Nurse Staffing Levels (Wales) Act 2016 – Statutory summary of nurse staffing level reports 2018-2021

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Executive Summary

- The purpose of this paper is to summarise the first three-year reports (covering April 2018 – April 2021) submitted to Welsh Government by health boards in October 2021. It will also include historical context and explanation where appropriate.
- Section 25E of the Act states that for each three year reporting period, health boards with wards where section 25B of the Act is applicable must submit a report outlining: the extent to which nurse staffing levels have been maintained; the impact the board considers that not maintaining nurse staffing levels has had on care provided to patients by nurses; any actions taken in response to not maintaining nurse staffing levels.
- The "nurse staffing level" is defined by the statutory guidance as two things: the *required establishment* (the total number of nurses required by a ward from which planned rosters can be compiled for each shift); and the *planned roster*.
- During this period, health boards have largely managed to maintain their required establishments through appropriate funding of their calculations. The main acceptations to this were seen in the first year and then overcome by years 2 and 3.
- Following the first triangulated calculations under the 2016 Act, there were 538.97 WTE additional nursing staff calculated as being required across Wales' adult acute medical and surgical wards (180.6 registered nurses and 358.37 healthcare support workers).
- However there was a difference between what was calculated and what was immediately funded with only 194.6 WTE of the 358.37 HCSW posts being funded from spring 2018 (as shown in table 1).
- Calculations have fluctuated significantly over the three year reporting period, notably due to health board boundary changes and the Covid19 pandemic in year 3; At the end of the three year reporting period, there were 139.74 (+3.3%) additional WTE RNs and 597 additional WTE HCSWs (+23.8) funded into the adult medical and surgical establishments compared to March 2018 before the Act's second duty came into force;
- When the second duty of the 2016 Act came into force on 6 April 2018, health boards lacked the necessary ICT infrastructure to capture all the data they would like to have been able to report on in terms of maintaining *planned rosters* on a shift by shift basis. Therefore health boards have not been able to provide data around the extent to which planned rosters have been maintained.
- A national contract for a standardised package of e-rostering software with a ward management module – which will be the key to overcoming this issues - has been procured by the NHS Wales Shared Services Partnership and is in the process of being rolled out across all health boards.
- There were a total of 40 serious incidents/complaints where failure to maintain the nurse staffing level was deemed to have been a contributing factor;
    - 8 incidents of hospital acquired pressure damage (of levels 3, 4 and unstageable)
    - 25 falls (of levels 4 and 5)
    - 0 medication never events
    - 7 complaints about care provided by nurses

Legislative Background

The Nurse Staffing Levels (Wales) Act 2016 received royal assent in March 2016 and had a phased approach to implementation in two parts.

The first duty under Section 25A sets out the '*overarching responsibility'* for local health boards and NHS trusts to ensure there *are sufficient nurses to care for patients sensitively* and applies to any setting where nursing care is provided and commissioned services. This duty came into force in April 2017.

The second duty under Section 25B (and its associated duties under sections 25C-E) requires Welsh local health boards to use a prescribed triangulated methodology to calculate and maintain the nurse staffing level for adult acute medical inpatient wards and adult acute surgical inpatient wards. This duty came into force in April 2018.

Section 25E sets out the reporting duty under the Act on any health board and trust to which the 25B duty applies. In practice, this means any health board with adult acute medical and surgical wards during the reporting period of April 2018 and April 2021. The Act states that for each three year reporting period, these health boards must submit a report outlining:

1. The extent to which nurse staffing levels have been maintained;
2. The impact the board considers that not maintaining nurse staffing levels has had on care provided to patients by nurses (by reference to increase in complaints, medication errors, patient falls and hospital acquired pressure ulcers);
3. Any actions taken in response to not maintaining nurse staffing levels

Section 25E of the Act states that health boards must submit their three-year reports to the Welsh Government within 30 days of the end of the reporting period (5th May 2021). However, investigations of serious incidents of harm often take months to close, meaning that there would be incidents from the latter quarters of year three which would still be open, and the data submitted in May 2021 would be incomplete.

It was therefore decided that health boards would submit caveated, incomplete reports in May 2021 to satisfy the letter of the law, but would then submit their finalised, complete reports by October 2021, giving them adequate time to close all serious incident investigations.

