru – SNSL(Org) 08

Consultation Response

Safe Nurse Staffing Levels (Wales) Bill

January 2015

Introduction

1. Age Cymru is the leading national charity working to improve the lives of all older people in Wales. We believe older people should be able to lead healthy and fulfilled lives, have adequate income, access to high quality services and the opportunity to shape their own future. We seek to provide a strong voice for all older people in Wales and to raise awareness of the issues of importance to them.
2. We welcome the opportunity to respond to the Health and Social Care Committee's call for evidence on the Safe Nurse Staffing Levels (Wales) Bill. It has been estimated that around two-thirds of people admitted into hospital across the UK are over the age of 65[1] yet most hospitals have inadequate nursing establishments on older people's wards[2].

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

3. Age Cymru welcomes the principle of safe nurse staffing levels for adult inpatient wards across Wales. Over recent years a number of inquiries[3] have sadly demonstrated the impact that unsatisfactory and undignified care have on the quality of care for patients, especially older people. Pressures on staff and low or reduced staffing levels have been identified as a factor in a number of these inquiries.

4. Legislating in order to ensure safe nurse staffing levels is one potential route to achieving improved levels of care. However, the National Institute of Health and Care

[1] Royal College of Physicians (2012): *Hospitals on the Edge? The time for action*
[2] Royal College of Nursing (Sept 2012): *Safe Staffing for Older People's Wards*
[3] Most specifically, the Francis report into the Mid-Staffordshire NHS Trust and the Keogh review of urgent and emergency care in England.

Excellence (NICE) guidance on safe staffing levels[4] was only published in July 2014 and it is questionable whether such guidance has had sufficient implementation time for its impact to be assessed effectively.

5. The Explanatory Memorandum[5] accompanying the Bill does suggest that the Local Health Boards have been making progress towards the principles on nurse staffing levels set out by the Chief Nursing Officer, although progress has been inconsistent. However, if guidelines are felt to be insufficient to ensure implementation by the Local Health Boards in Wales, creating statutory duties would ensure the issue was taken seriously.

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

6. The provisions of the Bill appear to be appropriate to achieving the Bill's overall purpose as stated.

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

7. In these difficult financial times, concerns about the impact of these provisions upon staffing budgets are inevitable. Evidence reviews prepared as part of the development of NICE guidance found that existing economic studies had very limited value with regard to their relevance to the context and situation of the NHS[6]. Concerns have been raised by other professional bodies about the potential implications for staff levels in other speciality. It should be recognised that other different professions make a significant contribution to the wellbeing and care of patients, and the importance of preventative services should not be overlooked.

- Are there any unintended consequences arising from the Bill?

8. In the wake of the Francis and Keogh reports, focus has switched to recruiting nurses, following earlier reductions in staff numbers. This has resulted in more nurses taking up NHS posts with implications for nursing care homes which may already be struggling to fill vacancies for registered nurses.

9. There is a risk that this Bill could lead to an even greater shortage of registered nurses available for nursing care home work. Even were recruitment to nursing degree schemes to be increased, the impact on job recruitment would not be felt for a number of years. Posts in nursing homes are often seen as less attractive than NHS work. However, recruitment shortages in the nursing home sector can only exacerbate existing problems allied to delayed transfers of care.

Provisions in the Bill

The Committee is interested in your views on the individual provisions in the Bill and whether they deliver their stated purposes. For example, do you have a view on:
- the duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided?

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[4] NICE (July 2014): *Safe staffing for nursing in adult inpatient wards in acute adults*, Safe Staffing Guideline 1

[5] Kirsty Williams AM (1 December 2014): *Safe Nurse Staffing Levels (Wales) Bill Explanatory Memorandum*: p

[6] P Griffiths et all (2014): *The association between patient safety outcomes and nurse/healthcare assistant skill mix and staffing levels and factors that may influence staffing requirements*, Evidence Review 1. Available at http://www.nice.org.uk/guidance/sg1/evidence

10. The work of the Royal College of Nursing has demonstrated that the ratio of patients to staff (both all staff, including healthcare support workers, and to registered nurses alone) is persistently higher on wards for older people than on other types of ward[7]. These higher ratios often have a negative impact on the quality of care that is provided and the dignity of older people receiving care and, if unaddressed, represent a potential form of discrimination against older people.

11. Older people often have a combination of complex needs that require more time-consuming treatment than other adults in hospital[8].For example, they may need help preparing for mealtimes or going to the toilet in ways that other adult patients do not. They are also more likely to be subject to episodes of delirium and wandering which requires greater levels of care and time. However, older people are often on wards which have fewer staff than general wards.

12. We therefore welcome the emphasis on health service bodies ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided, as this has implications for the provision of care to older people in settings other than adult inpatient wards in acute hospitals. This overall awareness should aim to ensure that the impact of potentially increasing the number of registered nurses working on adult inpatient wards does not have negative implications for the provision of NHS nursing care outside these settings.

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

13. As highlighted above, there are particular concerns with regard to staffing levels on wards for older people, despite the fact that these patients often require more care than younger adults with regard to carrying out daily tasks that most of us take for granted.

14. Therefore, establishing a duty to have regard to the importance of ensuring an appropriate level of nurse staffing is to be welcomed, especially the recognition of the need for flexibility to take decisions based upon local needs. The demands placed upon nurses can vary between specialties and depending on case mix, levels of acuity/dependence, ward layout and patient turnover. There is therefore no 'one-size-fits'-all' mechanism for determining safe staffing levels on a ward.

- the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

15. This approach fits with the recommendations of the NICE guidelines with the guideline being explicitly written for adult inpatient wards in acute hospitals. In part, this reflects the outcomes of the Francis and Keogh inquiries in England. The implications of introducing this statutory duty require monitoring and effective evaluation before decisions are taken about the appropriateness of extending the duty into other areas of care.

- the requirement for the Welsh Government to issue guidance4 in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:

[7] Royal College of Nursing (2010): *Guidance on Safe Nursing Staffing Levels in the UK*: p22

[8] Royal College of Nursing, Sept 2012

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

16. If the Bill is to be passed, it would be appropriate for the Welsh Government to set out evidence-based methods for use by NHS organisations to ensure there is a safe level of nurse staffing. These could be based on the existing guidance.

17. It is important that such methods take into account professional nursing expertise based upon the judgement of lead nurses when decisions of this kind are taken. Safe nurse staffing levels are clearly an important component of ensuring and enhancing quality of care. However, we must not lose sight of the way in which care is delivered, not just who is delivering the care and how many of these staff are on duty.

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

18. Ensuring that minimum ratios are not applied as an upper limit is essential. Employing a higher number of staff may be appropriate to local need and a flat 'minimum' rate should not become a target level to be achieved which would be a particular risk if decisions were taken without the input of professional nursing expertise.

19. It also needs to be clear that these nurses should be part of the regular hospital workforce. Relying upon agency of bank staff as a way of meeting a 'minimum' level potentially undermines the good intention of safe nurse staffing levels for older people's wards, as these staff may not always be able to meet the particular complex set of needs presented[9]. In addition, relying upon agency/bank staff can drive up costs further, placing financial pressure upon service delivery.

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

20. If ensuring a safe nurse staffing level becomes a statutory duty, it would be appropriate to ensure that information is available to patients and the public regarding the numbers of staff on duty. Such data should also be provided in formats that are appropriate for people with sensory impairments. It is important, however, that any such data is presented in a format which makes the context clear in order to prevent misunderstandings of what can be expected in terms of nurse staffing levels.

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

21. Such protections would be in line with the principles of prudent healthcare as promoted by the Welsh Government, where such activities can only be carried out by registered nurses.

- the requirement for Welsh Ministers to consult before issuing guidance?

[9] *Ibid:* p34

22. Before final guidance is issued, it would be entirely appropriate for a consultation on the details of its content in order to ensure that it is fit for purpose and will achieve the stated purpose on the face of the Bill.

- the monitoring requirements set out in the Bill?

23. The impact of any duty created as a result of this Bill being approved would need to be monitored, but also carefully evaluated. Data should not be collected for the sake of meeting targets but should be employed in order to improve service delivery.

24. With regard to monitoring indicators, the evidence review[10] carried out in preparing the NICE guidance concluded that while nurse staffing can be linked to a number of patient safety outcomes, the outcomes of the measures used are problematic as indicators of safe nursing care. Careful thought should therefore be given to the indicators used as monitoring the effectiveness of implementation.

- the requirement for each health service body to publish an annual report?

25. In order to demonstrate that the duties created by the Bill are being met, publication would be appropriate. However, in order to avoid generating additional work through the creation of a separate report, it would be useful to consider incorporating the relevant data into an existing document, such as the Annual Quality Statement.

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

26. It is clear given the potential for unintended consequences of this Bill on levels of staffing amongst other healthcare professionals and in other sectors that this amendment to the National Health Service (Wales) Act 2006 would need to be reviewed. This review would be to ensure that the duty created by the Bill was having the intended effect upon patient safety and quality of care delivered.

Impact of existing guidance
Guidance exists in England and Wales that aims to ensure safe staffing levels. This includes the 'All Wales Nurse Staffing Principles Guidance' issued by the Chief Nursing Officer in 2012 and the 2014 NICE safe staffing guidelines for 'Adult in-patient wards in acute hospitals' in England.
- Do you have a view on the effectiveness and impact of the existing guidance?

27. As the NICE guidance was only released in July last year, it is not possible to judge its effectiveness at this point.

Other comments
- Do you have any other comments you wish to make about the Bill or specific sections within it?
28. Age Cymru welcomes the proposal for its potential beneficial impact for older people. However, we recognise that this would only be one step towards improving the quality of care delivered to our older people and ensuring that their dignity and human rights are respected.

[10] Griffiths et al, 2014: p12

29. Age Cymru calls for all frontline health and social care staff to receive mandatory human rights, dignified care and dementia care training. This should include respectful communication, protecting privacy, promoting autonomy and addressing basic needs such as nutrition and personal hygiene.
30. The publication by Abertawe Bro Morgannwg of twelve principles[11] in ensuring quality and dignity in September last year is to be welcomed. It is important that such principles become embedded in the way in which both registered nurses and healthcare support workers operate. To reiterate, we must not lose sight of the way in which care is delivered, not just who is delivering the care and how many of those staff are on duty.

[11] Available at: http://www.wales.nhs.uk/sitesplus/863/news/33877

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Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Older People's Commissioner for Wales – SNSL(Org) 09 / Tystiolaeth gan Comisiynydd Pobl Hŷn Cymru – SNSL(Org) 09

Response from the Older People's Commissioner for Wales

to the

National Assembly for Wales, Health and Social Care Committee consultation on the

Safe Nurse Staffing Levels (Wales) Bill

January 2015

For more information regarding this response please contact:

Older People's Commissioner for Wales,
Cambrian Buildings,
Mount Stuart Square,
Cardiff, CF10 5FL

About the Commissioner

The Older People's Commissioner for Wales is an independent voice and champion for older people across Wales, standing up and speaking out on their behalf. She works to ensure that those who are vulnerable and at risk are kept safe and ensures that all older people have a voice that is heard, that they have choice and control, that they don't feel isolated or discriminated against and that they receive the support and services they need. The Commissioner's work is driven by what older people say matters most to them and their voices are at the heart of all that she does. The Commissioner works to make Wales a good place to grow older - not just for some but for everyone.

The Older People's Commissioner:

- Promotes awareness of the rights and interests of older people in Wales.
- Challenges discrimination against older people in Wales.
- Encourages best practice in the treatment of older people in Wales.
- Reviews the law affecting the interests of older people in Wales.

Safe Nurse Staffing Levels (Wales) Bill

The Older People's Commissioner for Wales welcomes the opportunity to respond to the consultation on the Safe Nurse Staffing Levels (Wales) Bill. Responses were also submitted to two previous consultations that were held by the member in charge, Kirsty Williams AM, which have been attached for reference.

As the independent voice and champion for older people across Wales, the Commissioner is supportive of any efforts made to improve the quality of care that is provided to older people in our hospitals. Older people are the largest users of the NHS in Wales, and the Welsh NHS has a duty of care to get it right for older people.

In 2011, the Commissioner published 'Dignified Care?', a report into the treatment of older people in Welsh hospitals in relation to dignity and respect. One of the main findings of this report was that staffing levels on wards had to better reflect the needs of older people both now and in the future. The needs of older people in hospital will be complex and varied, and many may be living with dementia or a cognitive impairment. The Commissioners, 'Dignified Care: Two Years On' report stated that "There is a clear link between staffing levels and the safety and quality of care on hospital wards. Routine and public reporting about the adequacy of staffing levels must be an immediate priority for the Welsh Government and the NHS."[1]

Ensuring that nurse staff are able to meet these needs is complicated and requires a great deal of planning. Staffing ratios are a useful tool to be used in monitoring staffing levels; they are a standard that act as a

[1] Older People's Commissioner for Wales, Dignified Care: Two Years On, The experiences of older people in hospital in Wales, 2013

warning signal if this changes below a certain level. However, this must be used in conjunction with an intelligent acuity tool that calculates the level of staffing based upon the complex, and variable needs of patients in order to achieve the best outcomes for patients.

The emphasis at all times should be on the duty of health service bodies to facilitate and deliver staff levels that produce safe, effective, appropriate and timely care in a kind and compassionate manner, as opposed to minimum standards or the use of staffing ratios to balance the bodies finances. Therefore it is welcome that the Bill recognises safe, rather than minimum nursing staff levels, and includes the use of acuity tools to determine safe levels.

Recording staffing numbers

The Commissioner's submission to previous consultations raised concerns that "there must be more clarity and accuracy in recording staffing numbers as currently this can include people on sick leave and those that are suspended".

The Bill includes provision for the protection of 'planned and unplanned leave' when determining safe staffing levels, and it can be assumed that this would include those staff members on sick leave. However, further clarification on whether this would include suspended staff would be welcome, and if not, what can be put in place to ensure that they are taken into account when workforce and rota planning.

The right staff with the right skills

Alongside using acuity tools to determine the number of staff that are needed to meet the needs of older people, those staff must be equipped with the right skills and must be present on the ward in the right mix.

Well-trained staff driven by a culture of care is essential to guarantee that patients get the best possible experience, and it is disappointing that despite the examples of excellent care that the Commissioner comes

across, recent reports demonstrate that older people are still not receiving the dignified and compassionate care that they have a right to receive. Following the Commissioner's 'Dignified Care?' reports, the Welsh NHS must now build upon the recommendations set out in the 'Trusted to Care'[2] report, especially around improving the skills and knowledge of staff in treating and caring for older people and delivering relationship-centred care.

The Bill recognises that the appropriate nursing skill mix is needed alongside numbers in order to achieve safe levels and reflect patient care needs. It is also welcome that in determining and maintaining safe levels, the Bill introduces protections for staff time for induction and continuous training. Ensuring that nurse staff have access to training so that they can gain and maintain the skills that they need to care for older people is just one element in providing high quality care to older people in hospital.

However it is essential that this protected time is achieved in reality, as without access to appropriately skilled staff, ensuring the numbers and mix are correct in itself will not improve patient care.

Leadership and professional judgement

The Commissioner's submission to the previous consultations stated that leadership and the ability to make decisions, especially when the needs of patients change quickly, should form part of the debate on improving nursing standards. Hospital staffing should be flexible so that it can adapt in response to the ever-changing needs of their patients. When difficult decisions need to be made, ward mangers need to have the power to respond and alter their staff balance accordingly.

Ward managers have told the Commissioner that despite considerable investment in initiatives and the development of clinical leadership programmes, they are often not allowed to select the staff for the ward themselves. This limits their opportunity to assess the skills, knowledge,

[2] 'Trusted to Care' An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board, Professor June Andrews, 2014

and the attitudes of the staff working on their wards[3]. It is welcome therefore that the Bill includes the exercise of professional judgement within the staff planning process.

Role of nursing staff in other settings

The Commissioner's recently published Review into the Quality of Life and Care of Older People Living in Care Homes in Wales, 'A Place to Call Home?' included significant evidence regarding the key role that the Welsh NHS and its nurses play in the quality of care and safety of older people in residential and nursing care homes. Ensuring there are adequate numbers of nursing staff is essential but, as has been recognised above in relation to hospital wards, it is also about ensuring staff have the right skills and knowledge, the ability to draw in other services and support where required, and are provided with the time not just to undertake clinical care but also to deliver crucially important, yet often intangible compassion and kindness. Please see Appendix A for the relevant section of the Review.

In addition to nursing care homes, there is a large number of nurse staff working across Wales in community settings. With the planned policy shift away from treatment and long stays within acute wards and towards care and treatment within the community, and also the need to better integrate health and social care services, responsive workforce planning and safe nurse staffing levels need to apply in those settings to ensure that potentially frail and vulnerable older people are receiving safe and appropriate care in all situations.

The Bill includes a subsection that would allow Welsh Ministers to extend the safe nurse staffing duty to 'additional settings within the National Health Service in Wales'. However, it is unlikely that this would support the extension of safe nurse staffing levels into nursing care home settings as these are often independently owned with placements commissioned by the Local Authority or Health Board. This is disappointing as there are vulnerable older people living in these

[3] Dignified Care: Two Years On' The experiences of older people in hospital in Wales, Older People's Commissioner for Wales, 2013

settings who receive care and treatment from nurse staff on a daily basis.

Furthermore in the context of community based nursing, it is unclear from the Bill whether the provision of nursing care within someone's own home would qualify as an 'additional **setting within** the National Health Service in Wales'.

Consideration should therefore be given to amending this subsection to include additional settings where care is delivered by a suitably qualified nurse or healthcare professional, such as care homes, health visitors and district nurses.

Annual report by health service bodies and indicators of safe nursing

The requirement that 'each health service body in Wales must publish an annual report' will be a method through which compliance against the safe nurse staffing levels duty can be judged, and is to be welcomed.

For example, as stated above -, 'it is essential that this protected time (for staff induction and training) is achieved in reality...'. The annual report would therefore present an opportunity to state if this was the case, and if not, why not.

Whenever a service 'gets it wrong' the price is never paid by that service. It is paid by the individual and that price is often far too high. The requirement to publish an annual report on compliance against the duty will act as a method of public assurance. For these annual published reports to achieve these aims, they must be truly accessible to, and understandable by the wider public.

The provision within the Bill for Welsh Ministers to undertake a regular review of the operation and effectiveness of the Act is essential to ensuring that it is having a meaningful impact on the quality and safety of patient care. Therefore the inclusion of 'indicators of safe nursing', which Welsh Government must report against, are to be welcomed.

The Commissioner's submission to previous consultations stated that 'because of the known demographic of the hospital population who have high acuity needs and levels of frailty, the addition of the number and severity of pressure sores would be beneficial'. It is welcome that the 'number and severity of hospital-acquired pressure ulcers' has now been included as an 'indicator of safe nursing'.

However this could be further strengthened by the addition of an indicator linked to the amount of staff time that has been protected for training and details on the content of that training, for example training on dementia awareness, sensory loss, human rights, POVA and raising concerns.

Impact Assessment

The average age of a hospital patient is over eighty[4], and the needs of older people in hospital will be complex and varied, many of whom may be a carer, living with dementia or a cognitive impairment. The findings of the Commissioner's 'Dignified Care?' reports, and more recently 'Trusted to Care' have clearly demonstrated the importance of the right number of nursing staff, with the right skills, in delivering safe, effective, appropriate and timely care to older people in a kind and compassionate manner.

It is noted that a Children's Rights Impact Assessment (a key mechanism for implementing the United Nations Convention on the Rights of the Child) was under taken and reported within the Bill's Explanatory Memorandum. In July 2014, the Welsh Government launched the Declaration of Rights for Older People in Wales[5] which clearly articulate the rights of older people in Wales as already underpinned by law. In light of the significant impact that proposed legislation would have on the care and safety of older people in hospitals, best practice in the development of impact assessments should be the specific and thorough consideration of the needs of people living with dementia, sensory loss or those who are carers.

[4] The Kings Fund, The care of frail older people with complex needs: time for a revolution, 2012
[5] Welsh Government, Declaration of Rights for Older People n Wales, 2014

Conclusion

Placing safe nurse staffing levels on a statutory footing, in a way that meets patient needs through the use of acuity tools and responsive staff planning will ensure that the nurse staff who are present on wards of Welsh hospitals are in the right number and appropriately skilled to meet the complex and varied needs of older people.

It is essential that positive provisions within the Bill, such as protected training time, become a reality and that financial pressures and the demands of daily work do not overshadow the importance of a skilled workforce in the delivery or treatment and care. Annual reports from health service bodies and Welsh Government reviews of the impact of the duty could provide the pressure and support necessary to turn positive aspiration into reality.

However, the provision to extend the duty to other settings must be amended to capture nursing care homes and broader community settings. Without doing so, there is a danger that the known risks to patient safety and dignity from inappropriate nurse staffing on an acute ward will also apply, unchecked and unmonitored in nursing care homes.

Finally, in order to capture the full benefits and impact of such legislation on older people who receive health services in settings that would be effected, impact assessments should include the specific and thorough consideration of the needs of older people living with dementia, sensory loss or those who are carers.

Appendix A

Older People's Commissioner for Wales, 'A Place to Call Home? A Review into the Quality of Life and Care of Older People living in Care Homes in Wales', 2014

Nursing Staff

Oral evidence from the RCN stated that there was disparity between the standards of nursing in the NHS and the standards found in nursing homes. They identified a number of reasons for this, including limited clinical supervision, a lack of peer support in nursing homes and a lack of opportunities for professional development, as well as nurses often having to make decisions on their own as they have no one to discuss issues with. These factors can be a particular issue in smaller nursing homes.

The RCN also stated that it is more difficult to recruit nurses to work in nursing homes due to a lower standard of pay and conditions, more isolated working environments and a general negative perception of nursing homes.

This can often result in newly qualified nurses being recruited to nursing homes who may have limited experience in working with older people and may require additional support and training. Retaining these nurses can also be difficult as many will move to a nursing role within the NHS.

Their evidence stated that Health Boards do not have a primary care strategy for nurses working in the residential care sector, which means that workforce planning for Wales is based on the needs of the NHS and

has failed to consider the needs of Welsh citizens living in residential care.

Whilst nurses working in nursing homes have a wide range of care skills, there will always be instances when older people will need timely access to specialist healthcare. The Commissioner received evidence from the RCN, Care Home Managers and independent providers that demonstrated there can be confusion about roles and responsibilities for medical treatment and care between the NHS and nursing care homes.

