



**PWYLLGOR DIWYLLIANT, POBL A DATBLYGU SEFYDLIADOL
PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 October 2024
TEITL YR ADRODDIAD: TITLE OF REPORT:	The reduction in the usage of nurse agency and bank and its impact on clinical outcomes.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Interim Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Janice Cole Williams, Assistant Director of Nursing Helen Humphreys, Head of Nursing, Professional Standards and Regulation

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This report provides an update on an action arising from the 15 April 2024 meeting. At that meeting, the Committee was updated on the nurse stabilisation work programme and the recruitment of internationally educated nurses and the discussion included what the impact of agency and bank reduction has had on clinical outcomes.

The action from the meeting was to “examine the triangulation between clinical outcomes and reduction of agency and bank staff, and report back to Committee”. This report provides an update on the action.

Cefndir / Background

Literature Review:

“Having the right number of nursing staff, with the right skills, in the right place, at the right time improves health outcomes, the quality of care delivered and patient safety” (Royal College of Nursing (RCN), 2021, p 4). There is a consensus amongst authors that the right number of nurses i.e. Registered Nurses (RN) with the appropriately training, knowledge and experience leads to better patient outcomes (Aiken et al., 2012; Aiken et al., 2014; Ball et al., 2014; Ball et al., 2019; Duffield et al., 2011; Griffiths, Ball, et al, 2018; Griffith, Recio-Saucedo, et al., 2018; Rauta et al., 2017; Recio-Saucedo et al., 2018; Royal College of Nursing, 2017; Royal College of Nursing, 2021; Shekelle, 2013; Twigg et al., 2014; Wynendale et al., 2019).

The duties set out in the Nurse Staffing Levels (Wales) Act 2016 (the ‘Act’) include:

- the health boards/trusts responsibilities to provide “sufficient nurses to allow the nurses time to care for patients sensitively” in all settings (Section 25a);
- The responsibilities of the designated person for calculating and maintaining the nurse staffing levels for those areas were S25b (3) applies (Section 25b and Section 25c);
- The Welsh Government’s responsibilities to develop statutory guidance (Section 25d); and
- The health boards/trust’s reporting responsibilities (Section 25e).

The statutory guidance (2021) published to support the application of the 'Act' defines nurse staffing levels as the number of RN and others who undertake nursing duties under the supervision of RN which is "appropriate to provide care to patients that meets all reasonable requirements" (Welsh Government, 2016; p. 3).

Impact of nurse staffing on patient outcomes

Studies have shown that there are links between patient acuity, nurse staffing levels, nurse to patient ratio and patient outcomes; for example, on mortality, length of stay, delays in recording vital observations, post-operative complications, patient satisfaction/dissatisfaction, rates of hospital acquired infection, missed care, falls, pressure damage and medication errors (Ball et al., 2016; Cooke et al., 2022; Dabney and Kalisch, 2015; Duffield, et al., 2011; Griffiths et al., 2014; Griffiths, Ball et al., 2018; Halm, 2019; Hirose et al., 2022; Kiekkas et al., 2019; Lasater et al., 2021; Lawless, 2014; Mitchell et al. 2018; NICE, 2014a; Persolja, 2018; Redfern et al., 2019; Rochefort et al., 2021; Shekelle, 2013; Twigg et al., 2013; Twigg et al., 2021).

The RCN's (2023) Impact of Staffing Levels on Safe and Effective Patient Care Literature Review noted that "workforce planning relies on a supply of temporary staff being available to cope with shortages, however the evidence shows that this is not an effective or efficient use of nurses when relied on in advance planning. Temporary workforces are essential to manage a shortfall of nurses but when the proportion of temporary staff is too much, this can impact patient care". There are studies which suggest that "higher registered nurse staffing levels reduce the risk of death in acute care settings" (Dall'Ora et al., 2022; p. 11; Sloane et al., 2018) and Dall'Ora (2019) found that heavy reliance on temporary staff is also associated with higher risk for patients dying. Zaranko et al. (2022) concluded that HCSW and agency staff are not effective substitutes for registered nurses who regularly work on the ward.

Staff Wellbeing: There is evidence that having the right nurse staffing levels has a positive impact on staff, with some studies showing that staff with the heaviest workloads were more likely to report job dissatisfaction; missed breaks; poor compliance with mandatory training; emotional exhaustion and their intention to leave their job whilst having the right number of staff leads to an increase in people wanting to join the profession and on retention figures (Aiken et al, 2012; Butler et al., 2019; Halm, 2019; Hill, 2017; Macphee et al., 2017; Tellez, 2012, Van den Heede et al., 2013; Wynendale et al., 2019).