The following paper will summarise the health boards' reports submitted in October 202 under the three above-mentioned headings, offering historical context and explanation where appropriate.

1. The extent to which nurse staffing levels have been maintained

Context

Firstly, it is important to recognise that the "nurse staffing level" is defined by the statutory guidance as two things:

- the *required establishment* (the total number of nurses required by a ward from which planned rosters can be compiled for each shift); and
- the *planned roster*.

Therefore according to section 25E 2(a) of the Act, health boards would need to report on the extent to which *both* had been maintained. In the case of the required establishment, this is a fairly straightforward exercise of comparing the calculated required establishments' vs the funded establishments (illustrated in Table 1 below) Maintenance of the planned roster on the other hand is a far more complex metric to first define and then to articulate for reporting purposes. Broadly speaking a comprehensive description of the extent to which planned rosters have been maintained would require complete data points for every shift within the reporting period capturing:

- The total number of shifts;
- The number of shifts where the planned roster was maintained;
- The number of shifts where the planned roster was not maintained but the staffing level was deemed appropriate in the professional judgement of the senior nurse due to mitigating factors with that professional judgement having been recorded;
- The number of shifts where the planned roster was not maintained and the nurse staffing level was deemed inappropriate;

Although not an explicit requirement under section 25E, for sake of completeness and to aid in informing future calculations, there is an argument to be made for also including the number of shifts where the planned roster *was* maintained but the professional judgement of the senior nurse deemed that the nurse staffing level was still *inappropriate* due to conditions on the ward (abnormally high acuity for example).

Capturing this data is not entirely impossible. With the right rostering software in place it would be fairly straightforward in fact. However when the second duty of the 2016 Act came into force on 6 April 2018, health boards lacked the necessary ICT infrastructure to do so. Not only was there no standardised rostering software on a national basis, there was not a single health board running a system of daily capture that would enable the straightforward harvesting of the abovementioned data.

Concerns about this lack of ICT infrastructure were raised during consultation at the first stage of bill scrutiny both by health board representatives and Welsh Government officials.

As quoted in paragraph 217 of the Nurse Staffing Levels (Wales) Bill explanatory memorandum (January 2016):

One concern was raised relating to the implied ICT investment. Welsh Government officials also subsequently raised the view that though the three indicators are already collected, adding the information on staffing levels at the time of collection is an additional cost which could be considered and that existing ICT systems may need further development in order for data to be 'pushed' into common reporting or collection systems. Further study was conducted to ascertain whether Health Boards currently have the current e-rostering systems to implement the Bill. The RCN provided evidence that while ICT systems in Health Boards will not be identical, all Health Boards currently have, or plan to have by the time the Bill is implemented, electronic systems to manage electronic rostering, manage the bank nursing, sickness, incidence monitoring and to measure against workforce planning. Therefore, ICT systems would not be required to change so there would not be any additional costs in terms of ICT administration to implement this Bill. Also, as records are electronic, records of staffing levels would be easily available from the date of Bill implementation, so there would be no additional costs in terms of storing administrative data in the future."

It is unclear what "evidence" could have been provided by the RCN to demonstrate ICT infrastructure would not pose a significant impediment to recording and reporting the data required under the Act. The real world experiences over the past three and a half years of implementing the legislation into practice would suggest a far greater level of scrutiny and forethought was required on this point, and failure to do so has effectively made it impossible for health boards to report on the extent to which the planned rosters have been maintained within the first reporting period.

This issue was immediately identified by the All Wales Nurse Staffing Group after the passing of the 2016 Act, and attempts to render a solution began shortly thereafter. A significant issue was the lack of consistency in e-rostering software across health boards. "*Allocate*" – one prominent e-rostering platform – offers a powerful ward management module called *Safecare* which with some modification would be able to capture all reporting data required under the 2016 Act as part of its daily use on wards. However almost half of the health boards at this point were using a competing piece of e-rostering software called *Roster-pro,* on a variety of contract lengths, meaning a national purchase and modification of the Safecare module was a potential long term solution, but not an immediate one.