Evidence received from Care Home Managers stated that there are assumptions that nurses working in nursing homes can ‘do everything’, which means that the NHS often does not provide support in a proactive way.

“She [NHS professional] said ‘what sort of nursing home are you that you can’t do a male catheterisation?’. But with an EMI psychiatric nursing home you don’t very often find a gentleman with advanced dementia with a catheter. The nurse felt ‘that big’.” Care Home Manager (Oral Evidence)

Evidence taken during the roundtable discussion on health also highlighted the historical attitude towards nurses working in care homes:

“When I joined the Health Board in 2008 or 2009, there was an appalling attitude to nursing homes. It was very negative, they were somehow below us and I was quite shocked at that because I’m from primary care, I’m a General Practitioner… I think we’ve come on leaps and bounds, I think there’s an awful lot of respect for our colleagues in the independent sector. They’re not NHS nurses but they’re still nurses… I think there is a long way to go yet, I still think that our opinions of care homes lacks a lot so I think there is still some work to do.” Abertawe Bro Morgannwg University Health Board (Oral Evidence)

It is clear that on-going support to nurses working in care homes, whether from their peers or from the wider health system, is vital, not only to ensure that they have the skills and experience necessary to carry out their role effectively, but also to ensure that older people are receiving the care they need.

This is something that was acknowledged by Health Boards across Wales during the roundtable discussion on health:

“There are some great examples of secondary care being provided in nursing homes that prevents people from coming into secondary care type services. We’ve got a range of those, so a question of Health Boards is, given that this is happening and it’s producing great results, why aren’t you doing that everywhere? So the reflection of our board is that there’s great practice in parts of our board, but why aren’t they consistently and reliantly doing this everywhere because it saves us money, it saves us time?” Abertawe Bro Morgannwg University Health Board (Oral Evidence)

Good practice: Betsi Cadwaladr University Health Board – Residential Care Liaison Nurse Project

The aim of this project is to take a proactive approach to maintaining the health of residents living in a residential care home, thus enabling them to stay in their home environment, preventing hospital admissions and being transferred to a nursing care home.

A trained nurse with the District Nursing team will coordinate and support the 29 registered residential care homes within the Health Board area. Initially a 12 month pilot project is planned where the liaison nurse will develop the role within one home over a four to six month period with a view of extending it to three homes within the year.

The team’s initiative will be to support the care homes by assisting them in identifying training and development needs and assisting them in enhancing their practise.

Workforce Planning

Evidence from CSSIW stated that workforce planning is challenging due to a lack of demographic projections about future need therefore it is not possible to quantify the ‘right’ number of care staff as this will vary depending on the support needs of individuals living in residential or nursing care homes.

“One of the things we battle with as an inspectorate is staffing sufficiency. There are no set number ratios and that is both a good thing and a bad thing. The bad thing is it is very hard for us to hold people to account for the number of staff that they’ve got on duty. On the other hand, you need to be flexible in terms of people’s increased dependency.” CSSIW (Oral Evidence)

Evidence from the Care Council for Wales stated that the unregulated nature of the care home workforce in Wales, which means that data is not held on the number of care home staff in Wales, can also lead to difficulties around effective workforce planning.

Evidence from the RCN identified that, in relation to nursing staff in particular, there is a lack of effective workforce planning. They stated that this planning is based on the needs of Health Boards and the hospitals they run and does not consider the needs of residential care.

Evidence from Carmarthenshire County Council and Rhondda Cynon Taf County Borough Council also stated that they have significant issues around the recruitment of nurses, particularly in recruiting Registered Mental Health Nurses and nurses to work in EMI care homes.

Issues around recruiting EMI nurses were also highlighted in evidence from Caerphilly County Borough Council.

“The EMI capacity, particularly in nursing capacity, is a real problem for us. Not so much on a residential EMI capacity, we’re doing okay on that. But it’s proving very difficult to persuade providers to go and provide those EMI nursing facilities. It is not an attractive market for them to move into. So those capacity issues, I can only see continuing, to be honest.” Caerphilly County Borough Council (Oral Evidence)

Local Authorities have also stated that the recruitment and retention of Registered Mental Health Nurses, alongside the higher cost of specialist nursing care in EMI settings, is a significant barrier to providers entering and sustaining this type of provision, especially in rural areas.

The Care Council for Wales also identified that a number of Care Home Managers are not registered and, although succession planning has

improved, there are still gaps in the number of registered managers that are needed for the future.

“Whereas there is some evidence of succession planning in that there were more services with more than one person qualified and registered as a manager than in 2012, there still needs to be careful succession planning for the service.” Care Council for Wales (Written Evidence)

Without the correct workforce – the right number of staff, with the right skills, in the right places – residential care provision will be unstable and unable to meet the needs of older people living in residential care both now and in the future.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Macmillan Cancer Support – SNSL(Org) 10 / Tystiolaeth gan Cymorth Canser Macmillan – SNSL(Org) 10

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
CF99 1NA

19 January 2015

Dear Committee Clerk

Consultation on the Safe Nurse Staffing Levels (Wales) Bill

I am writing in response to the Consultation on safe nurse staffing levels (Wales) Bill. We wrote to Kirsty Williams AM in September 2014, welcoming the recognition of the need for safe nurse staffing levels throughout Wales. This is of paramount importance to people affected by cancer not least as we know that the majority of these will be cared for on non cancer specialist wards.

By 2030, it is estimated that the number of people living with or beyond cancer in Wales will nearly double to a quarter of a million (from 130,000 in 2015 to 250,000 in 2030, around 8% of the population). As the nature of cancer changes, so do the needs of people who are affected by it, and the range of health and social care professionals and services required to help meet those needs. This growing and ageing population often with multiple co-morbidities will have significant implications for health and social care and will challenge existing models of cancer care.

People who decades ago would have died shortly after diagnosis will increasingly survive for longer. 1 in 4 people will be living with the consequences of treatment and disease and many will be living with an incurable cancer, remission and relapse. Nurses are in a prime position to ensure that care is holistic, addressing clinical and non clinical needs within the multidisciplinary team. There is evidence that nurse staffing levels have a significant impact on patient care and based on the numbers above, people affected by cancer will have an unprecedented need for safe and compassionate nursing care in future years. Nurses also play a crucial role in the provision of effective cancer information, care co-ordination, the promotion of co-production and supporting self management.

There is overwhelming evidence from the results of the first Wales Cancer Patient Experience survey, published in January 2014, which shows that having a Clinical Nurse Specialist enhances the delivery of cohesive care and provides an overall positive experience for patients and their family throughout and beyond their treatment. Nursing was by far the largest staff area for which comments were made by respondents.

Whilst the experience of nursing care was characterised broadly as positive, there were some areas of concern around general nursing and comments often reflected concerns about nursing workloads and staffing levels. In particular, when patients responded to the question - **In your opinion, were there enough nurses on duty to care for you in hospital?** only 60% of patients said there were always or nearly always enough nurses on duty to care for them in hospital; 29% said that there were sometimes enough on duty and a further 11% said there were rarely or never enough on duty.

Patient comments around nursing staff levels and availability collected from the Wales Cancer Patient Experience survey include observations such as the following:

“I always felt the nurses were under pressure and therefore time allocated to patients was limited which often leads to limited information at times. The Day Unit staff appeared to be rushed off their feel”

“During the period I was there I saw the rules of the ward go out of bathroom window. Whilst I was there someone fell to the floor. He pulled the red cord with no response. In the end he sat on a stool, dragged himself to the door and called for help. He waited more than ten minutes”

“I think the nursing staff do a very good job, but there should be more of them. Sometimes they are very stretched to give the right care and treatment needed. Nurses and other staff, most of them excellent but severely overworked”

“More nurses as they couldn’t take me to the toilet and wait with me as I was having dizzy spells due to low blood pressure. They left me on toilet, only to come back and find me on floor with bloody gash in my head”

“The nursing staff on the wards work very hard, but are very overworked. Staffing levels need to be improved”.

Legislating around safe staff nursing levels will go a long way to alleviate these pressures and we believe that the principles of providing safe nurse staffing levels will enhance the provision of holistic care and delivering ‘person-centred cancer care’ outlined within the Welsh Government’s Cancer Delivery Plan. We support the move towards putting in place mechanisms for safe nurse staffing levels and we would

expect to see robust monitoring around the implementation and learning from the challenges and opportunities to be shared throughout Wales to help reduce variation.

Debates and forums such as the Royal College of Nursing event held on 30 September 2014 have highlighted the international evidence to support this legislation and the benefits achieved around patient outcomes and increased job satisfaction within the nursing community. That said, this model has not been piloted in Wales, and we would expect its application to be cautiously applied to **our** healthcare system, taking into consideration detailed analysis around budgetary implications and the potential legal consequences for Health Boards and individuals with responsibility for overseeing its delivery.

Evaluation should also take into consideration safe nurse staffing levels in all settings which are not initially covered within the legislation eg community nursing, nursing homes and in the private sector. It is crucial that safe nurse staffing levels are implemented consistently throughout Wales and are flexible enough to respond to local demand, the requirements of each different acute and specialist service, the skill mix available and the ability to react to the complexity and dependence level of individual patients' needs.

If you would like further information from us regarding the findings of the Wales Cancer Patient Experience survey in relation to nursing levels, please do not hesitate to get in touch with me at [redacted] or phone me on [redacted].

Yours sincerely

Lowri Griffiths
Policy and Public Affairs Manager, Wales

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Pediatric Intensive Care Unit – SNSL(Org) 11 / Tystiolaeth gan Uned Gofal Dwys Pediatrig – SNSL(Org) 11

Submission of written evidence for the Consultation on the Safe Nurse Staffing Levels (Wales) Bill

We as clinicians agree wholeheartedly that there is a need for legislation to make provision about safe nurse staffing levels. However, the legislation should apply to both children and adult services.

As paediatric clinicians we are very concerned that children's services have currently been left out of the bill. Adult-centric legislation could lead to the funding and staffing of children's services being squeezed further, to compensate for the likely increased staffing levels rightly required in adult services as the result of this legislation.

Articles 2 and 24 from the UN Convention on the Rights of the Child, as detailed below also support the need for the Bill to apply to children's services.

Article 2 (Non-discrimination): The Convention applies to all children, whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from. It doesn't matter where children live, what language they speak, what their parents do, whether they are boys or girls, what their culture is, whether they have a disability or whether they are rich or poor. No child should be treated unfairly on any basis.

Article 24 (Health and health services): Children have the right to good quality health care – the best health care possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this.

There will be a need for robust workforce planning and dialogue between the Health Service and the Universities to ensure that sufficient numbers of nurses with the required skills are being developed.

We strongly support that the health service bodies have a duty to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided. The executive boards should be held accountable for this.

We strongly support that health service bodies have a duty to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios in both

paediatric and adult wards and critical care facilities, from the outset of its implementation.

Malcolm Gajraj

Lead clinician, Paediatric ICU,

Cardiff

(on behalf of the consultant body)

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Welsh Intensive Care Society – SNSL(Org) 12 / Tystiolaeth gan Cymdeithas Gofal Dwys Cymru – SNSL(Org) 12

Committee Clerk,
Health and Social Care Committee,
National Assembly for Wales,
Cardiff Bay, CF99 1NA.

20th January, 2015.

Dear sir,

Re: Consultation on the Safe Nurse Staffing Levels (Wales) Bill

I am writing to you in my role as Chair of the Welsh Intensive Care Society (WICS).

We note the aims of the Bill and support the principles laid out. WICS is fully in agreement that nurse staffing levels should not be permitted to drop below the accepted minimal levels that are agreed with professional bodies. Within the speciality of Intensive Care Medicine, there are well-established minimum nurse staffing levels that have been set out in published guidance on standards from the (UK) Intensive Care Society (ICS) and more recently in joint standards publications from the ICS and the Faculty of Intensive Care Medicine (FICM). The Core Standards for Intensive Care Units (2013) document has been widely endorsed by many different professional bodies, including the Royal College of Nursing (RCN) and the British Association of Critical Care Nurses (BACCN). Further guidance of nurse staffing for critical care units is provided in Chapter 2, Section 2.3 of the Guidelines for the Provisions of Intensive Care Services (GPICS), jointly published in draft form recently by the ICS and FICM.

The safe and effective provision of critical care depends upon the presence of a highly skilled nursing work force of sufficient numbers to at least meet the standards set out in GPICS. These standards should be regarded as a minimum. When critical care units are short of nursing staff, the care of the very sickest patients in the hospitals is compromised. This should be regarded as unacceptable.

The National Institute for Health and Care Excellence (NICE) published guidance on safe staffing for acute inpatient settings in July 2014, but did not specifically mention the staffing levels for

critical care services. WICS wishes to raise the issues of the impact of understaffed wards on critical care services. Patients who do not receive appropriate and timely care because of wards being understaffed may deteriorate to a point where critical care becomes necessary, this representing a poor use of such a costly service when safe staffing may have obviated such a risk. Understaffed wards often find it difficult to accept patients being discharged from a critical care unit, resulting in delayed transfer of care (DTOC) which is, again, a poor use of a costly service and which has adverse consequences for patients in terms of rehabilitation and hospital discharge.

NHS Wales currently exists in a state of financial challenge. However, as has been seen in Welsh critical care units in recent times, a failure to recruit new staff and retain those highly skilled staff members already in post puts those units under enormous strain, with delays in admitting critically ill patients, inability to admit critically ill patients and cancellations of surgery where post-operative critical care is warranted to achieve best possible outcomes. These issues lead to adverse outcomes of all magnitudes of severity. Failure to recruit and retain may seem financially advantageous in the short term, but such short-term thinking only results in greater difficulties later on as increasing demands are placed on all hospital services, including critical care services.

WICS therefore wishes to see that wards are adequately staffed to improve both the patient experience and the patient outcomes, helping to both reduce the need for critical care admission and reduce the problem of delayed transfers of care. If this Bill is to include recommendations for critical care services, those recommendations must at least match those set out in GPICS.

Yours faithfully,

Dr. Paul Morgan
Consultant Intensivist and Chair of WICS,
Adult Critical Care
Critical Care Directorate,
Cardiff and Vale University Local Health Board,
Heath Park,
Cardiff, CF14 4XW

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Royal College of Speech and Language Therapists – SNSL(Org) 13 / Tystiolaeth gan Coleg Brenhinol y Therapyddion Iaith a Lleferydd – SNSL(Org) 13

ROYAL COLLEGE OF SPEECH & LANGUAGE THERAPISTS

Wales Policy Office

Suite 2.3, 2nd Floor
33-35 Cathedral Road
Cardiff CF11 9HB

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

Health and Social Care Committee,
National Assembly for Wales
Cardiff Bay,
CF99 1NA

21st January, 2015

Dear Committee Member

Safe Nurse Staffing Levels (Wales) Bill – Written Evidence from the Royal College of Speech and Language Therapists

The Royal College of Speech and Language Therapists (RCSLT) welcomes the opportunity to provide written evidence to the Health and Social Care Committee on the above Bill. In providing evidence, we wish to reiterate our commitment to provide the highest standards of patient care and to the best outcomes for patients. However, we are firmly of the view that this can only be achieved through a holistic, multi-disciplinary approach based on the individual needs of the patient. We are also concerned that if resources are diverted to increase nurse staffing levels following legislation then this may have a detrimental impact on other essential services.

We also question whether legislation for minimum nurse staffing levels will hinder or enhance the Welsh Government's Prudent Healthcare Policy for Wales. Prudent Healthcare has not yet had sufficient time to become properly embedded in the delivery of healthcare in Wales and is likely to have an impact, not only on staffing levels, but also on the development of a more diverse workforce and mix of skills required in the future. We are of the view that the proposed legislation

will fetter the ability of NHS Health Boards and Trusts to respond to the Prudent Healthcare principles – particularly in terms of workforce planning, promoting equity and co-production.

For these reasons we do not support a legislative approach that is entirely focused on nurse staffing levels.

Response to consultation questions

1. **General**

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

We are committed to ensuring the highest quality patient care based on a person-centred approach that is safe, compassionate and effective. We are firmly of the view that delivering the best outcomes for patients can best be achieved through a multi-disciplinary approach based on the needs of the patient. Legislation for mandatory staffing levels will not guarantee patient care.

We are concerned that a focus on nurse staffing levels in isolation risks overlooking other important factors that affect outcomes and experience for patients.

1.2 Are the provisions in the Bill the best way to achieve the Bill's overall purpose (as set out in section 1 of the Bill?)

We have concerns over clarity in terms of terminology used. For example, the Bill states that nurses should be deployed in '*sufficient numbers*', to enable '*safe nursing care'*. However, it is unclear as to what '*sufficient numbers'* or what *'safe nursing care'* should be in relation to staffing levels.

We support the view of the NHS Nurse Director in Wales that there needs to be clear professional judgement to ensure that flexibility in staffing remains a critical part of meeting patient needs. In the wake of the Francis Report, there is already an assessment process to determine staffing levels on wards based on the severity of patients' conditions rather than on patient numbers.

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

The focus of the Bill is on nurse staffing levels but does not address wider workforce planning issues. We believe that nurse staffing levels should be planned as part of wider workforce planning for a healthcare system that is designed to meet the needs of its service users and is responsive to the major demographic changes and challenges it faces over the coming years - particularly the challenge of an ageing population and high rates of chronic conditions. We do not believe that minimum nurse staffing levels will be sufficient to meet those challenges if planned in isolation.

1.4 Are there any unintended consequences arising from the Bill?

Yes. We believe there are a number of unintended consequences.

- There are many factors contributing to patient safety and high quality care which may be overlooked if the focus is solely on nurse staffing levels;
- Diverting resources to meet minimum nurse staffing levels could mean the diversion of resources away from other essential services which would impact on patient outcomes;
- There is likely to be increased bureaucracy as hospitals and services will have to demonstrate that they are compliant with minimum nurse staffing levels;
- Legislation may limit the ability of NHS hospitals and services to plan care in a way that best meets the needs and demands of patients in the areas they serve and also stifle innovation;
- Minimum standards may be set too low to achieve the standards of care we are striving for.

2. Provisions in the Bill

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

Health Boards and Trusts are responsible for the quality and safety of care provided to patients and should be accountable to the Welsh Government for safe and effective staffing across all disciplines. We believe that a prescriptive legislative approach to nursing in isolation from other factors could impact adversely on accountability. We support a holistic approach which encompasses all factors contributing to the best outcomes for patients.

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

There would need to be a clear definition of what 'all reasonable steps' are considered to be. It is assumed that there will be clarification on the processes that would be put in place to ensure compliance with minimum nurse staffing levels and the consequences of non compliance.

2.3 The fact that, in the first instance, the duty applies to adult inpatients wards in acute hospitals only?

While we do not support legislation on nurse staffing levels, we are concerned that the proposed legislation applies only to adult in-patient wards in acute hospitals. An unintended consequence may be that resources are diverted to these settings which would create imbalances in provision and have an adverse impact on other staff groups and healthcare settings. This would be to the detriment of patients in other healthcare settings in terms of patient care, experience and outcomes. This is also contrary to policy direction to strengthen community services in order to reduce demand on acute services. Within community

hospital settings, the recent benchmarking UK audit showed that better patient outcomes correlated to diversity of professions around the patient.

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

We believe that each hospital and service should exercise their professional judgement in determining how services should be organised to meet demands. We are concerned that guidance specifying minimum nurse to patient ratios would restrict the ability of hospitals and services to respond flexibly to changing demands and patient needs.

2.5 The requirement for the Welsh Government to consult before issuing guidance.

It would be essential for the Welsh Government to conduct an extensive and wide-ranging consultation to ensure that the intentions of the legislation are fully understood and that the implications, risks and unintended consequences are thoroughly scrutinised and evaluated.

2.6 The monitoring requirements set out in the Bill?

The monitoring process should encompass all issues that impact on patient experience and outcomes and collect information relating to other professions and staffing as well as nursing.

2.7 The requirement for each health service body to publish an annual report?

- While we support the need for clear transparency and accountability, we are concerned that production of annual reports may place additional bureaucratic burdens on service providers;
- Reviews of the impact of the planned legislation should cover quality of patient care, experience and outcomes including impact on other service areas.

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

We recognise that review of the operation and effectiveness of the Act is an integral part of implementing the legislation. We would want to ensure that measures included in the review process are meaningful and cover factors across the range of services where impact of the legislation may have unintended consequences. Also, that indicators should encompass quality of care and patient outcomes.

3. Impact of existing guidance

Does the RCSLT have a view on the effectiveness of the existing guidance?

We believe that the existing All Wales Nurse Staffing Principles Guidance should be properly implemented to ensure adherence to its recommendations and form part of the Tier 1 indicators. We would wish to see staffing principles guidance introduced across the whole NHS workforce.

4. **Powers to make subordinate legislation**

We believe that legislation premised on only one health care setting would be flawed. We are concerned that powers for Welsh Ministers to amend settings to which minimum staffing levels would be conferred through subordinate legislation and not on the face of the Bill. We are concerned about the narrow focus of the Bill as currently proposed.

5. Financial implications

We reiterate our concerns that focus on nurse staffing levels could divert resources away from other essential services that play a vital role in patient care. Similarly, we are concerned that the proposed legislation could divert resources from community services and that financial implications of the Bill will not include consideration of the unintended consequences of its implementation.

The Royal College of Speech and Language Therapists

The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists (SLTs), SLT students and support workers working in the UK. The RCSLT has 15,000 members in the UK (600 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council. We promote excellence in practice and influence health, education, care and justice policies.

Submitted by Dr Alison Stroud
Wales Country Policy Officer,
Royal College of Speech and Language Therapists.

ROYAL CYMDEITHAS PHARMACEUTICAL FFERYLLOL SOCIETY FRENHINOL
Wales Cymru

2 Ashtree Court,
Woodsy Close
Cardiff Gate Business Park
Cardiff
CF23 8RW

T: [redacted]
E: [redacted]
W: www.rpharms.com

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Royal Pharmaceutical Society – SNSL(Org) 14 / Tystiolaeth gan Cymdeithas Fferyllol Frenhinol – SNSL(Org) 14

Committee Clerk
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA

20 January 2015

Dear Sir/Madam

Consultation on the Safe Nurse Staffing Levels (Wales) Bill

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to contribute to the consultation on the Safe Nurse Staffing Levels (Wales) Bill.

About the Royal Pharmaceutical Society (RPS)
The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession within the context of the public benefit. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums. Its functions and services include:

- **Leadership, representation and advocacy:** promoting the status of the pharmacy profession and ensuring that pharmacy's voice is heard by governments, the media and the public.
- **Professional development, education and support:** helping pharmacists to advance their careers through professional advancement, career advice and guidance on good practice.
- **Professional networking and publications:** creating a series of communication channels to enable pharmacists to discuss areas of common interest.