In the short term, the Health Care Monitoring System (HCMS) was identified by the All Wales Nurse Staffing Group as a potential interim solution. HCMS is a database, accessible to UHBs through their intranet sites. It contains a list of standards/audit questions against which clinicians record information such as: the annual health and care standards audit; monthly hand hygiene compliance; pressure damage prevalence; and nutrition assessment audit results.
It was originally developed to support wards in recording audit results against care standards and contains no data analytic capability, therefore the functionality is limited compared to newer, purpose-built pieces of software. Its use requires a member of staff to log on to the system and manually enter data rather than it being a tool in constant use in managing the ward.
However it is possible to amend the forms within it to include new question fields. For that reason, the adult inpatients working group of the All Wales Nurse Staffing Group was tasked with devising a list of questions to be embedded in an HCMS form that would allow the capture of data to at least allow some reporting on the extent to which planned rosters had been maintained.

After due consideration and discussion, an acuity assessment form was developed by the working group adding in questions on how the number of staff on shift compared to the planned roster and also the appropriateness of the number of staff on shift. Taking NWIS development and testing time into account, the intended timetable projected the HCMS amendments would be rolled out by April 2020 meaning that for the final year of the first three-year reporting period at least, there would be a quantitative measure of planned roster maintenance to be reported.

The outbreak of the Covid pandemic in early 2020 however led to inevitable delays to the ICT development as other work was understandably prioritised by NWIS. By the time the new HCMS system was live on the system in July 2020, the health boards were in the midst of an unprecedented staffing emergency due to the pandemic and its associated isolation protocols, rendering any expectations of a) training staff to use the new forms and b) ensuring consistent manual data capture, entirely unrealistic.

The result of those factors – which were either arguably or obviously outside of the health boards' control – is no reliable reporting data on the extent to which planned rosters have been maintained. Indeed, six months into the second three-year reporting period and the interim solution offered by HCMS is still not being utilised in a consistent enough fashion due to the residual effects of the pandemic.

A long-term solution however is on the near horizon. Due to a decision to end any updating to the *Roster-Pro* e-rostering system, the health boards that had been using it began a natural migration over to *Allocate*. The NHS Wales Shared Services Partnership seized on this opportunity to establish a consolidated All-Wales e-rostering contract with *Allocate* meaning that all health boards would finally be using the same system. With this came the opportunity to include the *Safecare* ward management module as part of the contract, and to instruct Allocate to make the necessary modifications so that the module would provide all the data capture and reporting functionality required by the 2016 Act.

It was hoped that this would be in place by the beginning of the second three-year reporting period in April 2021, however once again the disruption caused by the Covid pandemic has caused delays. Rolling out a new e-rostering and ward management module across the entire estate of each health board is a significant undertaking, especially in a time when the system will either still be dealing with the Covid pandemic or focussing on recovery from it. Capacity within local informatics teams that are leading on the roll out also varies from health board to health board.

The health boards are at varying stages of implementation, from those who have been running Allocate and even Safecare for years (such as Betsi Cadwaladr UHB) to those who have to migrate entirely from Roster-Pro over to Allocate as well as roll out the Safecare module (Cardiff and Vale UHB).

<u>Reporting</u>

With that contextual background in mind, the following table summarises the required establishment figures for registered nurses (RN) and healthcare support workers (HCSW) at each of the biannual calculating intervals. By comparing the calculated establishments with the establishments that were funded, we see an

illustration of the extent to which the nurse staffing level (required establishment) has been maintained. It also articulates what the establishments were immediately prior to the first triangulated calculations taking place, which shows at a glance how the workforce in these wards has changed over the first 3 years. For ease of reference, any positive figures have been coloured in green, and any negative figures in red.

Table 1

Establishment prior to 1 April 2018		Aneurin Bevan UHB						WTE difference between March 2018 and Nov 2020	
RN	**HCSW**							**RN**	**HCSW**
552.88	392.37	**Calculated**		**Funded**		**Difference**		**-33.76**	**112.34**
		RN	**HCSW**	**RN**	**HCSW**				
	May-18	557.94	436.38	557.94	436.38	0	0		
	Nov-18	595.62	422.88	595.62	422.88	0	0		
	May-19	572.56	440.73	572.56	440.73	0	0		
	Nov-19	481.99	474.88	481.99	474.88	0	0		
	May-20	513.43	503.29	513.43	503.29	0	0		
	Nov-20	519.12	504.71	519.12	504.71	0	0		
Establishment prior to 1 April 2018		**Betsi Cadwaladr UHB**						**WTE difference between March 2018 and Nov 2020**	
RN	**HCSW**							**RN**	**HCSW**
666	468.4	**Calculated**		**Funded**		**Difference**		70.73	105.64
		RN	**HCSW**	**RN**	**HCSW**				
	May-18	703	468.4	836.05	569.03	133.05	100.63		
	Nov-18	733.17	468.04	846.3	557.42	113.13	89.38		
	May-19	799.12	530.65	795.61	527.94	-3.51	-2.71		
	Nov-19	806.59	535.26	792.44	530.77	-14.15	-4.49		
	May-20	708.04	515.35	798.52	566.71	90.48	51.36		
	Nov-20	736.73	574.04	799.54	566.71	62.81	-7.33		
Establishment prior to 1 April 2018		**Cardiff and Vale UHB**						**WTE difference between March 2018 and Nov 2020**	
RN	**HCSW**							**RN**	**HCSW**
1176	541	**Calculated**		**Funded**		**Difference**		-69	19
		RN	**HCSW**	**RN**	**HCSW**				
	May-18	1176	541	1176	541	0	0		
	Nov-18	1176	541	1176	541	0	0		
	May-19	1127	530	1127	530	0	0		
	Nov-19	1127	530	1127	530	0	0		
	May-20	1028	452	1028	452	0	0		
	Nov-20	1107	560	1107	560	0	0		

Table 1 continued

Establishment prior to 1 April 2018		Cwm Taf Morgannwg UHB						WTE difference between March 2018 and Nov 2020	
RN	HCSW							RN	HCSW
348.33	255.12	Calculated RN	Calculated HCSW	Funded RN	Funded HCSW	Difference		282.42	195.39
	May-18	395.25	292.35	348.2	255.12	-47.05	-37.23		
	Nov-18	403.8	314.8	348.2	254.12	-55.6	-60.68		
	May-19	615.79	441.28	615.79	441.28	0	0		
	Nov-19	594.84	427.07	594.84	427.07	0	0		
	May-20	469.7	346.6	469.7	346.6	0	0		
	Nov-20	630.75	450.51	630.75	450.51	0	0		

Establishment prior to 1 April 2018		Hywel Dda UHB						WTE difference between March 2018 and Nov 2020	
RN	HCSW							RN	HCSW
604.01	436.76	Calculated RN	Calculated HCSW	Funded RN	Funded HCSW	Difference		-53.34	74.45
	May-18	642.63	535.59	604.65	445.78	-37.98	-89.81		
	Nov-18	607.04	527.95	587.6	473.61	-19.44	-54.34		
	May-19	609.69	530.29	601.87	522.71	-7.82	-7.58		
	Nov-19	591.46	525.51	594.03	526.1	2.57	0.59		
	May-20	381.25	329.35	376.2	313.62	-5.05	-15.73		
	Nov-20	550.67	511.21	552.02	482.19	1.35	-29.02		

Establishment prior to 1 April 2018		Swansea Bay UHB						WTE difference between March 2018 and Nov 2020	
RN	HCSW							RN	HCSW
806.78	408.67	Calculated RN	Calculated HCSW	Funded RN	Funded HCSW	Difference		-121.47	126.53
	May-18	859.78	586.97	817.01	449.61	-42.77	-137.36		
	Nov-18	895.45	615.89	842.52	562.36	-52.93	-53.53		
	May-19	660.36	453.1	660.36	453.1	0	0		
	Nov-19	671.69	507.58	671.69	507.58	0	0		
	May-20	672.14	508.36	672.14	508.36	0	0		
	Nov-20	685.31	535.2	685.31	535.2	0	0		

Conclusion

The above data show that:

- In the main, health boards have largely maintained their required establishments through appropriately funding their calculations.
  - Aneurin Bevan and Cardiff and Vale UHBs report having exactly funded their calculated required establishments throughout the 3 year reporting period.
  - Betsi Cadwaladr UHB shows having significant *over*-funding of their calculated establishments for the first and third years and minor under-funding in the second year. Over the course of the three year period this equates to the health board having more than maintained their calculated required establishments.
  - Swansea Bay and Hywel Dda UHBs both show significant under-funding in the first year. This is explained by conscious plans by both health boards at the time to take a phased, risk-based approach to increase funding, taking into account the inability to recruit nurses in that first year. Hywel Dda shows more minor under-funding in the third year (aligned with the Covid19 Pandemic) which is explained as a decision driven by the very frequent variation in the required nurse staffing levels on wards; the extensive redeployment of staff across sites; and the recruitment and allocation into ward teams of significant numbers of temporary staff specifically employed to assist with the pandemic response.
  - Cwm Taf Morgannwg UHB similarly shows significant under-funding in the first year. Unlike with Swansea Bay and Hywel Dda UHBs however, this was not down to a planned phased approach, but rather a failure at executive board level to fund the calculated staffing levels presented to them. Once this was identified centrally, the Chief Nursing Officer wrote to the Chief Executive Officer of the health board underlining the severity of the situation and articulating the necessary remedying actions. As set out in the 2016 Act's operational guidance, this issue was considered under the Joint Escalation and Intervention Arrangements by Welsh Government, Health Inspectorate Wales and the Wales Audit Office in January of 2019 as one of several reasons to increase the health board's escalation level to *enhanced monitoring.* However, following the aforementioned letter from the CNO, immediate action was taken by the health board to amend the failing, as can be seen by the funding data from the second and third years.
- The number of nursing staff in the adult medical and surgical system has increased nationally in the first three-year reporting period.
  - It is worth noting that a snapshot comparison of establishments from immediately before the reporting period and at its end is a simplistic metric based on the data presented for those two static points in time. It cannot take into account the dynamic nature of ward changes and staff investments within each of the three years - not least when the third year was so significantly disrupted by the Covid pandemic. Further detail can be obtained from the health board's annual reports linked within their full individual three-year reports at Annex 1.
  - Changes in the RN workforce have been variable across health boards.
  - Cardiff and Vale UHB reports a decrease of 69WTE.
  - Aneurin Bevan UHB reports a decrease of 33 WTE. Their report outlines how in 2019, against a backdrop of significant vacancies, a new ward model was

introduced based on the prudent healthcare principles emphasising safe and appropriate delegation practices. This new Core Care Team model introduced new and different non-registered roles such as assistant practitioners, roster creators and ward assistants. This would partly explain the apparent reduction in RN staff over the three years.

- Hywel Dda UHB has clarified in its report that the number of wards to which 25B is applicable has decreased from 32 to 28 in that time, which would explain the apparent reduction in RN staffing by 53 WTE.
- Swansea Bay UHB reports a more significant decrease of 121 WTE, however this is explained by the border change and transfer of Princess of Wales Hospital (PoW) and its 10 adult medical and surgical wards to Cwm Taf Morgannwg. In fact, given that Swansea's report calculated PoW's RN establishment as 223 RN in Nov 2018, a decrease in 121 represents a real world *increase* in registered nurses across the health board's remaining wards of approximately 101 WTE.
- Conversely, Cwm Taf Morgannwg UHB reports the most significant increase in calculated RN staff over the 3 year period at 282 WTE. This is mostly explained by the absorbing of Princess of Wales hospital's 10 wards in April 2019. Though again, the fact that the increase is significantly greater than the 223 RN establishment calculated in Nov 2018 for those PoW wards suggests that the establishments have increased more generally across the health board by approximately 59 WTE regardless of the border change.
- Betsi Cadwaladr UHB reports an increase of 70 WTE.
- HCSW numbers have risen more consistently in each of the reporting health boards over the reporting period. The skill mix ratio of RN:HCSW in March 2018 was 62:38. At the final calculation of this reporting period, that ratio had dropped to 58:42. This is likely in part down to management of nurse staffing during the Covid pandemic.
- The national totals equate to **139.74** additional WTE RNs (3.3%) and **597** additional WTE HCSWs (+23.8%) funded into the adult medical and surgical establishments in November 2020 compared to March 2018 before the Act's second duty came into force.