General comments
We welcome the attention that is currently being given to safe staffing levels in the NHS as a result of the introduction of the Safe Nurse Staffing Levels (Wales) Bill. We fully agree that driving up quality of patient care, improving patient safety and the patient experience are vitally importantly

issues requiring immediate attention in Wales. In these respects we are fully supportive of the spirit of the Bill.

We believe that patient safety must be the key driving force for statutory and legislative changes to workforce planning and the deployment of NHS staff groups. As such we believe any change should reflect the way in which patient care is being delivered in the NHS - through multi-professional teams. We are concerned therefore that the uni-professional nature of the current Bill may restrict opportunities in practice to address safe staffing levels across the full range of professional groups responsible for delivering patient care in Wales.

We appreciate the need for strengthening accountability for the safety, quality and efficacy of workforce planning and management as enshrined in the Bill. We believe legislation should only be considered however when all other avenues have been fully exhausted. In this respect it is not totally clear why existing guidance to ensure safe staffing levels as recommended by NICE and the Chief Nursing Officer have not delivered improvements across Wales or if other steps could be taken to improve workforce planning as an alternative to introducing legislation.

Provisions of the Bill

We agree that health service bodies should be held to account for ensuring an appropriate level of NHS staffing and that they should be required to publish an annual report detailing how this duty has been complied with. We are concerned that the Bill currently misses opportunities however to apply this principle to all staff groups involved in NHS care. We believe it would be more effective to ensure a duty is placed on health service bodies to undertake robust planning to meet patient need not only with adequate numbers of staff but importantly with the right skill mix of staff. Such an approach would allow for greater flexibility for matching NHS resources to local needs.

We agree there is a need to increase protections for certain activities and particular professional roles. Protected time for professional development for instance is essential for improving skills and delivering high quality and safe care. We are concerned however that guidance issued by the Welsh Ministers to health service bodies on specific protections for one professional group could restrict future planning, skill mix and scope for innovation. Setting staff protections in law at any given point of time may have significant implications for the future and inhibit plans by health service bodies to introduce new ways of working. We strongly believe that flexibility is needed for health service bodies to plan and deliver services that can meet patient need. We are concerned that these protections may have a negative impact on that flexibility.

Financial implications

We are concerned that the Bill as it currently stands could restrict the flexibility of health service bodies in their financial planning and the implementation of workforce plans to meet population and service needs. The notion of mandatory minimum nurse staffing levels may place a significant financial burden on health service bodies when complying with this duty and restrict plans to invest in other staff groups that are needed to deliver new models of care. We believe it is important that health service bodies are able to utilise their funding allocations appropriately and flexibly to meet the population and service needs identified in their geographical areas.

Unintended consequences

We also have concerns that assuring the numbers of one particular staff group may have unintended consequences for that staff group as well as other staff groupings. For instance roles may be redefined within the staff group simply to justify staff quotas and this may inhibit the

development of other staff groups where similar quotas are not in place. Introducing the proposed legislation as it stands could potentially restrict the flexibility needed for workforce planning across the full range of staff groups and professions and we are concerned that this could potentially have a detrimental effect on patient care, in direct contrast to the intentions of the Bill.

In conclusion, we are pleased to support action to strengthen workforce planning and increase the accountability of health service bodies to deliver safe levels of NHS staffing. We are adamant however that this should apply to all staff groups to more fully reflect the multi-professional and multi-disciplinary nature of healthcare provision in the NHS. If legislation is deemed the only solution to address these important issues then we believe it should include all health professional groups.

I trust this information is helpful and would be pleased to elaborate on any issues in further detail.

Yours sincerely,

Mair Davies FRPharmS
Chair, RPS Welsh Pharmacy Board

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Nursing and Midwifery Council – SNSL(Org) 15 / Tystiolaeth gan Y Cyngor Nyrsio a Bydwreigiaeth – SNSL(Org) 15

Nursing and Midwifery Council response to The National Assembly for Wales' Health and Social Care Committee call for evidence on the Safe Nurse Staffing Levels (Wales) Bill

1 We are the Nursing and Midwifery Council (NMC). We are the statutory regulator for nurses and midwives in the UK. We exist to:

1.1 protect the health and wellbeing of the public;

1.2 set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers; and,

1.3 ensure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards.

2 We hold the register of those who have qualified and meet those standards. If an allegation is made that a registered nurse or midwife is not fit to practise, we have a duty to investigate that allegation and, where necessary, take action to safeguard the health and wellbeing of the public.

3 We welcome the opportunity to provide written evidence to The National Assembly for Wales' Health and Social Care Committee on the Safe Nurse Staffing Levels (Wales) Bill, please find below our response.

Safe staffing

4 The importance of appropriate staffing was reinforced by the Francis Report into failings at Mid Staffordshire NHS Foundation Trust in England. Appropriate staffing plays a fundamental part in the delivery of safe and effective health and care. Safe staffing can be a complex area and has to take account of multiple factors. It must be matched to patients' needs and is about skill-mix as well as numbers, about other staff as well as nurses, and other settings as well as hospitals. It is the responsibility of health and care providers, which are regulated by system regulators in the four countries of the UK.

5 As a professional regulator it is not the role of the NMC to set or assure standards related to appropriate staffing. Registration is an important safeguard, but employers have the primary responsibility to make sure they employ the right number of staff with the right skills and experience in the right posts. As such, we do not expect the Safe Nurse Staffing Levels (Wales) Bill to have a direct impact on the work of the NMC.

6 However, we are aware that this area has a bearing on what we do in a number of ways and that aspects of the Code[1] and NMC guidance place an emphasis on nurses and midwives to raise concerns, including issues with regards to safe staffing levels. In June 2014 the NMC produced a briefing paper on appropriate staffing in health and care settings (please see **Annex 1**).

The Code and raising concerns

7 The Code contains the professional standards that registered nurses and midwives must uphold. UK nurses and midwives must act in accordance with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education, or research. The NMC will publish a revised version of the Code in January 2015, coming into effect in March 2015.

8 Environmental factors like staffing levels can affect nurses' or midwives' ability to uphold the values of the Code. Nurses and midwives have a professional duty to report any concerns from their workplace which put the safety of people in their care or the public at risk.

9 The revised Code places a greater emphasis on raising concerns, including concerns they have over staffing levels or as a consequence of staffing levels. The Code states nurses and midwives must:

9.1 *Act without delay if they believe that there is a risk to patient safety or public protection*. This includes raising and, if necessary, escalating any concerns held over patient or public safety, or the level of care people are receiving in the workplace or any other healthcare setting. Nurses and midwives must also raise concerns if being asked to practice beyond their remit, experience or training.

9.2 *Raise concerns immediately if they believe a person is vulnerable or at risk and in need of additional support and protection*. Nurses and midwives must take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse, and must disclose information if you believe someone may be at risk of harm.

9.3 *Be aware of, and minimise, any potential for harm associated with their practice*. Nurses and midwives must consider how to take measures to minimise the likelihood of errors, near misses, harms and the impact of harm if it occurs.

[1] The Code: Standards of conduct, performance and ethics for Nurses and Midwives (2008), NMC. (http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/)

10 We recognise that nurses and midwives who raise a genuine concern and act with the best of intentions and in line with the principles laid down in this guidance are meeting their professional responsibilities and adhering to the Code. Failure to report concerns may bring their fitness to practise into question and put their registration at risk.

11 A nurse or midwife has a professional duty of candour to be open and honest with a patient when something goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. The NMC alongside the General Medical Council (GMC) is in the process of consulting on its guidance on this. The draft guidance states that a nurse or midwife, must be open and honest with patients, with colleagues, and with employers. If something goes wrong when providing care, a nurse or midwife must report it whether or not it leads to actual harm.

Employers and management

12 It is not the role of the NMC to ensure that healthcare environments have safe and appropriate staffing levels.

13 Appropriate staffing is a collective responsibility of boards and executive teams. Nurses and midwives who hold senior positions, such as directors of nursing are not necessarily individually responsible for appropriate staffing, and staffing concerns do not automatically imply a fitness to practise concern about executive level nurses and midwives.

14 However the Code applies to every registered nurse and midwife whatever their role and scope of practice, including directors of nursing who are members of leadership teams responsible for safe staffing. Recent fitness to practise cases demonstrate that managers and directors can be sanctioned for presiding over poor care just as frontline nurses and midwives can be sanctioned for delivering poor care.

15 The Code states that nurses and midwives must uphold certain standards and values (see 8.1, 8.2, 8.3). A referral to the NMC could raise concerns about an individual's fitness to practise based on these standards and failing to raise concerns about staffing levels.

Staffing and fitness to practise

16 Our fitness to practise processes routinely test and weigh evidence about the responsibility of nurses and midwives and the impact of the care environment. While it is not the primary purpose of the NMC to ensure safe staffing levels, if a nurse or midwife is referred to the NMC on the basis of an allegation to do with staffing we may explore whether the registrant:

- raised concerns,
- assessed evidence of risk to patients,
- sought to mitigate risk.

17 Professional accountability means being prepared to account for difficult decisions and being able to give a robust account of acting on good evidence and in the best interest of patients.

18 Expectations of registrants will depend on their role and level of seniority. There may be higher expectations of a director of nursing in this regard than a ward manager, for example. However, all registrants should be aware of their individual and collective responsibilities.

19 If a nurse or midwife accepts responsibility for practice which is deemed to be beyond their capability and which has resulted in errors in practice, both the employee and employer are accountable. The employee for failing to acknowledge their limitations, and the employer for failing to ensure that the employee has the appropriate skills and knowledge.

Staffing and education

20 We set and monitor standards for education of nurses and midwives, which takes place in higher education institutions (HEIs) and in healthcare settings. Pressures on staffing can have an impact on practice placement settings, where they make it harder for nurses and midwives to dedicate time to supporting students. We require HEIs to monitor and mitigate risks to practice placements. If we have evidence that staffing levels may be affecting the training environment, we may ask education providers to investigate and provide assurance.

21 Our guidance places responsibility on nursing and midwifery students to raise concerns. *Guidance on professional conduct for nursing and midwifery students*, states that students should:

21.1 Inform their mentor, tutor or lecturer immediately if they believe that they, a colleague or anyone else may be putting someone at risk.

21.2 Seek help immediately from an appropriately qualified professional if someone for whom they are providing care has suffered harm for any reason.

21.3 Seek help from their mentor, tutor or lecturer if people indicate they are unhappy about their care or treatment.

Staffing and revalidation

22 From January 2016, nurses and midwives will have to undergo a process of revalidation every three years. Amongst other requirements, this will include showing that they have met the continuing professional development (CPD) standards and reflection on their practice, based on the requirements of the code, using feedback from service users, patients, relatives, colleagues and others.

23 Revalidation will ensure that nurses and midwives are regularly appraised, meet the standards of the Code, including those relating to raising concerns, and keep themselves up to date through CPD.

Working with others

24 We will inform the appropriate system regulator if we uncover concerns about a provider when we are investigating a fitness to practise referral or as part of our work in quality-assuring nurse training. Such concerns could include claims of unsafe staffing or the suppression of concerns raised by staff. We also encourage system regulators to inform us if they have concerns about the conduct or practice of individual nurses or midwives in respect of staffing or any other matter covered by the Code.

Annex 1

NMC Briefing

Appropriate staffing in health and care settings

What is the NMC's interest in staffing?

The importance of appropriate staffing was reinforced by the Francis Reports into failings at Mid Staffordshire NHS Foundation Trust in England. Appropriate staffing plays an important part in the delivery of safe and effective health and care. Safe staffing can be a complex area and has to take account of multiple factors. It must be matched to patients' needs and is about skill-mix as well as numbers, about other staff as well as nurses, and other settings as well as hospitals. It is the responsibility of health and care providers, which are regulated by system regulators in the four countries of the UK.

As a professional regulator it is not the job of the NMC to set or assure standards related to appropriate staffing.

However, it is a matter that has a bearing on what we do in a number of ways. This briefing sets out some of the regulatory considerations raised by this issue.

What does the Code for nurses and midwives say that relates to staffing?

The Code sets out the core standards of ethics and practice expected from nurses and midwives. It is intended to support registrants in ensuring their practice meets the standard required of the professions.

Environmental factors like staffing levels can affect nurses' or midwives' ability to uphold the values of the Code. The Code says that:

> **You must make the care of people your first concern, treating them as individuals and respecting their dignity**

This primary duty means that nurses and midwives should be vigilant about safety and quality:

> **You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care.**

It also means that they have a professional duty to act or speak out if quality and safety may be compromised:

> **You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.**
>
> **You must report your concerns in writing if problems in the environment of care are putting people at risk**

We require nurses and midwives to uphold nationally agreed standards as well as the Code:

> **You must inform someone in authority if you experience problems that prevent you working within this Code or other nationally agreed standards.**

For nurses and midwives in England, this would include guidance being developed by the National Institute for Health and Clinical Excellence (NICE) on safe staffing, and the National Quality Board/Chief Nursing Officer's 2013 guidance, *How to ensure the right people, with the right skills, are in the right place at the right time*.

What does the NMC's guidance on Raising Concerns say?

Our Raising Concerns guidance contains a list of examples of concerns that should be raised, including:

> **Issues to do with care in general, such as concerns over resources, products, people, staffing or the organisation as a whole**

The Code, senior registrants and staffing

Appropriate staffing is a collective responsibility of boards and executive teams. Registrants who hold senior positions such as director of nursing are not necessarily

individually responsible for appropriate staffing, and staffing concerns do not automatically imply a concern about executive level registrants. However, the Code states that:

> **As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.**

A referral to the NMC could raise concerns about an individual's fitness to practise based on the 'actions or omissions' of a senior registrant. Factors such as how staffing requirements were set, what mechanisms for monitoring these were in place and how well concerns were listened to would be important considerations in such a case.

We have always been clear that the Code applies to every registered nurse and midwife whatever their role and scope of practice, including directors of nursing who are members of leadership teams responsible for safe staffing. Recent fitness to practise cases demonstrate that managers and directors can be sanctioned for presiding over poor care just as frontline nurses and midwives can be sanctioned for delivering poor care.

Staffing and fitness to practise

Our fitness to practise processes routinely test and weigh evidence about the responsibility of nurses and midwives and the impact of the care environment. If a nurse is referred to the NMC on the basis of an allegation to do with staffing we may explore whether the registrant:

- raised concerns
- assessed evidence of risk to patients
- sought to mitigate risk

We understand that taking the right decisions about staffing on the ground is not always straightforward. For example, closing a ward to admissions may be in the best interests of patients already admitted and being treated, but may not be in the interests of those waiting for admission in A&E. Also, nurses may be advising operational managers rather than in direct charge. Professional accountability means being prepared to account for tricky decisions and being able to give a robust account of acting on good evidence and in the best interests of patients.

Expectations of registrants will depend on their role and level of seniority – there may be higher expectations of a director of nursing in this regard than of a ward manager, for example. However, all registrants should be aware of their individual and collective responsibilities.

Staffing and education

We set and monitor standards for the education of nurses and midwives, which takes place in higher education institutions (HEIs) and in healthcare settings. Pressures on staffing can have an impact on practice placement settings, where they may make it

harder for nurses and midwives to dedicate time to supporting students. We require HEIs to monitor and mitigate risks to practice placements. If we have evidence that staffing levels may be affecting the training environment, we may ask education providers to investigate and provide assurance.

Recruitment challenges and registrations

People must be registered with the NMC to practise as a nurse or midwife in the UK. We uphold the public interest by setting standards for entry to the register and being consistent in their application.

Registration is an important safeguard, but employers have the primary responsibility to make sure they employ staff with the right skills and experience in the right posts.

Staff shortages may lead employers to recruit overseas. Overseas nurses are a valuable resource for UK healthcare providers. It typically takes longer to register oversea applicants to the register. Although EU applications are usually quicker than non-EU applications, employers need to take responsibility in the interest of patients for checks on matters such as language competence that regulators cannot yet require as part of registration.

Regulators have challenging targets for completing registrations because our performance has a direct impact on the front line. But in order to protect the public we must not cut corners when it comes to making sure applicants are who they say they are, and are qualified to do the work of registered nurses and midwives.

However, there are things we can do to help:

- Provide clear guidance on the information we need to manage initial registrations and renewals
- Be proportionate – only require what is necessary to protect the public
- Process registrations as quickly as possible, consonant with taking the necessary steps to check eligibility
- Collaborate as appropriate with workforce bodies leading recruitment and returning campaigns

Working with others

We will inform the appropriate system regulator if we uncover concerns about a provider when we are investigating a fitness to practise referral or as part of our work in quality-assuring nurse training. Such concerns could include claims of unsafe staffing or the suppression of concerns raised by staff. We also encourage system regulators to inform the us if they have concerns about the conduct or practice of individual nurses and midwives in respect of staffing or any other matter covered by the Code.

NMC website address: http://www.nmc-uk.org/About-Us/Safe-staffing

References

2nd Francis report

DH (2013) Hard Truths

NQB/CNO (2013) How to ensure the right people, with the right skills, are in the right place at the right time.

Safety data (June 2014)

June 2014

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Socialist Health Association – SNSL(Org) 16 / Tystiolaeth gan Y Gymdeithas Iechyd Sosialaidd – SNSL(Org) 16

Safe nurse staffing levels in NHS Wales: a response from the Socialist Health Association (SHA) Cymru Wales

1. Purpose

This short paper offers the comments of the Socialist Health Association (Cymru Wales) on the Bill that seeks to ensure safe nurse staffing levels within Wales. It draws upon the expertise of the eclectic membership of SHA Cymru Wales. It repeats much of the advice given to Ms Kirsty Williams A.M. at an earlier stage in the process and is submitted to the Committee so that it too may be aware of its contents.

2. The SHA

SHA Cymru Wales is part of the UK Socialist Health Association (SHA) which has over 700 individual members (and many affiliated organisations). Its members have expertise, interest, or knowledge of, health care. It is affiliated to the Labour Party. It believes that health care systems should operate on the basis of meeting the needs of the population through a national, publicly owned, planned and delivered, system of care. SHA Cymru Wales has approximately 40 individual members, and several affiliated bodies with large memberships that share its aims.

The response comments upon aspects of the Bill. It also raises queries that arise from a reading of the Bill which it is hoped will be addressed.

3. Comments

3.1. SHA Cymru Wales understands the motivation for the Bill and has much sympathy with its aims. The best defence that the NHS can have against its detractors is that of offering consistently high quality care to its patients and their families who would be expected to be in the front line of defending the NHS from those who see it as an impediment to the relentless march of the alleged efficiency of profit- driven insurers and deliverers of health care. However, SHA Cymru Wales is not entirely clear how the precise legal vehicle chosen to ensure defined staffing levels will operate in practice.

3.2. Safe staffing levels must be a pre-requisite in ensuring that standards of care at all times meet all legal and professional requirements. Nurse staffing

levels in particular have received much attention as a result of recent enquiries - notably the Francis Enquiry related to Mid Staffs. However, SHA Cymru Wales would see the need for safe levels of staff to apply across a range of care professionals. In this regard we would wish the Bill to be so crafted that other care professionals would be brought within it purview as evidence to underpin required staff ratios / levels becomes available.

3.3. Even if the Bill is confined to nursing levels, determining what a safe nurse staffing level is at any point in time in different care settings (an acute "on take" medical ward or award caring for elective surgery) has to take into account the severity of the patient load and the needs of those patients. Thus the nursing staff that ought to be available for a given setting have to be adequate both in quantity and in quality (skill)[1].

3.4. It is understood that there is an evidence base for different ratios of staff to patients in different settings, but some of that evidence is from outside the UK. It is not clear whether the evidence base being cited is totally transferable to the UK / Welsh context. If the research that underpins specific ratios comes from non UK care settings, these may, or may not, generate similar care needs and nursing requirements for similar numbers of patients. It It is requested that great care is taken to understand the extent of the transferability of research data from any overseas settings.

It is less clear whether the evidence base in regard to skill levels is sufficiently well developed in all nurse settings but it would be hoped that the Bill would prompt urgent research to identify appropriate levels across all hospital and community settings.

3.5. It is noted that the safe level would apply on a shift by shift basis. It is not clear how sudden surges in workloads are to be accommodated within this legislation. Three very different approaches might be intended.
a) Is it intended that such surges would be met by deploying a "reserve" of trained staff (with the inevitable implication that current total levels of staff would need to be increased to maintain such a reserve?
b) Is it intended that "manageable" workloads would be adjusted to allow for the surge in unmanageable demand - with the result that elective work would act as the safety valve in the system?
c) Is it intended that calculated "safe levels" would be explicitly relaxed when high levels of sudden demand are placed upon one part of the hospital system - and if so how would this be permitted?.

We would expect the Bill to recognise the possible reactions that the service would need to take.

3.6. The Bill is silent with regard to the financial implications. SHA has received some views that the measure may be "self funding" in that any

[1] As ward setting become increasingly specialised it is important that staff have detailed knowledge of the care needs that arise from the precise clinical work being done. Nurses that have great experience of nursing patients recovering from major surgery may not be fully au fait with the needs of, say, elderly patients recovering from a stroke.

higher staff costs arising from the Bill will be covered by shorter lengths of stay and better outcomes. SHA Cymru Wales would have major concerns if this is indeed the expectation for it is reported that the Welsh average nurse: patient staffing ratio is currently 1:10 and the intended ratio is 1:8. This represents an increase in staffing of about 20% and thus an increase in cost of about the same percentage for a large part of the total nursing budget. Worse, were the predicted reduced lengths of stay to occur, far from releasing funds to pay for the higher staffing levels, there is every probability that this would lead to an increase in workload, rather than a reduction in cost unless very tight controls over admissions were introduced and the "spare capacity" gathered together in such as way as to allow it to be closed.

3.7. Following on from 3.6. a major concern of SHA Cymru Wales is that the Bill will lead to unintended consequences if NHS funding remains tight. If legally binding staffing levels are established, these will be high on the agenda of Boards, professionals and managers. Such staffing levels will be protected at all costs. In straightened times, staff cost centres that are not so protected will inevitably become prey to cost reductions. Medical staffing levels have some protection - as do the services that are outsourced and are protected by commercial legally binding agreements.

There is thus concern that other staffing levels that are not well protected - for example ambulance services, community staff, rehabilitationists, and diagnostic staff - will bear the brunt of providing funding to support nursing areas to which legally binding levels of staff apply. This may, perversely, drain staff from the very support services that assist nursing staff, so that nurses then find themselves undertaking tasks that were once the preserve of others.

3.8. It has been noted that the evidence that links safe nurse staffing levels to good care (using reduced mortality and other measures as evidence of such care) has been interpreted as emphasising the staff : patient ratio as being the main feature. It is accepted that if good staff levels are maintained, then staff might feel more secure and settled, leading in turn to lower staff turnover and high team spirit.

However, members believe that great importance should be attached to the continuity of care that a settled ward staff can deliver. Merely ensuring a defined staff : patient ratio in itself will not automatically provide for the same nurses to care for patients throughout their stay. Indeed, if the impulse becomes one of staffing wards to a given level, then there is a risk that the use of transient agency staff and staff re-deployed from other areas will be increase.

We would wish further work to be undertaken to understand what impact continuity of staffing has on care outcomes.

4. Questions

4.1. The Bill is clearly titled so as to refer to "nurse" staffing levels. SHA Cymru Wales assumes that this wording intends specifically to apply to

registered nurses only and not to staff sometimes seen as part of the nursing workforce at ward level, but who are not professionally qualified.

Is this understanding correct and if so, could this be made explicit within the Bill?

4.2. Again, in relation to the wording used, SHA Cymru Wales assumes that the Bill does not seek to bring midwifery staffing levels within the scope of the legislation. If so, SHA Cymru Wales is not persuaded that the omission of midwifery for any length of time can be justified. First, it is felt that the adequacy of staffing levels in this field can be predicted and assessed to a level similar to the (wider) range of nurse settings using an evidence base of comparable utility. Second, safe levels in this care area are just as important as in general nursing - especially given the nature of the care that is to be given to both mother and baby, the tragedies that arise from poor care, and the extremely high costs and that fall to be met by the NHS when avoidable harm arises from inadequate care. Third, workload in midwifery has some element of predictability that should aid the service in arranging adequate staff levels.

Could the Bill please allow for the inclusion of this service within its scope?

4.3. SHA Cymru Wales understands that much of the debate around the Bill has focussed on nursing care in acute hospital settings. SHA Cymru Wales however, would wish to see any "safe" level applying in all psychiatric care settings and would wish to be assured that this is so. In respect of 3.7. above SHA Cymru Wales would wish to see firm safeguards that protect investment in psychiatric settings and ensure that nursing levels here are set using appropriate metrics.

4.4. It is not clear whether the Bill intends that the safe staffing regime is to be applied to:

- NHS facilities operating in Wales only
- All health care facilities operating in Wales - public and private
- All health care facilities which provide services to Welsh patients as commissioned by the Welsh NHS.

SHA Cymru's reading of the Bill as drafted is that Welsh health bodies would need to apply the provisions of the Bill **both as providers** of NHS care **and as commissioners** of NHS funded care. Further, the logic of the Bill should also apply to ensure that all privately provided nursing care operating in Wales is "safe".

Clearly, if the Bill passes, NHS Wales should operate its own services in line with the Bill's requirements. However, NHS Wales as a commissioner of services (whether from the English NHS or the private sector) will then be expected to ensure that any services it acquires for its patients also operate to safe standards. Further, for privately funded nursing care, it would seem unwise to allow a two tier level of staffing to operate within the public and private sector; if safe levels are required, they must be required in both.

Could the Bill please make clear the application of its provisions to health providers serving Welsh patients - whether publicly or privately funded?

the call for evidence on the general principles of the Safe Nurse Staffing Levels (Wales) Bill

Annex A – Consultation questions

Please comment on as many of the questions as relevant to you/your organisation, providing an explanation of each answer given:

General

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

America and Australia have shown that mandated minimum nurse to patient ratios improved working conditions and facilitated the return to work of nurses.

Also the evidence from the pilot by Aneurin Bevan University Health Board of two wards over a 3 month period conducted at the end of 2012 of the 'perfectly resourced ward' provided useful evidence towards the argument for legislation.

By investing in the nursing establishment the cost reduction in agency and bank staff outweighed the increases and at the end of the period and there had been no overall increase in costs. This positively impacted upon staff sickness, reduction in clinical incidences and higher patient satisfaction. We would however have liked to have seen the Aneurin Bevan University Health Board pilot extended for a longer period of time as it was felt that a 3 month period was too short a time for evidence.

The Cardiff and Vale of Glamorgan Community Health Council would agree that there is a need for legislation, but would air on the side of caution of over regulation and tick box solutions.

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

Yes we would agree that the provisions in the Bill are the best way of achieving the Bill's overall purpose, but would wish to see assurances given when looking at the potential barriers at the next stage.

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

- *Staff are currently moved between wards, what monitoring is undertaken to ensure this does not impact on the ward which has had its staff reduced?*
- *What is the definition of an 'Acute' Ward?*
- *Staff will need to be ring-fenced on 'acute' wards to ensure they remain on that ward.*
- *Future plans impact on nursing levels and posts that may be held vacant because of this movement.*
- *There is a need to make the Ward Manager supernumerary so they are able to undertake their leadership role within the ward.*
- *Training issues ensuring that Ward Managers/Sisters in their 'Free to lead' capacity are able to share good practice to enable them to undertake their role must be addressed.*
- *It is noted that Patient acuity can impact on nursing to the remainder of the ward.*
- *Would not like to see staffing become a numbers game, it is about quality of care.*
- *Where are the quality measures – how will they be built in?*
- *Certain Healthcare Professionals have not been included in the Bill, so would seek reassurance that they are not included in the 'Nursing' compliment, especially if the Bill is eventually rolled out to include non-acute wards.*
- *Although children are included in the document the Bill only defines 'acute adult wards' – what about 16-17 years olds placed on acute adult wards?*

- Are there any unintended consequences arising from the Bill?

No comment.

Provisions in the Bill

The Committee is interested in your views on the individual provisions in the Bill and whether they deliver their stated purposes. For example, do you have a view on:

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

- *Poor levels of staffing impact on quality and working conditions, but overall responsibility lies with the Health Board.*
- *There should be uniform measures across all Health Boards.*
- *Where is the accountability – it is not explicit within the Bill?*

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

We would agree with this statement, but would note a word of caution that the minimum figure does not become the baseline. How will assurance be given that these are not applied as an upper limit? Does the acuity dependence tool ensure appropriate action in regard to ratios?

- the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

Staffing should be based on acuity of patients not just classification of ward.

- the requirement for the Welsh Government to issue guidance4 in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:

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

  We would fully endorse the need for guidance to be provided on the methods which NHS organisations employ to ensure appropriate nurse staffing. We would also like to see the Welsh Ministers reviewing the operation and effectiveness of the Bill at pre-determined times i.e. 6 monthly/annually.

  includes provision to ensure that the minimum ratios are not applied as an upper limit?5

  We would fully endorse the need for assurances that minimum ratios are not applied as an upper limit.

sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?6

Ensure that the Yearly Quality Assurance Statement is readily available for the public as well as ensuring that patient and their relatives are made aware of the numbers and roles of nursing staff on duty on the ward.

- includes protections for certain activities and particular roles when staffing levels are being determined?7

As stated in the Barriers to the Bill – we would seek reassurance that protection of Ward Manager are taken into account when determining staffing levels.

– the requirement for Welsh Ministers to consult before issuing guidance?8

As stated there is a requirement for Welsh Ministers to consult widely before issuing guidance.

– the monitoring requirements set out in the Bill?9

We would seek reassurance that Welsh Government will ensure accountability and ensure episodes, where Health Boards are lacking, are addressed.

– the requirement for each health service body to publish an annual report?10

Health service bodies are required to publish an Annual report.

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

As stated in the Barriers to the Bill we would seek assurance that Welsh Ministers will review the operation and effectiveness of the Bill.

Impact of existing guidance

Guidance exists in England and Wales that aims to ensure safe staffing levels. This includes the 'All Wales Nurse Staffing Principles Guidance' issued by the Chief Nursing Officer in 2012 and the 2014 NICE safe staffing guidelines for 'Adult in-patient wards in acute hospitals' in England.

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

Cannot comment on the existing guidance other than to argue the case for a Bill as current guidance has not improved staffing levels.

Powers to make subordinate legislation and guidance

The Bill contains provisions requiring Welsh Ministers to issue guidance to health service bodies about their compliance with the duty for staffing ratios, which will initially apply in adult acute wards. Sections 10A(5)(a) to (h) inserted by section 2(1) of the Bill set out the requirements for what this guidance must specify and include. The Bill also contains one provision which enables subordinate legislation to be made (section 10A(3) inserted by section 2(1)). This provision would confer powers on Welsh Ministers to amend the settings to which minimum staffing ratios will apply to extend it to settings other than adult inpatient wards in acute hospitals.

- Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

We would not want to see a change to minimum set staffing ratio's in future and would wish to see legislation extended to all wards.

Financial implications

- Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

We would wish to see dedicated enabling and identifiable resources made available to the Health Boards if the Bill is adopted, with Welsh Government monitoring the usage of that funding.

Other comments

- Do you have any other comments you wish to make about the Bill or specific sections within it?

- *If the Bill is introduced staff satisfaction surveys should be undertaken at pre-determined times to monitor the effectiveness on staff of the changes.*
- *P3 point 10(d) includes a detailed plan should read 'and include or take account of the guidance'.*
- *Although the CHC Advocacy Service within Cardiff and Vale have not received complaints associated with Staffing Levels, the programme of Secondary Care Monitoring has indicated that in certain acute and non-acute wards there appears to be a need for an increase in staffing levels, especially at night, due to patient acuity.*

Unite the Union (in Health) Professional Team
128 Theobald's Road, Holborn, London, WC1X 8TN
T: [redacted] | E: [redacted]

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Unite – SNSL(Org) 18 / Tystiolaeth gan Unite – SNSL(Org) 18

Unite the Union Response to:

Safe Nurse Staffing Levels (Wales) Bill

This response is submitted by Unite. Unite is the UK's largest trade union with 1.5 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport, local government, education, health and not for profit sectors.

Unite represents in excess of 100,000 health sector workers. This includes eight professional associations - British Veterinary Union (BVU), College of Health Care Chaplains (CHCC), Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Hospital Physicists Association (HPA), Medical Practitioners Union (MPU), Mental Health Nurses Association (MNHA), Society of Sexual Health Advisors (SSHA).

Unite also represents members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

Len McCluskey
General Secretary

1. Introduction

1.1. Unite welcomes the opportunity to respond to the Consultation on the *Safe Nurse Staffing (Wales) Bill (3).*

1.2. As part of this response, Unite has used its ongoing routes throughout the organisation to hear back the views of members in Wales and these have informed our response.

2. Is there a need for legislation?

2.1. There have been several highly publicised reports over recent years which have, to a lesser or greater degree, implicated both registered nurse staffing levels and skill mix in producing adverse outcomes for patients. The two most high profile reports are the Mid Staffordshire NHS Foundation Trust Public Inquiry, more commonly known as the Francis Report (2013) and the more local Trusted to Care Report, more commonly known as the Andrews Report (2014) which looked at standards of care in the Princess of Wales Hospital, Bridgend. Both of these evidenced not only individual failures of care, but also the failure of management to understand the importance of appropriate staffing levels for registered nursing staff.

2.2. There is a large body of available evidence which links registered nurse staffing levels to better patient outcomes in terms of speedier admission to discharge and reduced morbidity and mortality. Large scale studies have been undertaken in the United States and elsewhere which further demonstrate this (Shekelle, 2013, Spetz et al 2013 and Wallace 2013). However it is important to note that not all studies conducted to date agree that legislation is required, with some suggesting instead that empowering professionals is the key to getting the skill mix and staffing levels right.

2.3. NICE in England have reemphasised the role played by the registered nurse in patient care and have published guidance in England which is designed to alert both ward and general managers to trigger points which could indicate that patients might be at increased risk. The threshold is one registered nurse to eight patients. However, Unite supports the 4:1 campaign for a ratio of one registered nurse to four patients (http://4to1.org.uk/campaign-statement/). In Wales the current ratio is 10.5 patients per nurse, despite guidance from the CNO that the ratio should be 7 patients per registered nurse. This clearly demonstrates that guidance alone is not effective and consequently Unite would support the introduction of legislation around minimum staffing levels.

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

3.1. Unite considers that the provisions in the Bill do not support the overall purpose as set out in Section 1.

3.2. Numbers alone do not guarantee safe patient care, and there is no clarity around how working conditions are to be improved for other staff, nor indeed, any definition of who the "other staff" are.

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

4.1. Unite considers that the potential barriers include;

4.1.1. The financial circumstances that Health Boards in Wales find themselves in due to the impact of austerity.

4.1.2. The restriction of these provisions to Acute wards only could lead to reduced registered nurse levels in satellite hospitals as services seek to shore up the Acute sector.

4.1.3. The monitoring arrangements include data already provided to the Welsh Government. Some of which are not wholly indicative of poor care but could in fact relate to the level of patient need with those who are more seriously ill requiring a higher nurse/patient ratio.

4.1.4. The monitoring arrangements suggested have the potential to add a new layer of management to oversee progress in each Health Board.

4.1.5. Workforce planning tools, in the context of staffing, are generally retrospective, which means that by the time the data is received, the shift is completed.

4.2. The Bill, as is, does not address these potential consequences.

5. Are there any unintended consequences arising from the Bill?

5.1. The Bill could lead to additional expenditure being used to support the rostering of registered nurses, with expenditure removed from other front line clinical services.

5.2. In addition as care is increasingly undertaken in the community there is a risk that a focus on staffing levels in the acute will deplete nurse staffing levels in this setting.

5.3. A third area concerns the ethics of using incentives to meet statutory requirements. If RRPs are used to recruit to ensure that hospitals meet their statutory requirements this could leave other services with a worsening skill mix/staffing levels. I also think that we should argue against overseas recruitment as we are moving staff from, for example, Spain and Portugal, where there is a weaker economy, to the UK. This will create skill mix issues there – where there is even more challenge on the cost of training staff. Ultimately we need to do more on workforce planning and training here.

5.4. There may be some transition issues as the pool of trained staff will take time to emerge.

6. Provisions in the Bill

6.1. There is, as yet, no clarity around the phrase “all reasonable steps” in the context of maintaining minimum staffing levels. We would be concerned that this could include for example, staff being asked to give up annual leave/study leave to support the ward rota. We would expect all staff to be rewarded according to Agenda for Change terms and conditions.

6.2. There is no evidence that there will be consequences for any Health Body which fails to comply.

6.3. Restricting the legislation to Acute wards is disappointing for our members working in satellite hospitals who are caring for patients who, only a couple of years ago would have been regarded as being acute. Indeed, this seems to imply that the service provided for these frequently very vulnerable patients, is not as important.

6.4. Guidance and consultation on such guidance poses difficulties. Definitive guidance, likely to come from the CNO office, is already available, so it is unclear how reinforcing this will add to patient protection. The guidance is already there. With this in mind it is hard to see how we can expect an effective consultation on guidance which has already been issued and, unfortunately, not adhered to.

6.5. The monitoring requirements, as stated above, include information which is already available for the most part. Relating this to staffing levels/skill mix will not be straightforward unless a retrospective study is also undertaken to establish a baseline of previous practice.

6.6. The requirement to produce an annual report need not be an onerous as the Health Boards already produce annual quality statements, and a report on staffing levels could be part of this. It would be hard to justify a separate document.

7. Impact of existing guidance

7.1. As stated earlier the guidance is already there – it would seem to be reasonable to make this a duty on Health Boards to comply, rather than create another piece of legislation which only addresses a small amount of the staffing constraints in the NHS in Wales.

7.2. The guidance at the moment is ineffective as Health Boards do not choose to make Registered Nurse staffing levels a priority.

22 January 2015

This response is submitted on behalf of Unite the Union by:

Rachael Maskell

Head of Health
Unite the Union

For further information about this response please contact;

Richard Munn
Lead Officer for Health
Unite the Union
1, Cathedral Road
Cardiff CF11 9SD

Submitted to: SeneddHealth@Assembly.Wales

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Bwrdd Cynghorau Iechyd Cymuned Cymru
Ystafell 3.3
33-35 Heol y Gadeirlan
CAERDYDD
CF11 9HB

Board of Community Health Councils in Wales
Suite 3.3
33-35 Cathedral Road
CARDIFF
CF11 9HB

22 January 2015

Ms Sian Giddins
Deputy Clerk
Health & Social Service Committee
National Assembly for Wales
Cardiff Bay
Cardiff

Dear Ms Giddins

HSSC Inquiry – Safe Nurse Staffing Levels (Wales) Bill

As requested, herewith is the evidence of the Board of Community Health Councils in Wales in relation to the above inquiry.

I look forward to attending the meeting of the Health and Social Care Committee that is scheduled for 12th February in order to speak to this submission and take questions from Assembly Members. I would be happy to hear from you should you need to speak with me before then.

Yours sincerely,

PMS

Peter Meredith-Smith
Director
Board of Community Health Councils in Wales

Ffôn/Tel: [redacted] / [redacted]

Board of Community Health Councils in Wales

Health & Social Care Committee Submission: Safe Nurse Staffing Levels (Wales) Bill	
SUBJECT:	Safe Nurse Staffing Levels (Wales) Bill
STATUS:	Board of CHC Submission to H&SCC Committee (Final Draft)
CONTACT:	Peter Meredith-Smith, Director of the Board of CHCS in Wales
DATE:	22nd January 2015

INTRODUCTION

This submission to the Health and Social Care Committee of the National Assembly for Wales, relating to the Safe Nurse Staffing Levels (Wales) Bill, is submitted by the Board of Community Health Councils in Wales in advance of their attendance at a meeting of the committee scheduled for 12th February 2015.

Supported by the Board of Community Health Councils (CHCs), the 8 CHCs across Wales represent the interests of and act as the independent voice for the citizens of Wales regarding their NHS services. They fulfil these functions by: (a) continuously engaging with the populations they represent and the health service providers serving those populations, (b) systematically monitoring and scrutinising local health services, through service inspections and visits, (c) supporting the public to engage in consultations about major NHS service changes that have an impact on them and (d) enabling users of the NHS in Wales to raise concerns about the services they receive, primarily by providing an Independent Advocacy Service.

The views represented in this submission are informed by feedback from individual CHCs across Wales relating to this issue of interest to the Health and Social service Committee, and from data and information derived from the Board of CHCs' information systems (pertaining the monitoring of the core functions of the CHCs across Wales).

GENERAL COMMENTARY

The CHCs support the proposal to introduce this legislation. There is a general feeling amongst those who have contributed to this response that without the force of law, against the present background of severe financial restraint within NHS Wales, the well-publicised staffing pressures across our health services will continue. It is likely that this will have a consequent negative impact on the safety, efficacy and quality of patient care.

Feedback from CHC members who are involved in service visiting and scrutiny programmes frequently indicate a health service landscape across Wales that is characterised by a system that is under extreme strain. It is apparent to our members that nursing staffing shortfalls are often contributory factors to this unacceptable situation.

Having clarity about agreed safe staffing levels in clinical areas across the NHS in Wales would assist our members and staff to more effectively fulfil their health service scrutiny role.

We believe that the making of this legislation would be a key step towards strengthening public confidence in the safety of their NHS services.

The three most helpful sources of information available to the Board of CHCs to inform its views on the nursing staffing situation across the NHS in Wales are data and information derived from the CHCs':

- Continuous Engagement Work
- Service Monitoring and Scrutiny programmes
- Independent Advocacy Service

On the basis of what we learn from our continuous engagement and service monitoring and scrutiny work, it is possible to offer in general terms an overview of what the users of NHS services that we engage with "want" from their NHS. In summary, we are frequently told that they want:

- Services that keep them safe
- Reasonable quality of care
- Care delivery that assures that they are treated with respect
- Their privacy and dignity to be assured whilst in hospital
- Good engagement with clinical staff (being kept informed about their care)
- To be assured that services are safely staffed

Quite clearly, appropriate and safe levels and skill mix of nursing staffing are necessary if these expectations are to be met.

We are also able on the basis of our engagement work to provide a summary of how, in general terms, patients describe their experiences of the NHS. Typical perspectives offered being:

- Despite evident pressures, services are generally adequate
- When things go wrong nursing staffing problems are often significant
- When things go wrong it is not generally the "fault" of individual nurses
- Problems are usually a consequence of the situation that nurses are in
- Lack of nursing workforce stability leads to a lack of continuity of care

Specific themes directly related to nursing staffing that often feature in feedback from our members or the patients and relatives that we engage with include:

- Suggestions that nurses are often not readily available to provide assistance "at the time that they are needed"
- Nursing staff are constantly "rushed with too much to do"
- Nurses seem to be on duty for very long periods and often seem to be very tired at the end of what appear to be very long shifts
- Health Care Support Workers are often more visible that Registered Nurses

The Board of CHCs in Wales' *Concerns and Complaints Database* is another source of information relevant to this debate. Although the explicit issues of "nursing shortages" or "inadequate nursing staffing levels" do not feature in the data available to us, other information derived from the database may provide a "proxy indication" of staffing deficiencies across the NHS in Wales.

A recent review of information derived from the database indicated that, of the concerns or complaints logged on the system, 14% related to nursing in secondary care. Most of those complaints, in general terms, related either to failures or shortcomings in the "Clinical Practice" (61% of complaints reviewed) or "Poor Engagement or Communication" between clinical staff and patients (19% of complaints reviewed).

Drilling down into these overarching areas highlighted five specific areas of concern or complaint raised by those who contact us. They being:

- Failures in the Fundamentals of Care
- Failures in Treatment Delivery
- Negative Staff Attitudes
- Lack of Information
- Compromised Privacy & Dignity

Again, these are areas of service shortcoming or failure that can directly relate to staffing pressures (be they inadequate staffing numbers or skill mix problems).

The CHCs that have contributed to this response have also provided specific examples of serious issues that they have or are dealing with, that have inadequate nursing staffing as one of the root causes of significant clinical or service failings. For reasons of patient confidentiality, it would not be appropriate to detail these herein.

SPECIFIC QUESTIONS POSED BY THE HEALTH AND SOCIAL SERVICES COMMITTEE

Are the provisions in the Bill the best way of achieving the Bill's overall purpose?

The CHCs who offered a view agreed that the provisions in the Bill are generally the best way of achieving the Bill's overall purpose.