A lack of the requisite ICT systems to adequately record nurse staffing data, and the acute disruption caused by the Covid19 pandemic has limited what has been possible for health boards to report in terms of *the extent to which nurse staffing levels have been maintained.*

On the *planned roster* side there is no comprehensive reporting of data, however the ICT solution to this issue is in the process of being implemented and should be embedded on all wards that fall under section 25B of the Act within the current three-year reporting period (2021-2024).

2. The impact the board considers that not maintaining nurse staffing levels has had on care provided to patients by nurses

Context

In early 2018, discussions were had by the All Wales Nurse Staffing Group, Executive Nurse Directors of the health boards and the CNO/WG officials to arrive at a consistent interpretation of what would be reported against section 25E 2(b) of the 2016 Act.

> *(b)*
> *the impact the Board or Trust considers that not maintaining nurse staffing levels has had on care provided to patients by nurses, for example by reference to complaints about care provided to patients by nurses made in accordance with the Complaints Regulations or by reference to an increase in incidents of harm caused by—*
>
> *(i) errors in administering medication to patients;*
> *(ii) patients falling;*
> *(iii) patients developing hospital-acquired pressure ulcers;*

There was unanimous agreement early on that the reporting requirements should not be laborious to the extent of running counter to the intention of the law by excessively removing nursing capacity from time caring for patients. Indeed, concerns about this being a potential unintended consequence were raised during early scrutiny of the Bill.

Considering the lack of a standard national ICT system for capturing harm data (until the introduction of the new Once-for-Wales Concerns Management System in April 2021, health boards were using different local DATIX forms) or any automated data capture/analysis tools, the decision was made to focus on *serious incidents* of harm - against the four categories explicitly cited - on occasions where the failure to maintain the nurse staffing level was deemed to have been a contributing factor. Investigations into each incident of harm would need to be validated and rechecked for inclusion within a report, therefore focusing on only *serious incidents* (hospital acquired pressure damage grade 3, 4 and unstageable; falls of levels 4 and 5; medication never events; and complaints about nursing care resulting in patient harm) would significantly reduce the nursing hours spent on validating reporting data, and also prioritise the most significant instances of patient harm.

Reporting

The following table summarises the respective data reported in each health board's three-year reports articulating the impact they consider not maintaining the nurse staffing level has had on care to patients by way of hospital acquired pressure damage of levels 3, 4 and unstageable (P.D), falls of levels 4 and 5 (falls); medication never events (MNE); and complaints about nursing care resulting in patient harm.

Table 2

		Number of serious incidents				Number of serious incidents where failure to maintain the nurse staffing level was considered to have been a contributing factor			
		2018/19	**2019/20**	**2020/21**	**Total**	**2018/19**	**2019/20**	**2020/21**	**Total**
AB	P.D	20	14	36	70	0	1	0	1
	Falls	34	36	37	107	0	0	0	0
	MNE	1	0	2	3	0	0	0	0
	Complaints	x	103	128	231	x	0	4	4
BCU	P.D	84	54	98	236	2	0	0	2
	Falls	55	41	73	169	5	0	0	5
	MNE	4	0	14	18	0	0	0	0
	Complaints	x	5	10	15	x	0	0	0
C&V*	P.D				129				2
	Falls				63				4
	MNE				1				0
	Complaints	x			0	x			0
CTM	P.D	27	67	22	116	0	2	0	2
	Falls	24	5	1	30	0	2	0	2
	MNE	0	1	0	1	0	0	0	0
	Complaints	x	8	3	11	x	0	0	0
HD	P.D	13	25	15	53	0	0	1	1
	Falls	21	16	15	52	0	1	0	1
	MNE	0	0	0	0	0	0	0	0
	Complaints	x	34	37	71	x	0	0	0
SB	P.D	12	10	5	27	0	0	0	0
	Falls	26	26	7	59	11	2	0	13
	MNE	0	0	1	1	0	0	0	0
	Complaints	x	36	16	52	x	1	2	3
					1515				40

* Data not provided for individual years.

Conclusion

The statistical reality of this kind of reporting is that a single period's worth of even the most detailed information would not be enough to draw any causal links between the introduction of the 2016 Act and any changes to instances of harm. Patterns and trends will be observed over longer periods of time than 3 years.

However, the truncated nature of the harm data that has been reported in these first reports makes it particularly difficult to glean much valuable intelligence. In fact, the only clear information articulated is that of the 1515 pertinent serious incidents across all health boards during the three year period, failure to maintain the nurse staffing level was considered to have been a factor in only 40 of them.

This most minimal interpretation of section 25E 2(b) lacks some important contextual data that would help of the process undertaken including:

- The number of serious incidents that took place on shifts where the nurse staffing level had not been maintained; and arguably, though not explicitly stated within the Act as a requirement,
- The number of incidents that took place on shifts where the nurse staffing level *was* maintained, yet nurse staffing levels were still deemed to have been a contributing factor.

The All Wales Nurse Staffing Group and Executive Nurse Directors are currently considering these revisions to the reporting template to be used for the second reporting period (2021-2024).

As well as including the abovementioned additional pieces of information, the CNO is of the view that more work is needed to align the output of these three-yearly reports with the kind of quality metrics that will underpin the reporting against the recently-passed Quality and Engagement Act 2020. This will be given due consideration - and developed in parallel where possible - as the regulations and statutory guidance for that legislation is developed over the coming months.

3. Actions taken in response to not maintaining nurse staffing levels

Context

As already mentioned above, the "nurse staffing level" is defined as both the required establishment *and* the planned roster. The actions taken when the required establishment was not maintained has already been touched upon under the section on the extent to which nurse staffing levels have been maintained (Cwm Taf UHB taking immediate action to rectify their lack of funding of calculated establishments, and Hywel Dda and Swansea Bay's phased approaches).

The same ICT issues described earlier in this report also have an affect here. Reporting on actions taken in *every* individual instance where the planned roster wasn't met is not currently possible due to the same lack of standardised system for capturing data. This is also something that will become more possible upon the national roll-out of the Safecare module of Allocate e-rostering software.

In their first 3-year reports, health boards have instead focussed on the actions taken in response to the incidents of harm where failure to maintain the nurse staffing level was deemed to have been a contributing factor (those outlined in the above section).

Reporting

As no quantitative data can be reported against this aspect, we are only able to assess health boards' written accounts of their actions taken in response to not maintaining nurse staffing levels. Level of detail varies slightly between health boards but they generally follow a theme of:

- General assurance around the *reasonable steps* (as set out in the statutory guidance) taken to maintain nurse staffing levels;
- Detailed root cause analysis for individual incidents of harm that occurred;
- Detailed feedback to ward sisters following that root cause analysis;
- Organisational learning around falls and hospital acquired pressure damage;
- Falls prevention training;
- Pressure damage prevention training;
- Reviews of staff redeployment decisions;
- Adapting cross-site risk assessment procedures for nurse staffing levels;
- Changing patient pathways;
- Establishing home support teams to enable earlier discharge;

Any complaints made about patient care already come under *Putting Things Right,* in which all health boards are well-versed. This procedure spells out steps health board must take to address concerns and within what timescales.

Context of Covid19 disruption

As the Covid19 pandemic took hold and societal restrictions came into force, the CNO wrote to executive nurse directors on 24 March 2020 to clarify the ways in which she expected the pandemic to disrupt business as usual processes under the 2016 Act.

That letter set out that none of the duties under the Act would be suspended, but clarified that wards that fall under section 25B of the Act would likely change. At that point, the Act's second duty was only applicable to acute adult medical and surgical inpatient wards. In the event that such a ward were repurposed to care primarily for patients acutely ill with Covid19, it would cease to be an adult medical or surgical ward and would therefore not fall under section 25B of the Act.

This guidance was given based on the reasonable worst case scenario modelling at the time, which suggested that hospitals could become predominantly occupied by such critically ill Covid19 patients. Thankfully, those grim projections were never fully realised, and by October 2020, it was clear that the reality of how hospital sites dealt with patients with Covid19 was more nuanced and complex.

Different quarantining protocols and the repurposing of inpatient bed areas were applied across NHS Wales. These ranged from: entirely Covid-free wards; wards with Covid-positive patients who are asymptomatic and being treated for other medical or surgical conditions; Covid-positive patients who are symptomatic but not acutely ill from the disease and being treated for other medical or surgical conditions; and wards where all patients are critically unwell with Covid requiring intensive care primarily for that reason.