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

The CHCs have offered the following suggestions:

- Inadequate numbers of staff "in the system" to support an acceptable nursing staffing model
- Inadequate numbers of student nurses "in training" to support future nursing staffing needs
- Poor workforce planning throughout the NHS in Wales
- Inadequate financial resources to support an adequate nurse staffing model
- An approach to workforce planning (and workforce management) in Wales that prioritises financial planning over a needs-based workforce

Are there any unintended consequences arising from the Bill?

Because the proposed law would only require safe staffing on adult inpatient wards in acute hospitals, against the background of resource pressures referred to above, there is a risk that HNS managers would denude staffing levels in other clinical areas to ensure that adult in-patient wards are compliant with the law. This would lead to potentially unsafe staffing levels in clinical areas that are not subject to the legislation.

There is a risk that establishing "safe staffing levels" could set a "ceiling on staffing numbers" that could fetter appropriate workforce development – i.e. minimum "safe" staffing levels do not always ensure the best quality care (which may require higher numbers of staff than minimum numbers).

Provisions in the Bill

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

- The CHCs fully support this provision.

- There must be a standardised methodology for approaching this across all Health Boards. Workforce planning needs to be strengthened from the bedside to the Board (and across Wales).

- The LHB Chief Executive should be clearly identified in the legislation as the accountable officer regarding this provision.

- Safe staffing is not easy to quantify and monitor using current systems and approaches employed in Wales; such systems need urgent development.

- Safe staffing should be included as a key "quantifiable" LHB Health Board performance measure, open to scrutiny in public Board meetings.

- The Francis Report was very specific on the need for enhanced "Ward to Board" ownership and communication of front-line care and performance. Such clear measures could help in addressing this Board-level communication and scrutiny.

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

- CHCs agree with this but "reasonable steps" need to be defined to avoid ambiguity.
  .
- The sanctions for failure in this duty need to be clear.

The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

- Safe staffing should be a legal requirement in all clinical environments, not just adult inpatient wards (this should include community and primary care environments too).

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

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

  The CHCs very strongly endorse the requirement for guidance to be provided as stated. Welsh Ministers should keep such guidance under continuous review.

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

  The CHCs fully support this and regard such an approach as essential (see relevant comments above).

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

  Such transparency is crucial. It will engender public confidence. Some CHCs have suggested that the *Annual Quality Assurance Statement* could provide a vehicle for informing the public regarding this in general terms .

  It is also crucial that patients and their relatives are made aware of the numbers of staff that should be on duty against those that are actually on duty "in real time" at ward level (and other clinical area level). The CHCs would be happy to explore how they might support LHBs to keep the public informed reading safe staffing levels.

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

  These protections are absolutely essential and are fully supported by the CHCs. The activities listed in the Bill must be considered and properly accounted for in workforce planning methodologies.

The requirement for Welsh Ministers to consult before issuing guidance?

This is supported by the CHCs.

The requirement for each health service body to public an annual report?

This is supported by CHCs. Such transparency is essential if public confidence is to be maintained.

The requirement for Welsh Ministers to review the operation and effectiveness of the Act?

Supported. CHCs would like firm assurance that Welsh Ministers will review the operation and effectiveness of the Bill. If legislation is agreed, CHCs would expect that regular close monitoring of implementation takes place with regular performance reports provided, with a formal evaluation being undertaken. There should be active involvement from professional and academic bodies to support the development and monitoring of any measures.

View on the effectiveness and impact of existing guidance?

Current guidance has not sufficiently improved staffing levels; hence the need for legislation. We would expect agreed nurse/patient ratios to be met

consistently, although there may be an argument for sensible tolerances to be built into any workforce planning and management systems. Where agreed nursing staffing ratios are not met, we would expect to see urgent recovery plans developed and implemented, and for Welsh Government to take action if problems persist.

Balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

No specific comments.

Financial implications of the Bill.

Quite clearly, if nursing staffing establishment have been under-resourced to date, there may be additional cost implications as a consequence of this legislation. However, this could be significantly offset by a concomitant reduction in spend on nursing bank and agency staff and overtime. Additionally, we might expect reduced sickness levels amongst nurses as staffing levels improve (so mitigating the extra costs that might be associated with the introduction of this legislation). Finally, we are aware that international evidence indicates a positive impact on treatment and care outcomes when nursing staffing levels are optimum. It has been argued that this too contributes to cost reduction across the "whole system" of healthcare.

Other Issues

No additional comments.

- ENDS-

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from North Wales Community Health Council – SNSL(Org) 20 / Tystiolaeth gan Cyngor Iechyd Cymuned Gogledd Cymru – SNSL(Org) 20

Please find the North Wales Community Health Council (NWCHC)'s response to the Safe Nurse Staffing Levels (Wales) Bill consultation below. Please note that comments are from individual members of the NWCHC.

- *What a Bill Kirsty Williams has introduced. Extremely worthy aims and enormous challenges for the Health Boards in Wales and obviously an effective level of staffing by trained nurses, care assistants and doctors is a prerequisite for good care in our health system. Good Patient Outcomes must be the aim of every health establishment but I wonder how difficult it will be to attract sufficient nursing personnel and contain the undoubted massive increase in costs within already strained financial budgets without an increase in taxation or by achieving a higher level of efficiency within the health service. Obviously the best answer would be to reduce the number of patients by promoting better health, combating obesity and penalising those people who consume too much alcohol and smoke. We are becoming a much more unhealthy nation and unfortunately a much older one.*

- *It would be great if Kirsty's aims come to fruition.*

- *Please express the North Wales Community Health Council's support for the principles of safe nurse staffing levels.*

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Healthcare Inspectorate Wales – SNSL(Org) 21 / Tystiolaeth gan Arolygiaeth Gofal Iechyd Cymru – SNSL(Org) 21

Response to consultation on the Safe Nurse Staffing Levels (Wales) Bill

About Healthcare Inspectorate Wales:

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

Our response:

General

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

  Healthcare Inspectorate Wales (HIW) strongly supports the objectives of the Bill to:

  - Enable the provision of safe nursing care to patients at all times;
  - Improve working conditions for nursing and other staff;
  - Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

  Most of our findings relating to staffing come from our dignity and essential care inspections and our mental health inspections. During the current year

we have published 30 dignity and essential care inspections. We have identified issues relating to staffing in half of these.

The issues identified have tended to relate to shortfalls in staffing numbers, difficulties encountered with recruitment and retention and a high degree of reliance on bank and agency staff. In three instances we sought immediate assurance from the Health Boards that the issues were being addressed.

Guidance on the principles underpinning safe nursing were issued to Health Boards in Wales by the Chief Nursing Officer in April 2012 and acuity tools for adult acute hospital wards were introduced in April 2014. Progress is being made, but we continue to find that implementation is inconsistent: not all ward areas have set their own local safe minimum staffing levels and wards are not regularly using an acuity tool to reflect and match staffing numbers to patient needs.

It is possible that legislation in this area may help to provide the focus and momentum necessary to embed this guidance fully in daily practice.

We are pleased to see that the proposals recognise that it is important to look beyond simple ratios. Safe staffing is dependent upon more than numbers: it must also reflect the need of the patients, the environment in which care is being provided, the skills and experience of the staff members and the proportion of care provided by bank and agency staff who may have limited experience in the area. We therefore support the intention to ensure that minimum staff ratios are seen as a baseline and not as a target.

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

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

The availability of Registered Nurses and the ability to recruit is likely to be a barrier. The Bill will need to be supported by effective workforce planning and provision of education to ensure that there are sufficient trained and experienced nurses available to meet the identified needs.

It is right to recognise that determining appropriate staffing levels is not straightforward and cannot be done by applying a simple formula. However, the need to balance professional judgement, and the constantly changing nature of demand, will make it difficult to be specific in the guidance. This in turn will make it challenging to communicate clearly to patients how the staffing in place meets the guidance. It will also make it more challenging to hold health bodies to account for delivery against the legislation.

The current financial environment facing Health Boards is likely to present challenges for them in meeting safe staffing levels at all times

- ***Are there any unintended consequences arising from the Bill?***

  It is possible that, at least in the short term, attempts to maintain staffing numbers would significantly increase the proportion of bank and agency. This may impact on continuity and quality of care.

  There is a possibility that Health Boards may move resource from areas without statutory guidance in order to meet the requirements of the guidance in acute adult wards. For example, we have already identified staffing problems in NHS Mental Health inspections and have highlighted these in all reports on these inspections published so far this year.

Provisions in the Bill

The Committee is interested in your views on the individual provisions in the Bill and whether they deliver their stated purposes. For example, do you have a view on:

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

  There is a lack of clarity over the intended scope of this provision. It would be helpful to establish whether the provision is intended to encompass care commissioned from providers in other administrations such as England or commissioned from/ provided in independent care settings.

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

- ***the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?***

  We have also found staffing challenges evident in mental health wards and in community hospitals which would not be covered by the initial guidance. We therefore welcome the provision to enable guidance to be provided in these and other settings.

  However, given our comments about scope in relation to provision 1(a) we would question whether the reference to “settings within the NHS” is too restrictive and whether this might more appropriately be “settings in which NHS care is provided”.

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

  - ***Sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing***

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

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

  We support the need for openness and transparency in communicating to patients.

- ***Includes protections for certain activities and particular roles when staffing levels are being determined.***

  We have conducted three inspections where the Ward Sister has had to undertake a direct care role due to staffing difficulties and had therefore found difficulty in undertaking their role in providing leadership, co-ordination of care and support to other staff. This can result in poor communication, lack of attention to care planning and documentation and also weak discharge planning. We therefore welcome inclusion of protection for the supernumerary status of persons providing supervisory clinical expertise and leadership functions.

  We also welcome the recognition of the need to make time available for training. A number of our inspections have highlighted incomplete mandatory training. We have also highlighted instances where staff have not been able to be released for training or have completed training in their own time.

- ***the monitoring requirements set out in the Bill***

- ***the requirement for each health service body to publish an annual report***

  We welcome the recognition within the Bill that each of the above requirements could be incorporated within existing monitoring and reporting processes. It is important that the requirements of the Bill do not impose additional and excessive bureaucratic overheads on health bodies.

Impact of existing guidance

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

  The existing guidance applies only to general medical and surgical wards. It is a useful baseline, but is not sufficient on its own and needs to be applied alongside acuity tools and professional judgement. Currently the acuity tool is mandated twice a year. Although it could be used more frequently we do not see this often during our inspections and its use could be encouraged further.

Powers to make subordinate legislation and guidance

- ***Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?***

  The balance proposed appears to provide sufficient flexibility for the substantive guidance to be readily amended in light of new research and understanding and in responses to changes in the delivery of care.

Financial implications

- ***Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?***

  HIW is not in a position to comment on the financial implications of the Bill.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Public Health Wales – SNSL(Org) 22 / Tystiolaeth gan Iechyd Cyhoeddus Cymru – SNSL(Org) 22

Public Health Wales's Response to the Consultation on the Safe Nurse Staffing Levels (Wales) Bill

December 2014

Consultation Questions

General:

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

The safety of patients is paramount and any move to improve this further is to be welcomed. However, nurses are part of a multidisciplinary team and there are also other factors to consider such as training, education etc, in the delivery of quality care.

If legislation is agreed there needs to be consideration for the local needs of patients, and flexibility in the application of the legislation to allow for local interpretation. The complexity and needs of patients vary, and setting a minimum standard for one area, may not be sufficient for another area if they have very complex patients with a high level of need.

The Mid Staffordshire Public Enquiry identified that having minimum staffing levels in place does not necessarily improve patient outcomes. Overall we feel the focus should be on ensuring the correct levels of all staff (including nurses) to meet the needs of patients in order for them to gain their optimal outcome, rather than legislation.

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

The purpose of the Bill sets out to provide "safe nursing care to all patients at all times" but does not then define what "safe nursing care" is. It is therefore difficult to determine whether the overall purpose of the Bill is met by the provisions set out within it.

The focus needs to remain on the ability for professionals to use their judgement and flexibility in the use of staffing to meet the needs of patients. Workforce and acuity tools are already in place across Wales as are a number of core principles set out by the Chief Nursing Officer which includes a suggested staff to patient ratio.

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

The main barrier to the implementation of the Bill is having sufficient numbers of qualified nurses available to meet the suggested minimum staffing levels.

In addition to the increasing aging population in Wales and increase in chronic conditions we are increasingly working within an austere environment. Previous growth in workforce numbers has stopped and traditional roles and means of delivery are not going to provide the workforce of the future. The future workforce needs to be adaptable and wok within the principles of Prudent Healthcare.

Consideration needs to be given to future workforce planning and related training and education.

4. **Are there any unintended consequences arising from the Bill?**

The main consequence arising from the Bill is that the professional judgement of nurses could be compromised in relation to the need and acuity level of patients. This could result in less flexibility to move staff around wards to respond to changing needs and demands.

There is a concern that the "minimum staffing level" could become accepted as the "maximum staffing level" despite guidance stating that this should not be the case. It will be difficult to monitor the application of the levels and adopting the minimum as the maximum levels could put increasing stress on clinical staff.

The introduction of minimum levels could also result in staff being moved from other settings such as community to cover acute wards (where the

levels apply). Settings such as the community traditional have less staff than the acute setting and as a consequence of the Bill could be further depleted causing an impact on their ability to care for patients within their own homes, and potentially having a negative impact on the acute setting.

Another unintentional consequence could be the diversion of money away from other professional groups such as physiotherapists to fund additional nursing posts in order to meet the minimal requirement. As previously stated nurses are one group of professions within a multidisciplinary team and any diversion away from other members would have a detrimental impact on patients' outcomes and length of stay.

Provisions in the Bill:

The Committee is interested in your views on the individual provisions in the Bill and whether they deliver their stated purposes. For example, do you have a view on**:**

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

Within Health Boards and Trusts there are robust systems for monitoring the levels of staffing. This is regularly reported to the Health Boards Board and also Welsh Government.

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

As previously mentioned nurses need to be able to exercise professional judgement in relation to their patients' needs and complexity.

7. **the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only**

If the intention is at some stage to roll out this duty further across the NHS consideration needs to be given to needs of patients in different settings such as community. Patients nursed at home are often highly complex but do not have nurses with them 24 hours/ day, and are often visited by many members of the Multi Disciplinary Team.

Should this duty be extended in the future to include those patients funded under NHS funded nursing care or NHS Funded Continuing Health Care, within Nursing Homes this would cause a significant increase in workload for Health Boards and they would not have the direct authority to influence nursing staffing levels.

8. **the requirement for the Welsh Government to issue guidance4 in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:**
   - **sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing (including methods set out in section 10A(6) inserted by section 2(1) of the Bill)?**

As previously mentioned there is concern that the Bill will lower the value of nurses professional judgement which may result in organisations not being able to respond to changes in patient acuity or complexity of need.

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

As previously stated there is concern that the minimum levels proposed will be applied as a maximum. This does not allow for any flexibility to change depending on the professional judgement of the nurses, relating to patient complexity and acuity.

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

Overall we support the move to greater transparency and openness although care should be given to how this reflects the complexity and needs of the patients.

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

Different hospitals provide different services, with different demands, so it would be difficult to protect certain activities and roles.

9. **the requirement for Welsh Ministers to consult before issuing guidance?**

We welcome the opportunity for Health Boards and Trusts to comment on any guidance before issuing.

10. The monitoring requirements set out in the Bill?

Current arrangements for monitoring staffing levels within NHS hospitals are adequate and appropriate.

11. the requirement for each health service body to publish an annual report?

All NHS organisations are currently required to publish an annual report. This could include information on staffing levels for acute hospitals.

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

Whilst a level of scrutiny is to be welcomed, as this can assist in improving patient safety, examining data alone can be misleading. Data needs to be looked at within context on the area it relates to and a triangulated with additional quality indicators/ information. There is also concern about the lack of definition in relation to the measures – without clear definition or explanation it is unclear how the measures would be monitored.

Impact of Existing Guidance

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

The CNO and Nurse Directors have a programme of work in place relating to collating evidence on staffing levels that improves patient outcomes. There is also regular monitoring of progress against the Nurse Staffing Principles by the Welsh Government.

Powers to make subordinate legislation and guidance

1. **Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?**

The Bill requires a clear definition of the "provision of safe nursing care".

Financial implications

1. **Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?**

It is likely that the implementation of the Bill will incur significant costs, not just in relation to additional staff costs but also in relation to administration. In austere times any additional expenditure could have an adverse impact on the delivery of services. Consideration needs to be given as to whether the outcome proposed (improving patient safety) could be achieved by other means.

Other comments

1. **Do you have any other comments you wish to make about the Bill or specific sections within it?**

As previously stated, nurses are one professional in a much larger multidisciplinary team. If minimal levels are to be set for nurses, then the question needs to be asked as to whether they should be set for all professional groups?

Concern remains that the professional judgement of nurses will be undermined in relation to the need and complexity of their patients, and the flexibility to move nurses around to respond to changing demands. Not all wards are the same, or require the same level of patient to staff ratio. What is important is ensuring that there are sufficient nurses when and where patients need them, to meet their care needs.

Whilst we support the principle of having a minimal nurse staffing level, there has to be recognition that this will not necessarily improve the quality of care provided, and may in fact indirectly, due to cost and reallocation of resources, have a detrimental effect on care received by patients.

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Richard Jones – SNSL(Ind) 01 / Tystiolaeth gan Richard Jones – SNSL(Ind) 01

As a Registered Nurse with 44 years experience of working in or with The NHS in Wales, I would ask the Health & Social Services Committee to give this extremely crucial Bill your utmost consideration to ensure that your constituents are given the legal right to Safe Nurse Staffing Levels, when they are being cared for by the NHS in Wales.

I have always believed that the People of Wales deserved the highest standards of health care being delivered by appropriate numbers of Registered Nurses and trained Healthcare Support Workers, and would want the National Assembly of Wales to be in the vanguard across the UK in ensuring that Safe Nurse Staffing Levels are enshrined within the legal framework of law.

I believe that your constituents will overwhelmingly support the introduction of such an important law and respectfully ask that all members of the committee support the passage of this Bill into law.

Regards

Richard Jones

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Wendy Hughes – SNSL(Ind) 02 / Tystiolaeth gan Wendy Hughes – SNSL(Ind) 02

I fully support the Bill to make safe nurse staffing levels in Wales mandatory as it would have a direct impact on safer patient outcomes, reduced mortality, giving nurses the time to dedicate to safe and quality care.

Wendy Hughes

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Susan Fletcher – SNSL(Ind) 03 / Tystiolaeth ganSusan Fletcher – SNSL(Ind) 03

Hello.

I am concerned about the working conditions for nurses regarding staff levels. This appears to be prevalent all across Wales whichever type of nurse you speak to in a variety of care settings. I write to you today about acute mental health settings as this is what I am familiar with.

There appears a general consensus that safe staffing equals a set amount of nurses and healthcare support workers on duty on any particular shift. This is not so, having a 'certain number' of staff on duty does NOT make for safe staffing. For example, the number of staff on shift does not reflect skill mix or the amount of highly acute patients upon the ward and pertinent to mental health the unpredictably of patients. In mental health there are certain patients that require being within eyesight observations or within arms distance from a member of staff.

To prevent patients being over-sedated and maintain a good quality of life the minimum therapeutic doses of psychotropic medication is prescribed and administered. As excellent practice this is alongside other therapeutic interventions the 'negative side' to this an increase in aggression (particularly in dementia patients) and challenging behaviour. This manifests itself in a number of ways, for example,as verbal and physcial aggression towards staff, other patients and visitors to the ward. Other behaviours include, sexual disinhibition, undressing in public places, invading personal space of others, collecting and hoarding items that they see, destructive behaviour (ie. ripping hand rails off walls), throwing furniture and smaller items, toileting themselves in inappropriate places, climbing furniture, answering and breaking telephones, taking away paperwork away from staff that staff is writing on and refusing to hand back and destroying it. This list is not exhaustive.

Staff planners are utilised effectively but if a member of staff is in a meeting and four members of staff have to take a very aggressive patient to the toilet (it takes a minimum of 3 staff legally to restrain a patient who is aggressive) who has been incontinent of urine of faeces (and only 5 staff in total being on duty on shift) there is no-one to observe the other patients who are within eyesight observations or within arms distance of a member of staff. Nurses are then working illegally, after many pleas and negotiations for more staff, which mostly gets ignored and statements such as " That's the nature of the ward" and "You are not utilising your staff effectivley" becomes the 'catchphrases' on the unit and thus nurse morale becomes broken. Some nurses have to go without a break on a 12 hour shift and quite often do not even get to use the toilet as the ward will be left even more unsafe.

There are a lot of fantastic nurses but they are not miracle workers, after patients are washed, dressed and had medication and breakfast in the morning they do not sit still in chairs all day, they are not inanimate objects. Nurses have to give care in very challenging circumstances anyway due to the nature of the illnesses the patients suffer. Many nurses, however hard they strive cannot deliver the high standards of nursing care they wish to deliver due to the ridiculously unsafe conditions they have to work in. It's fine if everything is going according to plan and nothing serious happens but if a major incident occured it will be the nurse in charge's responsibility and not those who created unsafe conditions for nurses to work in. In a lot of cases it is illegal for a nurse to simply turn up for duty due to the unsafe conditions they will be working in. Many nurses carry on regardless because the patients are important to them and making a difference to sick peoples' lives.

Please vote for the Safe Nurse Staffing Bill. At some point in your life you may have had or will have nurses looking after you or your family members. Let us nurse you safely and give of our best to you and your loved ones.

Kind Regards

Sue Fletcher

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Professor Anne Marie Rafferty CBE – SNSL(Ind) 04 / Tystiolaeth gan Yr Athro Anne Marie Rafferty CBE – SNSL(Ind) 04

Health and Social Care Committee: Written Evidence on Safe Staffing Bill, Anne Marie Rafferty CBE

I am making my comments in my capacity as Professor of Nursing Policy, King's College, London and researcher in the area of workforce, specifically, nurse staffing and patient outcomes, not as a member of an organisation or stakeholder.

General

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

Safe staffing legislation could provide a helpful vehicle to set and ensure adherence to 'best practice' staffing guidelines in the absence of responsiveness within the system to changes in demand such as acuity and dependency and alignment with capacity. There is significant evidence of variation in workload management and workforce planning practices and methodologies across England (see attached papers) including historical methods with consequent negative impacts on nurses and patients where these fall short. The chronic understaffing of wards had serious impacts on the welfare of patients and nurses and poses a major threat to the sustainability of the NHS. History suggests that nurse staffing patterns are sensitive to the economic cycle of 'boom and bust' and that variations are unrelated to demand or patient need though this is not the only driver of staffing as the draft Bill indicates. Setting staffing levels on a safe, secure and scientific footing would bring benefits to patients, carers, the multidisciplinary team and the system as well as nurses making it attractive to enter and remain in as a career. Safe staffing should, however, be seen as part of a wider Human Resources strategy with clear accountability for staffing at Board level and not an isolated event or end in itself.