On 15 October 2020, the CNO wrote an update letter to executive nurse directors pointing to the Act's statutory guidance that under lines "the primary purpose of the ward" is ultimately what determines its designation as an acute adult medical or surgical ward. Therefore, this letter clarified that a ward where the primary purpose of a ward remains the treatment of patients for medical or surgical conditions (regardless of whether they were Covid-positive), and the Welsh Levels of Care tool was still applicable to that setting, then it would remain under the auspices of section 25B of the Act.
Conversely, if a ward was legitimately repurposed to treat those critically unwell Covid19 patients - as we expected in March to be a more common occurrence – the CNO's view remained that those wards would be considered exclusions under section 25B.

The lived experience of the health boards - especially during the first six months of the pandemic – was highly complex and fast paced. Wards were repurposed, closed and opened with a frequency and rapid urgency that rendered the standard triangulated calculation process mandated by the 2016 Act unreasonable under the conditions. Health boards report having been led mostly by professional judgement during that period to calculate their nurse staffing levels.

Closing summary

Given the limitations to capturing and analysing data due to a lack of ICT systems referred to in this summary report, reporting in this first three-year period was always going to prove challenging for health boards. Coupled with the unprecedented disruption to process caused by the Covid19 pandemic in the third year – which was completely unpredictable when the 2016 Act was passed -

It has largely been a period of reporting on what they can, while identifying in detail, and beginning the roll-out of the solutions that will enable more detailed reporting in future three-year periods.

Headline facts are that:

- Following the first triangulated calculation under the 2016 Act in Spring 2018, there were 538.97 WTE additional nursing staff calculated as being required across Wales' adult acute medical and surgical wards (180.6 registered nurses and 358.37 healthcare support workers;
- However there was a difference between what was calculated and what was immediately funded with only 194.6 WTE of the 358.37 HCSW posts being funded from spring 2018 (as shown in table 1);
- Calculations have fluctuated significantly over the three year reporting period, notably due to health board boundary changes and the Covid19 pandemic in year 3;
- At the end of the three year reporting period, there were **139.74** additional WTE RNs and **597** additional WTE HCSWs funded into the adult medical and surgical establishments compared to March 2018 before the Act's second duty came into force;
- That equates to approximately **£21.94m** additional funding of band 3 and band 5 nursing staff (based on midpoint Agenda for Change salaries for 2021/22 with 30% on-costs);
- There were a total of 40 serious incidents/complaints where failure to maintain the nurse staffing level was deemed to have been a contributing factor;
    - 8 incidents of hospital acquired pressure damage (of levels 3, 4 and unstageable)
    - 25 falls (of levels 4 and 5)
    - 0 medication never events
    - 7 complaints about care provided by nurses

For more detail on the health boards' individual returns, please refer to their full 3-year reports attached at Annex 1.

Annex 1 – Full 3-year reports

Aneurin Bevan University Health Board
https://abuhb.nhs.wales/files/key-documents/public-board-meetings/public-board-papers-22nd-september-2021/ (Item 4.1, page 143)

Betsi Cadwaladr University Health Board
Bundle Health Board 23 September 2021 (nhs.wales) (Item 4.9, page 449)

Cardiff And Vale University Health Board
https://cavuhb.nhs.wales/files/board-andcommittees/board-2021-22/2021-09-30-final-boardbook-v5-pdf/ (Item 7.8, page 231)

Cwm Taf Morgannwg University Health Board
Microsoft Word - 7.5b Three Yearly WG Nurse Staffing Update UHB 30 September 2021 (nhs.wales) 7.5a

Hywel Dda University Health Board
https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2021/board-agenda-and-papers-30th-september-2021/agenda-and-papers-30th-september-2021/item-4-6-nurse-staffing-levels-wales-act-2016-three-yearly-2018-2021-statutory-report/

Swansea Bay University Health Board
https://sbuhb.nhs.wales/about-us/key-documents-folder/board-papers/october-2021-health-board/4-3-nsa-appendix-1-pdf/