Are the provisions in the Bill the best way of achieving the Bills overall purpose?

England has implemented 'safe staffing guidance' but stopped short of setting ratios. The provisions made in the proposed Bill have much in common with those proposed and currently being implemented in England but Wales would be unique in going a step further by enacting legislation. It is too soon to appreciate the impact of implementing safe staffing guidance in acute wards in England but setting out provision in legislation would provide a strong signal that the Welsh Assembly was serious about supporting safe staffing. It would also provide an opportunity to compare the impacts of different approaches to safe nurse staffing across devolved administrations, especially England, which has implemented guidance on the issue by comparing the differential implementation as a natural experiment.

What, if any, are the potential barriers to implementing the provisions of the Bill?

The Bill takes account of the potential costs but savings that can be off set against those costs, including the costs of operationalising implementation. Costs are not simply economic but have to be considered in terms of the costs of not acting and the calculus of human suffering associated with poor staffing, which is well documented in The Report of the Francis Inquiry referred to in the background Memorandum. Barriers beyond the economic to implementation could be recruitment in 'difficult to recruit to areas' both in geographical and sub-speciality terms. Recent experience of implementing safe staffing guidance suggests that staff may be redeployed from better to less well staffed areas and this may not prove popular with staff but could form part of an evaluation and options appraisal framework underpinning the review outline in the Bill.

Are there any unintended consequences in the Bill?

These seem to be well covered in the Bill

Provisions in the Bill

The duty on health services bodies and holding Boards accountable for staffing decisions is essential for safeguarding standards and providing stewardship of resource. Specifically, the public reporting of data is and risk management surrounding decisions are central to ensuring public accountability for safe staffing. The wording on the other two provisions has changed from minimum to safe staffing and I concur with the provisions as outlined. It is prudent to adopt an incremental approach to implementation since different environments and specialities may have needs and demands.

The requirement for the Welsh government to issue guidance setting out methods and other items outlined in the draft Bill are positive in supporting the enactment of the Bill. The requirement to review the operation of the Act is to be welcomed.

Impact of existing guidance

It is too early to tell but liaising closely with experience in England would be crucial to guiding implementation of provisions made.

Powers to make subordinate legislation and guidance

These elements seem well covered at present.

Financial implications

I have no further evidence to add beyond that outlined in the Explanatory Memorandum.

Other comments

Only that safe staffing needs to go hand in hand with good human resource practice and be capable of responding to changes in patient acuity and dependency not seen as a 'magic bullet' or isolated event. Everything depends on how it is implemented at local level. The opportunity for

implementing safe staffing as a complex intervention through a randomised controlled trial, for example, could also be considered.

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

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

Summary

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

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

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

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

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Introduction

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

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

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

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*Members are listed at end of paper

Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing, Philadelphia, PA, USA (Prof L H Aiken PhD, D M Sloane PhD, M D McHugh PhD); **Centre for Health Services and Nursing Research, Catholic University Leuven, Leuven, Belgium** (L Bruyneel MS, K Van den Heede PhD, Prof W Sermeus PhD); **Faculty of Health Sciences, University of Southampton, Southampton, UK** (Prof P Griffiths PhD); **Department of Health Care Management, WHO Collaborating Centre for Health Systems, Research and Management, Berlin University of Technology, Berlin, Germany** (Prof R Busse MD); **Faculty of Nursing, University of Athens, Athens, Greece** (M Diomidous PhD); **Department of Health Policy and Management, University of Eastern Finland, Kuopio, Finland** (Prof J Kinnunen PhD); **Institute of Nursing and Midwifery, Faculty of Health Science, Jagiellonian University Collegium Medicum, Krakow, Poland** (Prof M Kózka PhD); **Leuven Biostatistics and Statistical Bioinformatics Centre, KU Leuven, Leuven, Belgium** (Prof E Lesaffre PhD); **Nursing and Healthcare Research Unit, Institute of Health Carlos III, Madrid, Spain** (M T Moreno-Casbas PhD); **Florence Nightingale School of Nursing and Midwifery, King's College, London** (Prof A M Rafferty PhD); **Institute of Nursing Science, Basel, Switzerland**

(R Schwendimann PhD); **School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland** (Prof P A Scott PhD); **Medical Management Centre, Department of Learning, Informatics, Management and Ethics, Karolinska Institutet, Stockholm, Sweden** (Prof C Tishelman PhD); **and Scientific Institute for Quality of Healthcare, Radboud University Nijmegen Medical Center, IQ Healthcare, HB Nijmegen, Netherlands** (T van Achterberg PhD)

Correspondence to: Prof Linda H Aiken, Center for Health Outcomes and Policy Research, University of Pennsylvania School of Nursing, Philadelphia, PA 19104, USA **laiken@nursing.upenn.edu**

association between large proportions of auxiliary nurses (which implies a low overall mix of nursing skill) and high mortality in hospitals in England. Rafferty and colleagues[9] noted that low hospital mortality in England after common surgeries was associated with nurses each caring for few patients. Research in Belgium[10] found hospital mortality after cardiac surgery was significantly lower in hospitals with lower patient to nurse staffing ratios and in hospitals with a higher proportion of nurses with bachelor's education than in hospitals with higher staffing ratios and fewer nurses with bachelor's education. Likewise, data from a Swiss study[11] suggested significantly increased surgical mortality associated with inadequate nurse staffing and poor nurse work environments.

This nascent but growing scientific literature about nursing outcomes in Europe is complemented by research from North America showing that improved hospital nurse staffing is associated with low mortality.[12] Additionally, growing evidence exists that bachelor's education for nurses is associated with low hospital mortality.[13–17]

Research into nursing has had little policy traction in Europe compared with the USA where almost half the 50 states have implemented or are considering hospital nurse staffing legislation.[18,19] On the basis of findings showing improved outcomes for patients, the Institute of Medicine recommended that 80% of nurses in the USA have a bachelor's degree by 2020,[20] and hospitals have responded with preferential hiring of bachelor's nurses. European decision makers might be unclear about the applicability of research done in individual countries in Europe or North America to Europe more generally. Specifically, scientific evidence is needed to inform the continuing European Union policy debate about harmonisation of professional qualifications for nurses.[21]

RN4CAST, funded by the European Commission, was designed to provide scientific evidence for decision makers in Europe about how to get the best value for nursing workforce investments, and to guide workforce planning to produce a nurse workforce for the future that would meet population health needs.[22] Investigators of the study of 488 hospitals in 12 European countries noted substantial variation between countries with regards to patient to nurse workloads and the percentage of nurses qualified at the bachelor's level.[23] These variations in nursing resources are important predictors of patients' satisfaction with their care and in nurses' assessments of quality and safety of care.[24]

We aimed to assess whether differences in patient-to-nurse workloads and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data are associated with variation in hospital mortality after common surgical procedures. The nine countries are representative of variation in Europe with respect to organisation, financing, and resources given to health services. The study's findings provide previously unavailable evidence to guide important decisions about improvement of hospital care in Europe in the context of scarce resources and health-system reforms.

Methods

Study setting

Data for this observational study were from administrative sources on hospital patients and characteristics of hospitals, and surveys of 26 516 bedside care professional nurses done in 2009–10 in 300 hospitals in nine European countries (Belgium, England, Finland, Ireland, the Netherlands, Norway, Spain, Sweden, and Switzerland). Similar patient discharge data consistent with the patient mortality protocol were not available for three RN4CAST countries (Germany, Poland, and Greece). The study included most adult acute care hospitals in Sweden, Norway, and Ireland, and geographically representative samples of hospitals in the other countries.[22]

The European study protocol received ethical approval by the lead university, Catholic University of Leuven, Belgium. Each grantee organisation in the nine participating countries received ethical approval at the institutional level to do nurse surveys and analyse administrative data for patient outcomes. We also obtained country level approvals to acquire and analyse patient outcomes data.

Outcomes

We obtained patient mortality data for postoperative patients discharged from study hospitals in the year most proximate to the nurse survey for which data were available, which ranged between countries from 2007 to 2009. Our analyses included patients aged 50 years or older with a hospital stay of at least 2 days who underwent common general, orthopaedic, or vascular surgery, and for whom complete data were available for comorbidities present on admission, surgery type, discharge status, and other variables used for risk adjustment. We used the procedures published by Silber and colleagues[25] to define common surgeries and comorbidities (appendix). We selected common surgeries for study because almost all acute hospitals undertake them, risk adjustment procedures for surgical patients have been well validated, and risk-related comorbidities can be more accurately distinguished for surgical patients than for medical patients because they are present at admission by contrast with complications arising in the hospital. We coded data in all countries with a standard protocol by use of variants of the ninth or tenth version of the International Classification of Diseases.[26] Researchers are not able to validate coding in administrative hospital discharge files. Countries can have validation protocols for administrative data but this information is not available. Findings of studies in Europe show that routinely collected administrative data predict risk of hospital death with discrimination similar to that obtained from clinical databases.[27] We restricted

See Online for appendix

hospitals to those with 100 or more targeted patients. The primary outcome measure was whether patients died in the hospital within 30 days of admission. Risk adjustment variables included patient age, sex, admission type (emergency or elective), 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission, which are included in the Charlson index.[28]

Nurse staffing and education measures were derived from responses to surveys of nurses in each hospital with the RN4CAST nurse survey instrument.[22] The term nurse refers to fully qualified professional nurses. In all countries except Sweden, hospitals were sampled in different regions, after which a variable number of adult medical and surgical wards were randomly sampled in each hospital, depending on hospital size (between two and six wards in each hospital in every country except England, where all wards were sampled, up to a maximum of ten). All nurses providing direct patient care in these wards were surveyed. In Sweden, all hospitals and all medical and surgical wards were included by sampling all medical surgical nurses nationally.

In the RN4CAST study, nurse staffing for each hospital was calculated from survey data by dividing the number of patients by the number of nurses that each nurse reported were present on their ward on their last shift, and then averaging ratios across all nurse respondents in each hospital. Low ratios suggested more favourable staffing. Collection of data for hospital nurse staffing directly from nurses avoided differences in administrative reporting methods across countries and ensured that only nurses in inpatient care roles are counted. We measured nurse education by calculating the percentage of all nurses in each hospital that reported that the highest academic qualification they had earned was a bachelor's degree or higher.

Statistical analyses

We estimated associations between nurse staffing and nurses' education and 30 day inpatient mortality for patients before and after adjusting for additional hospital characteristics and risk-adjusting for differences in patient characteristics. Hospital characteristics included country, bed size, teaching status, and technology; we defined high technology hospitals as those that undertook open heart surgery or organ transplantation. We included the hospital nurse work environment, measured by the Practice Environment Scale of the Nursing Work Index, as a control variable like in previous studies of nursing and mortality.[15] Patient characteristics included age, sex, admission type, type of surgery (with 43 dummy variables for the specific surgery types), and presence of 17 comorbidities (appendix). Because individual patient outcomes were modelled with a combination of hospital and patient characteristics, we estimated the effects of different characteristics with population average models using a generalised estimating approach and random intercept models using hierarchical linear modelling. Both approaches took into account patients being nested within hospitals, and in both types of models we included dummy variables to allow for unmeasured differences across countries. Because the results were almost identical, and the estimated effects of nursing characteristics were the same in terms of their size and importance, we show only the generalised estimating results. We tested for the effects on mortality of an interaction between nurse staffing and education, which was not significant and is not included in the results. All statistical analyses were done with SAS (version 9.2).

Role of the funding source

The sponsors of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results

We obtained mortality data for 422 730 patients; the number of hospitals and surgical discharges varied across countries (table 1). The percentage of surgical patients who died in the hospital within 30 days of admission was 1·3% across the nine countries combined, and was lowest in Sweden and highest in the Netherlands (table 1).

Response rates for surveys of nurses ranged from less than 40% (2990 of 7741) in England, to nearly 84% (2804 of 3340) in Spain, and averaged 62% (29 251 of 47 160) across the nine countries. Differences in both nurse staffing and nurse education were large both between

	Number of hospitals	Mean discharges per hospital (range)	Deaths/discharges (%)
Belgium	59	1493 (413–4794)	1017/88 078 (1·2%)
England	30	2603 (868–6583)	1084/78 045 (1·4%)
Finland	25	1516 (175–3683)	303/27 867 (1·1%)
Ireland	27	738 (103–1997)	292/19 822 (1·5%)
Netherlands	22	1419 (181–2994)	466/31 216 (1·5%)
Norway	28	1468 (432–4430)	518/35 195 (1·5%)
Spain	16	1382 (186–3034)	283/21 520 (1·3%)
Sweden	62	1304 (295–4654)	828/80 800 (1·0%)
Switzerland	31	1308 (158–3812)	590/40 187 (1·5%)
Total	300	1308 (103–6583)	5381/422 730 (1·3%)

Only hospitals with more than 100 surgical patient discharges were included in the analyses. Data shown are for discharged patients for whom information about 30 day mortality, age, sex, type of surgery, and comorbidities were complete. Data were missing for those characteristics for less than 4% of all patients.

Table 1: **Hospitals sampled in nine European countries with patient discharge data, numbers of surgical patients discharged, and numbers of patient deaths (RN4CAST data)**

countries and between hospitals within each country (table 2). In Spain and Norway, all nurses had bachelor's degrees. The mean age of the patient sample was 68 years (SD=10); table 3 shows other patient characteristics. Of 439 800 patients studied more than 50% had orthopaedic surgeries, whereas roughly four in ten underwent general surgeries, and slightly less than one in 10 underwent vascular surgeries. The most common comorbidities were diabetes without complications, chronic pulmonary disease, metastatic carcinoma, and cancer.

	Nurse staffing (patients to nurse)		Nurse education (% of nurses with bachelor's degrees)	
	Mean (SD)	Range	Mean (SD)	Range
Belgium	10·8 (2·0)	7·5–15·9	55% (15)	26–86%
England	8·8 (1·5)	5·5–11·5	28% (9)	10–49%
Finland	7·6 (1·4)	5·3–10·6	50% (10)	36–71%
Ireland	6·9 (1·0)	5·4–8·9	58% (12)	35–81%
Netherlands	7·0 (0·8)	5·1–8·1	31% (12)	16–68%
Norway	5·2 (0·8)	3·4–6·7	100% (0)	100–100%
Spain	12·7 (2·0)	9·5–17·9	100% (0)	100–100%
Sweden	7·6 (1·1)	5·4–9·8	54% (12)	27–76%
Switzerland	7·8 (1·3)	4·6–9·8	10% (10)	0–39%
Total	8·3 (2·4)	3·4–17·9	52% (27)	0–100%

Means, SDs, and ranges are estimated from hospital data—eg, the 59 hospitals in Belgium have a mean patient-to-nurse ratio of 10·8, and the patient-to-nurse ratio ranges across those 59 hospitals from 7·5 to 15·9. Similarly, the 31 hospitals in Switzerland have, on average, 10% bachelor's nurses, and the percent of bachelor's nurses ranges across those 31 hospitals from 0% to 39%.

Table 2: **Nurse staffing and education in nine European countries**

	Number (%)
Men	189 815 (45%)
Emergency admissions	141 584 (34%)
Inpatient deaths within 30 days of admission	5381 (1·3%)
Surgical categories	
General surgery	162 974 (39%)
Orthopaedic surgery	220 301 (52%)
Vascular surgery	39 455 (9%)
Comorbidities	
Cancer	15 297 (4%)
Cerebrovascular disease	7400 (2%)
Congestive heart failure	10 274 (2%)
Chronic pulmonary disease	28 373 (7%)
Dementia	5744 (1%)
Diabetes with complications	6478 (2%)
Diabetes without complications	35 450 (8%)
AIDS/HIV	50 (0%)
Metastatic carcinoma	17 911 (4%)
Myocardial infarction	12 002 (3%)
Mild liver disease	5953 (1%)
Moderate or severe liver disease	1354 (0%)
Paraplegia and hemiplegia	2043 (1%)
Peptic ulcer disease	2323 (1%)
Peripheral vascular disease	12 452 (3%)
Renal disease	10 085 (2%)
Connective tissue disease or rheumatic disease	6962 (2%)

Table 3: **Characteristics of surgical patients (n=422 730) in the study hospitals**

Table 4 shows results of modelling the effects of the two nursing factors (staffing and education) on mortality after adjustment for differences across countries in mortality (in the partly adjusted model) and for differences in the full set of potentially confounding factors (in the fully adjusted model). After we considered severity of illness of the patients and characteristics of the hospitals (teaching status and technology) in the adjusted model, both nurse staffing and nurse education were significantly associated with mortality (table 4). The odds ratios (ORs) suggest that each increase of one patient per nurse is associated with a 7% increase in the likelihood of a surgical patient dying within 30 days of admission, whereas each 10% increase in the percent of bachelor's degree nurses in a hospital is associated with a 7% decrease in this likelihood. These associations suggest that patients in hospitals in which 60% of the 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 the nurses had bachelor's degrees and nurses cared for an average of eight patients. We worked out this 30% reduction (reduction in mortality by a factor of 0·70) by applying (and multiplying) the reciprocal of the OR associated with nurse staffing across two intervals (from eight to six patients per nurse) and the OR associated with nurse education across three intervals (from 60% to 30%)—ie, $1/1{\cdot}068 \times 1/1{\cdot}068 \times 0{\cdot}929 \times 0{\cdot}929 \times 0{\cdot}929 = 0{\cdot}703$.

Discussion

Our findings shows that an increase in nurses' workload increases the likelihood of inpatient hospital deaths, and an increase in nurses with a bachelor's degree is associated with a decrease in inpatient hospital deaths (panel). Findings of the RN4CAST study showed more

	Partly adjusted models		Fully adjusted model	
	OR (95% CI)	p value	OR (95% CI)	p value
Staffing	1·005 (0·965–1·046)	0·816	1·068 (1·031–1·106)	0·0002
Education	1·000 (0·959–1·044)	0·990	0·929 (0·886–0·973)	0·002

The partly adjusted models estimate the effects of nurse staffing and nurse education separately while controlling for unmeasured differences across countries. The fully adjusted model estimates the effects of nurse staffing and nurse education simultaneously, controlling for unmeasured differences across countries and for the hospital characteristics (bed size, teaching status, technology, and work environment), and patient characteristics (age, sex, admission type, type of surgery, and comorbidities present on admission). OR=odds ratio.

Table 4: **Partly and fully adjusted odds ratios showing the effects of nurse staffing and nurse education on 30 day inpatient mortality**

variation in hospital mortality after common surgical procedures in European hospitals than is generally understood. Variation in hospital mortality is associated with differences in nurse staffing levels and educational qualifications. Hospitals in which nurses cared for fewer patients each and a higher proportion had bachelor's degrees had significantly lower mortality than hospitals in which nurses cared for more patients and fewer had bachelor's degrees. These findings are similar to those of studies of surgical patients in US and Canadian hospitals in which similar measures and protocols were used.[14,15]

Our finding that each 10% increase in the proportion of nurses with a bachelor's degree in hospitals is associated with a 7% decrease in mortality is highly relevant to the recent decision by the European Parliament (Oct 9, 2013) to endorse two educational tracks for nurses—one vocational and one higher education.[21] In view of the RN4CAST findings, the goal of standardised qualifications of professionals as expressed in the Bologna process[29] is a long way off from being achieved. Our findings support the recent EU decision to recognise professional nursing education within institutions of higher education starting after 12 years of general education. However, our results challenge the decision to continue to endorse vocational nursing education after only 10 years of general education because this training might hamper access to higher education for nurses in some countries—eg, Germany where no nurses in the 49 hospitals studied in RN4CAST had a bachelor's degree.[23]

The RN4CAST finding that improved hospital nurse staffing is associated with decreased risk of mortality might be inconvenient in the present difficult financial context and amid health-system reforms to shift resources to community-based settings. Nevertheless, this study is the largest and most rigorous investigation of nursing and hospital outcomes in Europe up to now, and has robust results. Our findings reinforce those of smaller studies in Europe,[8–11] and a large body of international published work.[12,14] Our data suggest a safe level of hospital nurse staffing might help to reduce surgical mortality, as called for by the European Surgical Outcomes Study.[3]

Beyond improvements in care, investments in nursing could make good business sense. In the USA, each US$1 spent on improvements to nurse staffing was estimated to return a minimum of $0·75 economic benefit to the investing hospital, not counting intangible benefits.[30] Furthermore, a move from less qualified licensed vocational nurse hours to qualified professional nurse hours is estimated to save lives and money.[31] Improved nurse staffing in US hospitals is associated with significantly reduced readmission rates, which is compelling in view of financial penalties in 2013 to 2225 hospitals for excessive readmissions.[32] Although hospital finance and payment policies differ between the USA and Europe, the underlying goal of better value for investments is the same.[33]

Panel: Research in context

Systematic review

We searched PubMed for original research articles published in English between Jan 1, 1985, and Aug 10, 2013, with the search terms (separately and in combination): "nursing", "staffing", "administrative data", "outcomes", "mortality", "European Union", and "cross-national" and "international." We also did a manual search based on bibliographies of papers we found. Studies linking nursing and clinical patient outcomes were restricted in Europe to one country studies[8–11] and to research in North America.[12–17] In Europe, cross-national studies assessing how hospital nursing affects patient outcomes are restricted to assessment of outcomes based on patient or nurse report rather than objective clinical outcomes.[24]

Interpretation

We report the first study to use detailed information about nursing workforce such as staffing and education level to investigate how these factors affect patient mortality across countries in Europe. We relied on unique data from direct-care nurses collected with a common method across many hospitals in different countries. We used a standardised approach across countries to measure and adjust the risk of mortality on the basis of administrative records. Findings of our analysis of 300 hospitals in nine countries show that an increase in nurses' workloads by one patient increases the likelihood of inpatient hospital mortality by 7%, and a 10% increase in bachelor's degree nurses is associated with a decrease in odds on mortality by 7%. These findings emphasise the risk to patients that could emerge in response to nurse staffing cuts and suggest that an increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

Our study has several limitations. We assessed one outcome, mortality, and only in patients undergoing common general surgeries. Our measure of education relied on each country's definition of bachelor's education for nurses, which differs by country. Our global measure of nurse staffing shows nurse workloads across all shifts, and might be skewed in some hospitals if nurses working at night (when patient-to-nurse ratios are higher than in the day) responded to our survey at different rates than nurses on day shifts. The models we used to measure associations allowed us to control for unmeasured differences in mortality across countries and for measured differences across patients and hospitals, but unmeasured confounding factors at the individual, hospital, and community level could have affected our results. We cannot link the care of individual patients to individual nurses. Additionally, mortality outcomes for patients were taken from the year that most closely matched the nurse survey year, but because of lags in patient data availability, the two data sources were not always perfectly aligned. Finally, our data are cross-sectional and provide restricted information about causality.

Additional research in Europe is needed to establish whether our multicountry findings can be replicated for high mortality surgeries and for medical patients; and whether in Europe, like in the USA, nursing is related to a range of adverse outcomes that contribute to high costs. Longitudinal studies of panels of hospitals would be especially valuable to help to establish causal associations between changes in nursing resources and outcomes for patients. Comparative effectiveness research is needed to identify what workforce investments return the greatest value, and under what circumstances. Research beyond simple mortality outcomes would be welcome to help to establish standards of care by which performance of health-care organisations could be more fully assessed. In a context of widespread health-system redesign and reforms, increased funding for studies of health workforce investments could result in high-value health care.

In summary, educational qualifications of nurses and patient-to-nurse staffing ratios seem to have a role in the outcomes of hospital patients in Europe. Previous findings from RN4CAST show that patients are more likely to express satisfaction with hospital care when nurses care for fewer patients each.[24] To add to these findings, our data suggest that evidence-based investments in nursing are associated with reduction in hospital deaths.

Contributors

LHA, WS, LB, MM, PG, RB, and MTM-C did the literature search. LHA, WS, DMS, KVdH, AMR, PG, MM, RB, AS, and CT designed the study. WS, LHA, KVdH, RB, PG, MD, JK, MK, MTM-C, AMR, RS, AS, CT, and TVA collected data. LHA, DMS, LB, MM, WS, and TVA analysed data. All of the authors contributed to data interpretation, writing, and revision of the report.

RN4CAST consortium

Walter Sermeus (Director), Koen Van den Heede, Luk Bruyneel, Emmanuel Lesaffre, Luwis Diya (Belgium, Catholic University Leuven); Linda Aiken (Codirector), Herbert Smith, Douglas Sloane (USA, University of Pennsylvania); Anne Marie Rafferty, Jane Ball, Simon Jones (UK, King's College London); Peter Griffiths (UK, University of Southampton); Juha Kinnunen, Anneli Ensio, Virpi Jylhä (Finland, University of Eastern Finland); Reinhard Busse, Britta Zander, Miriam Blümel (Germany, Berlin University of Technology); John Mantas, Dimitrios Zikos, Marianna Diomidous (Greece, University of Athens); Anne Scott, Anne Matthews, Anthony Staines (Ireland, Dublin City University); Ingeborg Strømseng Sjetne (Norwegian Knowledge Centre for the Health Services) Inger Margrethe Holter (Norwegian Nurses Organization); Tomasz Brzostek, Maria Kózka, Piotr Brzyski (Poland, Jagiellonian University Collegium Medicum); Teresa Moreno-Casbas, Carmen Fuentelsaz-Gallego, Esther Gonzalez-María, Teresa Gomez-Garcia (Spain, Institute of Health Carlos III); Carol Tishelman, Rikard Lindqvist, Lisa Smeds (Sweden, Karolinska Institute); Sabina De Geest, Maria Schubert, René Schwendimann (Switzerland, Basel University); Maud Heinen, Lisette Schoonhoven, Theo van Achterberg (Netherlands, Radboud University Nijmegen Medical Centre).

Conflicts of interest

We declare that we have no conflicts of interest.

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Nurse staffing and education in Europe: if not now, when?

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By financing the RN4CAST project,[1] the European Union (EU) showed its concern about patient safety: the project's aim was to measure the value of nursing care. Such measurement has long been recognised as challenging. Drawing on discharge data from nine of the 12 RN4CAST countries for more than 420 000 patients aged 50 years or older, Linda Aiken and colleagues[2] in *The Lancet* show that an increased workload of one patient per nurse was associated with an increase in the odds of surgical inpatient mortality, within 30 days of admission, by 7% (odds ratio 1·068, 95% CI 1·031–1·106). Patients in hospitals in which 60% of the nurses had a bachelor's degree, who looked after an average of six patients, had a mortality rate almost 30% lower than patients in hospitals where only 30% of the nurses had a bachelor's degree and cared for an average of eight patients. The investigators included hospitals from two countries of the European Free Trade Association (Switzerland and Norway) and seven of the 28 countries in the EU. The EU is a vast area linked by bilateral agreements in which the prevailing objective of a European market has recently introduced a social dimension to address inequalities (eg, workers' rights and safe working conditions);[3] patients can circulate freely to get the best care, and nurses can travel for optimum occupational working conditions.[4,5]

To search for associations between mortality and nurse staffing and educational level, the investigators developed a European study with an ecological design. The analytical methods applied were consistent with the state of knowledge in the specialty, and researchers introduced the necessary control variables to account for differences in the environment in which patients and nurses were surveyed. The investigators recognise the limitations of the study and possible effects on their results. However, the findings are consistent with those already documented in the USA[6] and Europe,[7,8] and contribute to a body of knowledge that should provide information for health-care policies of several countries.

The study is the first pan-European public report to monitor how many patients were managed by nurses during their last work-shift. This method is more accurate than the nurse–population ratio, which often includes midwives too,[9] and is more informative than other measures (eg, number of full-time equivalent nurses), which provide information about how many nurses are in employment, but not how many work in the clinic. The data suggest important variability within and between countries, possibly because no homogeneous standards exist, even in countries with a public health service where patients should receive a standard level of nursing care and nurses should work in similar conditions. The study includes information about how decisions with respect to university nursing education were indicative of the composition of daily nursing staff and their patients, which raises an important question about variability despite the tenure in Europe, since 1999, of the Bologna Process. This declaration includes more than 47 EU, European Free Trade Association, and other countries (ie, European higher education area), and aims to harmonise university education.[10]

Results of the study by Aiken and colleagues[2] show that the skills of the staff acquired at university create the conditions for safe staffing. The investigators report a 7% reduction in patient mortality for every 10% increase in the number of nurses with bachelor's degrees. The continuing presence of graduate nurses in the staff (ie, at least one per shift), able to guarantee surveillance and clinical judgment, creates a protective environment for surgical patients.

The data refer to the years 2007–10, so the researchers did not document the situation immediately before the EU economic crisis or the effects of austerity

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measures introduced in several countries.[11] If the study was replicated, the results might be different; in many countries, austerity measures have caused a reduction in the number of nurses at patients' bedsides.[12] The nurses remaining at the bedside have large workloads, with negative results on patients, and as a result the public image of nurses is worsening in several countries.[13]

Recession has highlighted the cost of graduate education for nurses; therefore, health-care organisations could be attracted by vocationally trained nurses, in the belief that costs might be lower and the nurses more effective. Paradoxically, and notwithstanding the support for research (including from the EU's Seventh Framework Programme), in November, 2013,[5] the EU decided to approve two pathways for nursing education: a vocational school or training after 10 years of general education; and a higher education or university pathway after 12 years of education, which is a change from the previous directive that envisioned at least 12 years of general education before nursing education.

The study by Aiken and colleagues[2] provides evidence in favour of appropriate nurse–patient ratios and also provides support for graduate education for nurses. Whether these findings are used to inform health-care policy or how they are implemented in practice will be interesting to see. We fear that the evidence here will not be tried and found wanting, but will rather be deemed too expensive to act upon.

Alvisa Palese, Roger Watson
Department of Clinical and Biological Sciences, University of Udine, Udine 33100, Italy (AP); and Faculty of Health and Social Care, University of Hull, Hull, UK (RW)
alvisa.palese@uniud.it

We declare that we have no competing interests.

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Caring nurses hit by a quality storm

Low investment and excessive workloads, not uncaring attitudes, are damaging the image of NHS trusts, argue the authors of groundbreaking research into Europe's nurse workforce

Nurses are getting a bad press in England for being 'uncaring' at a time when nursing in the United States is benefiting from favourable public perceptions, supportive policy initiatives and the largest and most talented pool of applicants to nursing schools in history.

Interestingly, both countries had nursing commissions that released reports in 2010 heralding the future of nursing; the responses could not have been more different.

The US Institute of Medicine's report called for nurses' scope of practice to be broader, for nurses to lead innovative care models, for at least 80 per cent of the nurse workforce to have bachelor's degrees, and the number with doctoral degrees to be doubled by 2020. Media coverage was positive and initiatives to implement recommendations came swiftly.

In contrast, much of the media response to the Prime Minister's Commission on the Future of Nursing and Midwifery accused nurses of having uncaring attitudes and scoffed at recommendations for them to receive bachelor's education.

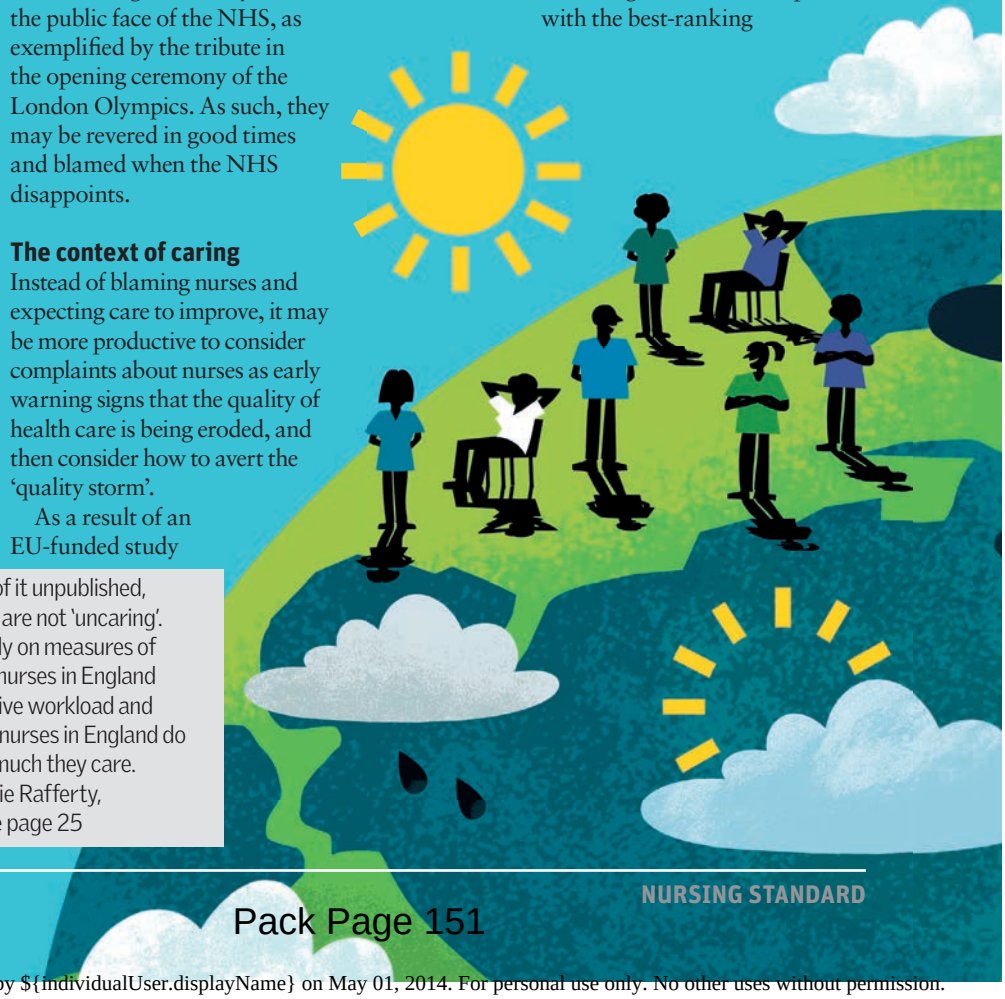
The annual Gallup public opinion poll in the US shows nurses leading all other occupations when it comes to trust. What is different about nurses in England? They are the public face of the NHS, as exemplified by the tribute in the opening ceremony of the London Olympics. As such, they may be revered in good times and blamed when the NHS disappoints.

The context of caring

Instead of blaming nurses and expecting care to improve, it may be more productive to consider complaints about nurses as early warning signs that the quality of health care is being eroded, and then consider how to avert the 'quality storm'.

As a result of an EU-funded study of the nurse workforce in 12 European countries, RN4CAST, we know much about the challenges faced by nurses working in NHS hospitals in England. We are also able to compare nurses' reports on conditions of practice in NHS hospitals with nurses' experiences in 11 other European countries and the US (Aiken *et al* 2012). RN4CAST's findings about 488 European hospitals through the eyes of 33,659 nurses, including 2,918 nurses practising in 46 NHS hospitals in England, are revealing and informative.

In Box 1 (see page 24) we show England's rank compared with the best-ranking



SUMMARY

Research by the authors, some of it unpublished, indicates that nurses in England are not 'uncaring'. On the contrary, they score highly on measures of caring. Negative perceptions of nurses in England can be explained by their excessive workload and inadequate skill mix. Put simply, nurses in England do not have the time to show how much they care.

Authors Linda Aiken, Anne Marie Rafferty, Walter Sermeus. For details see page 25

European country, based on five hospital nurse workforce dimensions: job-related burnout; staffing and resource adequacy; skill mix; proportion of nurses with a bachelor's degree; and work environment quality.

Countries were ranked based on averages across all hospitals in each country. While we use nurses as informants about their hospitals, our ranking is related to resources and nurse workforce outcomes at the hospital level because policies to address quality concerns will likely be directed to hospitals rather than to nurses. This approach also takes into account that some hospitals are better than others on these dimensions, but public perceptions of hospital care are likely to be a result of the experiences of patients and their families.

Nurse burnout, measured with a well-validated instrument, revealed that, on average, 44 per cent of bedside care nurses in the representative sample of NHS hospitals studied scored in the 'high burnout' range. Indeed, only one other country has hospitals with a higher percentage of 'burned out' nurses than England.

England ranks unfavourably compared to many other countries in Europe on dimensions that suggest why nurses in NHS hospitals may suffer from high burnout. Nurses in each study hospital in the 12 countries rated the overall adequacy of staffing and resources. Only four of the 12 countries ranked worse than England on nurses' assessments of staffing adequacy. Nurses also rated their hospitals on the quality of their work environments, and England again ranked near the bottom.

COMPLAINTS ABOUT 'UNCARING' NURSES CAN BE EXPLAINED BY THE UNDER-RESOURCING OF SERVICES

On another measure of staffing, known as nursing skill mix, which is the proportion of all hospital care staff who are professional nurses, England scored worse than all but two other countries. A significant proportion of caregivers in NHS hospitals are not professional nurses, although the public may not be aware of this.

A growing research literature shows that hospitals with a higher proportion of nurses qualified at bachelor's degree level have lower risk-adjusted mortality and fewer adverse patient outcomes (Aiken *et al* 2014). However, hospitals in England averaged only 28 per cent of bedside care nurses with a bachelor's degree, compared with 45 per cent across Europe. Only four countries had lower proportions than England. All hospital nurses in Norway and Spain held at least a bachelor's degree.

Despite high rates of burnout in England and resources that are less generous than elsewhere in Europe, we found no evidence that the attitudes of nurses in England towards their ▶

PETE ELLIS

Box 1: England's rank among 12 European countries

	England's rank	Best-ranking country
Nurse burnout	11	Netherlands
Staffing and resource adequacy	7	Switzerland
Skill mix (% of registered nurses)	10	Germany
Nurses with bachelor's degree	8	Norway and Spain
Work environment quality	10	Norway

Source: unpublished results from RN4CAST. The countries included are Belgium, England, Finland, Germany, Greece, Ireland, Netherlands, Norway, Poland, Spain, Sweden and Switzerland.

Note: Rankings are based on hospital averages for each characteristic (for example, the percentage of nurses with high burnout, and the percentage reporting adequate staffing and resources, was calculated for each hospital, and then the average across all hospitals in each country was calculated). On the four favourable characteristics, countries were ranked from high (rank 1) to low; on nurse burnout, countries were ranked from low (rank 1) to high.

▶ patients are negative and no support for media reports that nurses are uncaring. We asked nurses in each country how frequently they felt that they 'don't really care what happens to some patients'. Nurses in England nurses ranked best on this dimension, with 89 per cent responding 'never'.

Some media stories suggest that recent requirements for nurses in England to obtain a bachelor's degree are responsible for less caring behaviour. We explored our data to see whether nurses in England with a bachelor's education had more negative perceptions of patients than other nurses. The answer was no; they showed high regard for patients regardless of their educational qualifications.

Rationing of comfort

We did find a possible explanation for why some patients might perceive nurses in England to be uncaring – and it relates to workload.

Box 2 examines the types of care nurses say they cannot complete because of their heavy workloads. Norway was selected as a comparison country because of its well-resourced healthcare system, and because most of its hospitals were ranked by nurses as having good work environments.

A significant share of nurses in hospitals in both countries report that not all of their patients have all of their care needs met because of nurses' demanding workloads. But, overall, nurses in England are significantly more likely than nurses in Norway to report omitted care.

These findings suggest that nurses may be implicitly rationing some kinds of care because of their high workloads. Critical needs such as pain control and medication and treatment administration are less likely to be omitted than educating patients and families about self-care after discharge and spending time talking with patients and families about their concerns (Ball *et al* 2013).

Two-thirds of nurses in hospitals in England report that they do not have time to comfort and talk with patients. This is consistent with higher nurse workloads in NHS hospitals, fewer professional nurses among care staff at the bedside, and poorer nurse work environments than is the case in Norway and many other European countries.

Box 3 provides additional insight into unmet care needs, particularly the comforting functions of nurses that may be important to patients' positive perceptions of care. Nurses who assess their work environments as poor are twice as likely as those who assess them as excellent to report a lack of time to comfort and communicate with patients.

Our findings suggest that increasing nurse resources and improving work environments in NHS hospitals are more likely than blaming nurses for uncaring attitudes to result in patient-centred care (Aiken *et al* 2012).

Box 2: tasks for which nurses (%) say they lack time

	England	Norway
Pain management	7	4
Treatments and procedures	11	7
Prepare patients for discharge	20	14
Skin care	21	30
Administer medications on time	22	15
Oral hygiene	28	30
Adequately document nursing care	33	21
Patient surveillance	34	25
Educate patients and family	52	24
Comfort and/or talk with patients	66	38

Source: unpublished data from RN4CAST provided by authors.

The difficult economic context in Europe and elsewhere is contributing to the gathering 'quality storm'. Cost containment, especially as applied to 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, 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 (Cimiotti *et al* 2012).

Increasing the intensity of services and patient throughput in inpatient care, while maintaining quality and safety, is not possible if nursing resources are reduced, as documented in the Francis report on failures of care at Mid Staffordshire NHS Foundation Trust. Also, having too few nurses can cost more if complications increase.

Early warning signs

We make a case here for thinking more broadly about the meaning of negative perceptions of nursing care in the NHS and elsewhere.

Policy solutions rely on an accurate diagnosis of problems. Getting nurse resource levels and hospital culture correct are crucial. We found no evidence that public concerns about a lack of caring by nurses in England is associated with less professionalism, commitment or hard work.

On the contrary, the high rate of burnout in England suggests that nurses are trying their best under difficult circumstances. It is likely that complaints about 'uncaring' nurses can be explained by the fact that nursing services are comparatively under-resourced in hospitals in England.

Investments in evidence-based strategies to improve nurse work environments, as exemplified in the Magnet Recognition Program (McHugh *et al* 2013); applying evidence to achieve safe nurse staffing and nursing skill mix; and moving to a bachelor's qualified nurse workforce (Aiken *et al* 2014), hold promise for stabilising quality and safety gains and staving off the gathering quality storm in health care in England.

About the authors

Linda Aiken is director of the Center for Health Outcomes and Policy Research, University of Pennsylvania.

Anne Marie Rafferty is director of the Florence Nightingale School of Nursing and Midwifery, King's College London.

Walter Sermeus is programme director, Centre for Health Services and Nursing Research, Catholic University Leuven, Belgium.

Journal Club #NursingJC

Join our First Friday Twitter discussion about issues raised in this article. Friday May 2 from 12.30-1.30 using #NursingJC

In the US, close to 10 per cent of hospitals have qualified for Magnet status by demonstrating excellence in nursing care, a distinction that is recognised by national quality benchmarking organisations as the mark of a high-performing healthcare organisation. There is no equivalent form of recognition of nursing excellence in England or elsewhere in Europe.

Hospitals in the US are preferentially hiring bedside care nurses with bachelor's degrees, a market indicator of their higher value to their employing organisations.

The Institute of Medicine of the US National Academy of Sciences has elected nurse members, creating a forum for high-level interprofessional discourse on healthcare challenges, an organisational model that again does not have an equivalent in Europe.

Nurses' concerns about quality of care, patients' reports of negative care experiences, and press reports about uncaring nurses are harbingers of declining quality and safety, and should be considered warning signs that austerity measures may be risking harm to patients **NS**

Box 3: care linked to environment

Nurse rating of work environment	% of nurses lacking time to comfort and/or talk with patients
Poor	83
Fair	72
Good	56
Excellent	41

Source: unpublished data from RN4CAST provided by authors

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Professor Dame June Clark – SNSL(Ind) 05 / Tystiolaeth gan Yr Athro Fonesig June Clark– SNSL(Ind) 05

Consultation on Safe Nurse Staffing Levels (Wales) Bill

Response from: Professor Dame June Clark

General
Is there a need for legislation?
Yes. The defining characteristic of "advice" is that it doesn't have to be taken There is ample evidence both from other fields and in this field that "guidance" or "advice" is not enough to ensure compliance. Examples of other fields where we have seen the effect of legislation as opposed to "guidance" in changing behaviour include seat belts, crash helmets, smoking in public places, use of carrier bags, among others.

In the case of nurse staffing levels, the research which forms the evidence base for this Bill was first published fifteen years ago and has been repeated and validated by other studies many times since. Professional associations such as the Royal College of Nursing have been making recommendations based on this research for many years. Senior nurses responsible for setting staffing levels should have been, and probably were, aware of the research evidence and the professional recommendations; it is likely that it was used in their advice on staffing levels, but the reality is that their advice has been consistently ignored or over-ruled, usually for financial reasons (I have personal experience of this). Before the introduction of general management into the NHS in the late 1980s/1990s the chief nurse had much more power than now: she was an equal member of the management team with the power of veto in management decisions, she held the nursing budget (which was usually the largest budget), and directly managed the whole nursing service. It is often not realised that nowadays although Directors of Nursing carry the title of Director, they do not actually control nursing in their organisations and do not hold the budget for it.: they are accountable to a general manager/chief executive who (along with the Health Board) will weigh the advice of the nurse against the advice of the Director of Finance – the Director of Finance usually wins! The Francis Report, and other similar reports, frequently comment on this "powerlessness" of the nurse in the multi-disciplinary management team. This may be difficult for Nurse Directors to admit ! It was also commented by the BMA representatives at the evidence session on 29th January: when Peter Black asked to what extent nurses were listened to, the BMA representative responded with the remark that while they might be able to raise concerns, they were not listened to; this was expanded by Victoria Wheatley who described how nurses often called upon medical colleagues to support their case.

Even the CNO is vulnerable to this phenomenon. For example, although the "CNO Principles" issued in 2012 in respect of the nurse:patient ratios reflect the research evidence and the professional association guidance, the recommendations on skill-mix are a downgrading of the professional advice – a reduction from 65/35 to 60/40, ie the replacement of qualified nurses by (cheaper) Health Care Assistants, presumably in order to save money. (In fact this belief is erroneous: the research shows that the greater the proportion of registered

nurses in the nursing workforce the better the patient outcomes). It is perhaps significant that in the same year that the "CNO Principles" were issued, the number of commissions for pre-registration nursing education was reduced to 919, compared with 1035 in the previous year and 1,387 in 2003. A reduction in training places in 2012 will lead inevitably to a shortage of newly qualified nurses in 2015 and 2016. The committee might like to explore these decisions with the CNO and the then DG, in particular the extent to which they were driven by affordability rather than assessment of need. I am sure that these decisions were based on affordability rather than any valid estimate of need. Legislation would greatly strengthen the influence of Directors of Nursing on staffing decisions at Health Board level, and perhaps the CNO's position at national level.

The meeting of 29th January included an interaction about a ward in Salford that appeared to conform exactly with the best practice without legislation. This was used as an argument to suggest that legislation was unnecessary. The argument is specious – there are probably individual examples even in Wales where best practice is achieved: the purpose of legislation is to ensure that these standards are met by **all.**

Are the provisions in the Bill the best way of achieving the Bill's overall purpose?
I believe so. None of the alternatives so far suggested are able to achieve the Bill's purposes, because although they have all been available, experience has shown that they have not done so. The provisions in the Bill cover all three of the purposes of the Bill as set out in Clause 1.

Potential barriers to implementing the provisions of the Bill; does the bill take sufficient account of them?
The main barriers to implementation are the availability of nurses and the funding to support them. It is clear that the provisions of the Act could not be implemented overnight. There is some evidence (eg supplied by the RCN) that there are nurses in Wales who have left the NHS because they can no longer tolerate the stress who would be willing to return (this is also reported in California where following implementation of their legislation there is now no shortage of applicants to nursing posts). In Wales the nurses are obviously there, because they are working as agency nurses – what is needed is to convert their employment to normal NHS employment.

The most important and urgent action is to increase the number of education commissions for pre-registration nursing students. There is no shortage of applicants: there are ten applicants for every available place, the problem is the number of places commissioned. As mentioned above, the substantial drop in 2012 and the years since then will be reflected in an acute shortage of newly qualified nurses over the next few years

On funding, the evidence suggests that initial costs are recouped through fewer complications and reduced length of stay. Meanwhile the choice is stark: failure to increase nursing numbers above demonstrably unsafe levels will lead to avoidable deaths.

Unintended consequences
I have used the opportunity of visits to [redacted] California to talk with colleagues there about their experiences. I have also followed reports of their experiences in their media. They indicate that all of the concerns about unintended consequences that have been raised in Wales were also raised before and during the legislation in California – and none of them were realised.
There is no evidence that improving staffing in one area has resulted in depletion in other areas (eg community services). In any case, the distribution of nursing resources within the overall nursing service has always been a responsibility of the relevant nurse manager.

I have never been able to understand why when there is a gap in medical cover (eg a paediatrician goes sick) it would never be considered acceptable to fill the gap with a doctor from another specialty (eg a geriatrician), but it is considered an acceptable solution to move a nurse from one specialty to another in this way.

Provisions in the Bill

Duty on health service bodies to have regard to the importance of ensuring an adequate level of nurse staffing.

This is important because it makes clear the corporate responsibility and accountability of Health Boards to actually listen to, and hopefully act upon, the advice given by their Director of Nursing

To take all reasonable steps to maintain minimum registered nurse to patient ratios, initially in adult inpatient wards in acute hospitals

Duty applies to adult inpatient wards in acute hospitals only

I confirm the advice given in my earlier evidence that the word "minimum" should be replaced by the word "recommended" throughout the Bill. This enables some flexibility for example as knowledge develops, while retaining the advantage of the sustainability ensured by specification in legislation.

The word "initially" is important. I hope that the requirement for safe staffing will in due course be extended to other settings and other disciplines, and I am pleased to see that the Bill includes specific provision for this to happen. I hope that one of the consequences of this legislation will be that, as I personally have been recommending for many years, Wales begins to develop the IT infrastructure which will provide the data that can be used to provide the evidence required for other fields. The information available from the USA (now many states, not just California) and Australia includes recommended ratios which have been developed for other specialties, and there is already UK guidance for children's nursing, midwifery, and A&E departments on which we can build – but this is not yet evidence based.

There are several reasons for the initial focus on adult inpatient wards in acute hospitals:

1. This is currently the only part of healthcare on which we have hard and overwhelming evidence;
2. The key outcome which can be demonstrated is mortality which must trump all other areas of patient experience;
3. This area is covers a large (possibly the largest?) area of services and patient experience
4. This area has been made visible by reports such as the Francis report which have caused major public concern
5. Nurses are the most numerous of health workers, provide 80% of direct patient care, on a 24.7/365 basis and have a continuity of patient contact far greater than any other group.

I was shocked to see and hear the evidence presented by the Chartered Society of Physiotherapists. While agreeing with everything they say about the importance of multidisciplinary teamwork, I reject the view that because one cannot provide everything for everybody right now, one should not provide anything for anybody until everything is available. The advice to the CSP should be to start **now** to do the research and collect the data that will provide the evidence base they need.

To take all reasonable steps to maintain minimum registered nurse to healthcare support workers ratios.

While most of the debate has focused on the ratio of nurses to patients, the ratio of nurses to healthcare support workers (skill mix) is equally important. It is assumed that replacing qualified nurses by healthcare support workers is cheaper, but although the evidence base on skill mix is not as robust as for nurse:patient ratios, a review of skill mix studies, McKenna (1995) states that there are now sufficient studies available to show that rich skill mixes of qualified nurses are related to: reduced lengths of patient stay; reduced mortality; reduced costs; reduced complications; increased patient satisfaction; increased patient recovery rates; increased quality of life; and increased patient knowledge/compliance. In recent years in Wales the ratio has been lowered below the professionally recommended ratio of 65/35, specifically by the "CNO Principles" in 2012. The assumption that qualified nurses can be replaced by healthcare support workers is based on the (incorrect) assumption that nursing is simply a collection of tasks which can easily be re-allocated. In fact the key difference is not in the task, but in the qualified nurse's knowledge based decision making and clinical judgement.I am pleased that specific provision on this issue is included in the Bill (Clause 5c)

Requirement to issue guidance
The provision of detailed guidance, based on the evidence and professional advice, is absolutely critical. I am content that the provisions of section 5 cover what is required, subject to the additional points I make below.

Methods to ensure appropriate level of nurse staffing
I am content that provision has been included in Subsection 6. As I suggested in my initial eveidence, I suggest replacing the term "dependency" by the phrase "evidence-based and validated workforce planning tools". Without wishing to undermine the efforts of the CNO to develop a Welsh acuity tool, it should be recognised that this is still not validated and it was reported by Ruth Walker in the meeting of 29th January that in the pilot studies it was found not to be very helpful; the work on developing acuity tools is many countries is vast; there are already several validated tools available and in use in other countries. The most important point is that made by Rory Farrelly the meeting of 29th January when he referred to the importance of "triangulation" ie the combination of the ratios with acuity measurement and professional judgement

Provision to ensure that the minimum ratios are not applied as an upper limit
This is appropriately provided for in section 5e. There was some debate on January 29th about the difficulty of defining "safe care". While it may be difficult to define "safe care", the research clearly defines the level at which the risk for **"unsafe** care" becomes demonstrable and quantifiable.

Process for publication to patients of information
I believe that patients have the right to know whether they are being cared for by a registered nurse or some other person, and it is patronising to assume that they will be unable to interpret the information they are given. Full information should be made available to patients in exactly the same way as the position on the incidence of pressure sores is currently made available in the "1000 lives" project.

Protection for certain activities and roles
These provisions are important

Requirement to consult

It is important that this consultation does not fall into the trap described at the beginning of this paper: in particular the advice of professional nursing must not only be listened to but actually taken.

Monitoring requirements
Requirement for annual report
Requirement to review the operation and effectiveness of the Act
Impact of existing guidance
The failure of compliance with existing guidance that has now been revealed in preparation for this Bill demonstrates the importance of adequate monitoring and review. At the same time it is important that the "paperwork burden" is minimised and is not laid on nurses.

Powers to make subordinate legislation and guidance
A balance between what is on the face of the Bill and what is left to subordinate legislation
I think it is right to minimise the face of the bill and keep it simple, and I believe this has been achieved.

Financial implications
Of course the implementation will need to be costed. The research evidence suggests that initial increases in cost are outweighed by subsequent savings eg on the use of agency nurses, costs of recruiting overseas nurses (estimated at £5000 per nurse recruited), fewer complications etc.

Other comments
I support the key points presented by the RCP:

- The Act must be properly enforced to ensure that it is effective
- Detailed guidance on implementation must be issued to NHS bodies
- Staffing data must be publicly available and easily accessible
- Staffing numbers should be displayed in every ward
- Outcomes must be published in a transparent accountable way to inform future service improvement

June Clark DBE PhD RN FRCN FAAN FLSW
January 2015

Consultation on the Safe Nurse Staffing Levels (Wales) Bill: written submission of evidence to the health and Social care Committee.

Professor Peter Griffiths, RN, BA, PhD
Chair of Health Services Research University of Southampton, England &
National Institute for Health Research Collaboration for Applied Research in Health and Care (Wessex)

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Introduction & overview

I am making this submission in a personal capacity. I draw on over 25 years of experience of working in and alongside the NHS as a clinical nurse, advisor and applied health services researcher.

I have undertaken research related to the impact of the size and configuration of the health care workforce on patient and staff outcomes. From 2006–2011 I was director of the National Nursing Research Unit in England, funded by the Department of Health's Policy Research Programme to undertake research into the nursing workforce. I lead the work on patient outcomes in the international RN4CAST study, exploring associations between the hospital nursing workforce and patient outcomes in 16 countries, in Europe and beyond. I also co-led the English arm of the study. Last year I led the team that undertook evidence reviews for the National Institute for Health and Care Excellence's Safe Staffing Committee as it developed guidance for nurse staffing on hospital wards and in emergency departments.

In addition to the evidence reviews for NICE, I have published extensively on this topic including contributions to recent papers of relevance, such as:

Aiken, L.H., Sermeus, W., Van den Heede, K., Sloane, D.M., Busse, R., McKee, M., Bruyneel, L., Rafferty, A.M., Griffiths, P., et al, 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ 344 (7851), e1717.

Aiken, L.H., Sloane, D.M., Bruyneel, L., Van den Heede, K., Griffiths, P., et. Al. 2014. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet 383 (9931), 1824-1830.

Ball, J.E., Murrells, T., Rafferty, A.M., Morrow, E., Griffiths, P., 2014. 'Care left undone' during nursing shifts: associations with workload and perceived quality of care. BMJ Qual Saf 23 (2), 116-125.

Griffiths, P., Dall'Ora, C., Simon, M., Ball, J., Lindqvist, R., Rafferty, et. al, 2014. Nurses' shift length and overtime working in 12 European countries: the association with perceived quality of care and patient safety. Med Care 52 (11), 975-981.

Griffiths, P., Jones, S., Bottle, A., 2013. Is "failure to rescue" derived from administrative data in England a nurse sensitive patient safety indicator for surgical care? Observational study. Int J Nurs Stud 50 (2), 292-300.

Below I offer some observations and analysis drawing on this expertise and related to research evidence that are relevant to the committee's questions.

Nurse staffing and patient outcomes

It seems clear from extensive evidence that lower levels of nurse staffing in hospitals are associated with poorer patient outcomes.

- There are inconsistencies in the evidence. Not all studies show an association. However, for a number of outcomes, including death, the overall pattern of evidence is clear. There are a number of evidence overviews (including our recent reports to NICE) supporting this.[1–3] I am not aware of any recent substantial reviews that come to a different conclusion.
- Relatively little of the evidence is from the UK, but what there is tends to be broadly consistent with this pattern.
- It does not follow from this evidence that the relationship between nurse staffing and patient outcomes is *causal*. That is, just because hospital death rates are higher in hospitals with fewer nurses, this does not mean that it is a lack of nurses that causes the increase in deaths. There might be other factors at play and indeed, there must be. For example, hospitals with fewer nurses also tend to have fewer doctors. There is also evidence on the importance of *medical* staffing levels for mortality rates. [4 5]
- However, taken in the round, the evidence is consistent with poor nurse staffing *causing* some of the adverse patient outcomes observed in studies.[1–3]

A considered appraisal of the evidence supports a conclusion that low nurse staffing is one cause of the variation in death rates, and other adverse outcomes between hospitals.

Local determination

It does not necessarily follow that mandatory staffing levels are an effective approach to addressing the problem. In principle, the argument that staffing levels are best determined locally is appealing. However, the evidence available suggests that local determination is not sufficient to assure safety.

- The consequence of variation in staffing levels seen between hospitals does not clearly indicate the correct level of staffing on particular wards.

- However, our review for NICE found little evidence about the use of any formal systems for local determination of staffing levels.[1] Crucially we do not know whether patient outcomes / experiences are improved when such systems are used.
- In our RN4CAST study we found that most of the English Trusts we surveyed claimed to be reviewing nurse staffing regularly and a majority used formal tools to determine staffing levels.[6]
- Despite this, we still found that variation in staffing levels was substantial, with many Trusts routinely operating at staffing levels far below that recommended by international guidance or required by legislation, including the level of 1 registered nurse to 8 patients which was identified by NICE as a threshold.[7]
- Crucially, it also appears that this variation in staffing is still associated with variations in mortality.[6 8] The Mid-Staffordshire enquiry and the more recent Keogh review also highlight staffing deficiencies.

It is hard to conclude that 'local determination' alone (with or without the use of tools) is sufficient to assure safe staffing levels.

Mandatory staffing

By contrast, there is some evidence that points to improved outcomes for patients and nurses associated with various mandatory safe nurse staffing policies.

- Evidence from studies of mandatory staffing policies in the US and Australia, while not conclusive, do suggest that hospitals that meet the mandatory ratios have better outcomes than those that do not. There is some evidence of improvement over time and little evidence of adverse consequences. [9–15]
- Benefits attributed to the policies include improved patient outcomes and improved staff outcomes, including hospital's abilities to recruit and retain staff.[16]
- I am not aware of an unbiased comprehensive high quality review of this evidence. It is of note that NICE explicitly excluded consideration of such policies from their evidence review for guidance "safe staffing for nursing in adult inpatient wards in acute hospitals".

It appears that mandatory minimum staffing policies, which allow staffing to flex above specified minimums, can be beneficial to patient care.

Identifying the minimums

Recommended minimum staffing levels can operate (broadly) in one of two forms. A ratio of patients per nurse or an average number of number of nursing hours per day that are to be available to patients on wards of a given type.

- Typically, mandatory ratios from other countries are in the range of 4-6 patients per nurse in general wards. Ratios recommended for care of older people wards are sometimes lower, although the rationale for this is far from clear.[17]
- NICE identified ratios exceeding 8 patients to 1 nurse as a threshold associated with increased risk of harm and advised additional steps to assure safety once if this threshold was exceeded.[18] The emphasis is on assuring safety if the 8:1 threshold is exceeded, implying 8:1 is safe.
- This figure (8:1) is appears to originate from that identified by the Safe Staffing Alliance (SSA). It is worth noting therefore the basis of the Alliance's campaign.
- The SSA position is that a ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety. This is the level at which care is definitely considered to be unsafe, putting patients at risk. The emphasis here is on demonstrating and determining a safe staffing level at a ratio of 8:1 or below.
- The figure of 8:1 does not directly emerge from any research evidence as a clear 'cut point'. However, for most UK studies where specific patient to nurse ratios can be identified, ratios above 8:1 are clearly in the higher risk group. However, insofar as there is evidence of a threshold, it may occur at a lower ratio than this. For example in our study on missed nursing care, rates of missed care were only significantly reduced for wards with the highest staffing levels, where nurses cared for about 6 patients or fewer (see figure 1 below).[19]

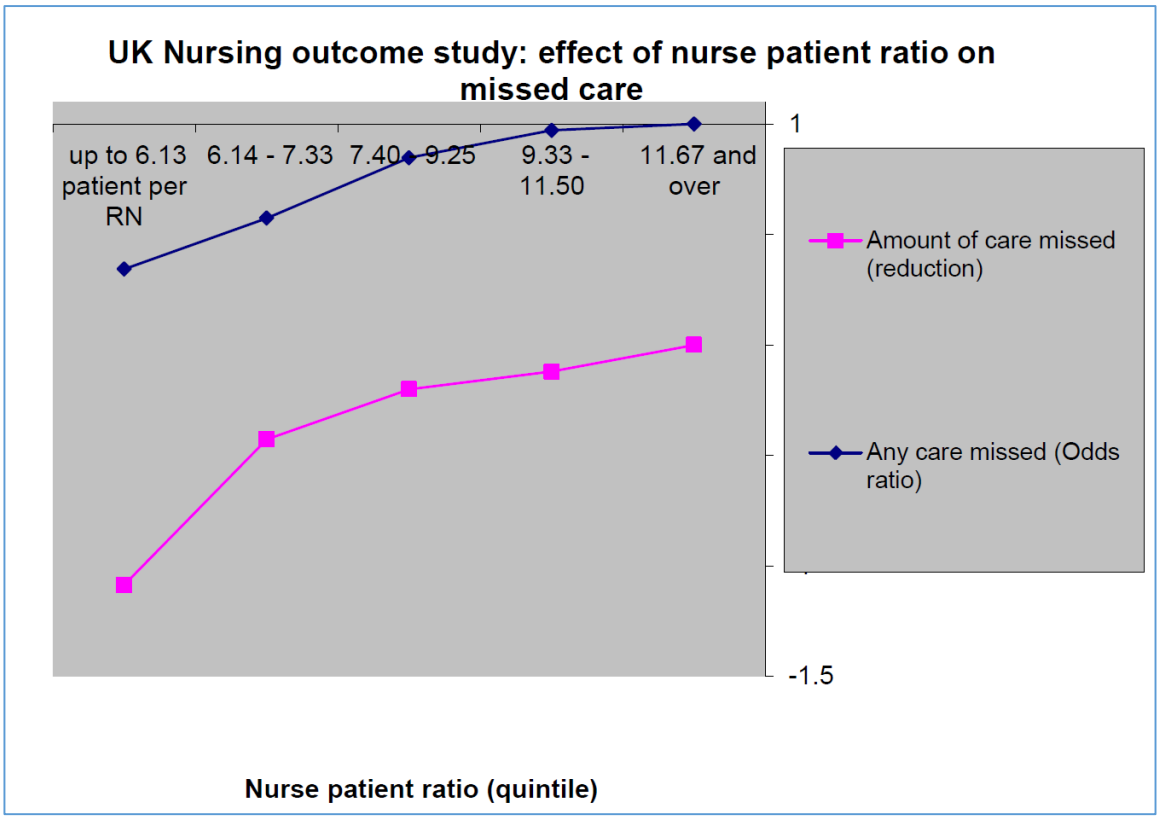

Figure 1: Data from 'Care left undone' during nursing shifts: associations with workload and perceived quality of care

- In all UK studies of nurse staffing patient outcomes, risk increases between the best-staffed hospitals compared to the next best-staffed group of hospitals. Risk is increased before staffing reaches levels that would be considered 'low' if benchmarked against the average (see addendum to the evidence review for the NICE safe staffing guidance[1]).

The correct minimum staffing level cannot be derived solely from the scientific evidence base. Professional and indeed social judgement must be exercised. The international evidence points towards levels of staffing that are much higher than currently found in many hospitals the UK.

It is at least conceivable that while a policy that specifies a minimum level of (say) 6 patients to 1 nurse may have a positive effect, a policy that specifies a different level may have a different effect.

The 'correct' mandatory staffing level remains unclear. However, the widely recognised figure of 8 patients to 1 nurse should not be regarded as a safe level. Ratios from other countries general identify safe staffing minimums for general wards as between 4 & 6 patients per RN, depending on the setting.

Other considerations

While attention is focussed on mandating a staffing level, with the Safe Staffing Alliance campaign focussing on daytime staffing, consideration needs to be given to other factors.

- There is substantial evidence that night-time staffing in some units is extremely low.[20] There is a danger that focussing on daytime staffing could exacerbate this.
- One strategy for increasing the efficiency of the nursing workforce is a move from a three shift per day system to a 2 shift system. The potential advantages are efficiencies from reduced handovers and overlaps between shifts.[21]
- The 2 shift system also means that 'night time' staffing levels, typically much lower, can be operated for a longer period of the day.
- While it may indeed be that in many wards the requirements for nursing care are lower at night, a reduction in staff in this evening period is not necessarily warranted.
- There is growing evidence that these so called '12 hour shifts' are associated with poorer patient outcomes irrespective of the nurse to patient ratios.[22–24] This could be in part because of reductions in the total amount of nursing care that is available or because of other factors.

While closely equivalent, mandating the average daily nursing hours per patient over 24 hours rather than the patient to nurse ratio at a given time, may be more appropriate than a mandatory ratio to be applied at particular times of day. This Nursing Hours Per Patient Day approach is taken in Western Australia.

The Nursing Hours Per Patient Day method gives some additional flexibility around how patient care is organised across the day but reduces perverse incentives to alter shift patterns and night-time staffing levels for reasons unrelated to patient need.

Conclusion

While the evidence is broadly in favour of mandatory minimum staffing levels, it is by no means conclusive and a careful, properly resourced evaluation of any such policy seems essential.

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