Asesiad / Assessment

One of the objectives of the All-Wales Control Framework for flexible workforce capacity (WHC/2023/046) is to enhance the quality and safety of patient experience by delivering more care by our own workforce who are employed and familiar with our organisations and processes, with the focus of the work on reducing avoidable agency deployment through a clear control framework; and enhancing the supply of substantive and flexible employed workforce capacity including through NHS Workforce Banks.

The RN nursing stabilisation work programme and the recruitment of internationally educated nurses has focused on the recruitment of substantive staff to fill the nurse staffing deficits, which have required bank and agency usage, with the aim of getting to a no planned agency position across the HB by the 1 November 2024 (apart from in Bronglais Hospital (BGH) where there will be no planned agency as of the 1 March 2025).

The data for Unscheduled Care, BGH, Glangwili Hospital (GGH), Prince Phillip Hospital (PPH), Withybush Hospital (WGH); Planned Care; Mental Health and Learning Disabilities; Women and Children and Carmarthenshire, Ceredigion and Pembrokeshire counties shows that for the nursing and midwifery workforce:

- The monthly Whole Time Equivalent (wte) usage on temporary nursing workforce reported though 'Allocate' shows that the Registered Nurse agency usage has continued to reduce month on month to 143.06wte as at 30 September 2024 - (compared to 341.25wte in January 2023 - on and off contract agency usage); a reduction of 58%. The agency usage will reduce further during October as there will be newly registered nurses commencing their employment with us; internationally educated nurses also becoming registrants and agency staff continuing to take up substantive or bank posts.
- The Band 5 RN vacancy position, as of the September 2024, is 166wte compared to 277wte in May 2023 - a reduction of 40%. The vacancy position will reduce further once all the newly registered nurses commence their employment and the internationally educated nurses become registrants.

Impact of the Reduction of agency/bank on clinical outcomes

The data set out below relates primarily to 2023/24 and whilst the use of registered nurse agency was reducing during this period, there was still agency workers being utilised. Whilst there may be evidence of changes in the trends of key outcomes during 2023/24, the full impact of the reduction in agency usage won't be fully understood until after the no planned agency decision comes into effect on the 1 November 2024 (1 March 2025 in BGH). Further analysis would also be required to understand any correlation between the reduction of agency workers in particular and any changes in clinical outcomes.

Action: we will continue to monitor the impact of the reduction in agency on clinical outcomes through the development of key indicators and provide a further update to the Quality, Safety and Experience Committee in August 2025.

Datix Incidents: The reporting of incidents, accidents and near misses is key to the reduction and prevention of work-related occurrences which can result in unexpected and unwanted harm or distress for staff, patients, and others (RCN, 2024) and it is essential that staff are encouraged to report incidents. Under-reporting is a recognised issue, lack of knowledge, time, workload, personal fear, and embarrassment cited as factors in under-reporting. Staff should feel confident and psychologically safe to report openly. Having a just and learning culture, one where individuals can confidently ask for help, raise a concern without fear, and where people and innovation can flourish.

The Hywel Dda NHS Survey (2023) initial findings showed that 51% agreed and 19% strongly agreed that the organisation 'encourages us to report errors, near misses or incidents.

Patient Safety					
Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My organisation encourages us to report errors, near misses or incidents.	3%	6%	21%	51%	19%
My organisation treats staff who are involved in an error, near miss or incident, fairly.	4%	9%	48%	31%	7%
We are given feedback about changes made in response to reported errors, near misses and incidents.	7%	15%	41%	29%	7%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	3%	8%	38%	41%	10%

Patient safety incidents: There were 14,984 Patient Safety Incidents reported on Datix Cymru in Hywel Dda UHB between 1 May 2023– 30th April 2024. There were 13 incidents where workload and staffing issues were identified in that there was a mismatch between the workload and staff provision around the time of the incident, with a further 3 incidents where the investigator indicated that they may have been workload and staffing issues around the time of the incident.

Pressure Damage

- **All our services**
 - The number of pressure damage incidents which developed or worsened in our care (closed and open incidents) has seen the number being reported decrease from an average of 117 incidents a month during 2023/24 to an average of 90 incidents being reported a month for the first 5 months of 2024/25. The number of incidents reported in August 2024 was 82 incidents, a 36% reduction on the number reported in April 2023.
 - The number of incidents of avoidable harm across all our services has also decrease from an average of 21 incidents a month during 2023/24 to an average of 15 incidents a month for the first 5 months of 2024/25 (range of a high of 25 in Sept 2023 to low of 9 in August 2024). The number of incidents reported in August 2024 was 9, a 50% reduction on the number reported in April 2023.
 - The number of pressure damage incidents where a temporary worker was involved (across all our services) has also seen a decrease from an average of 7 incidents per month during 2023/24 to an average of 4 per month for the April to August 2024 period, with three incidents in August 2024 involving a temporary worker (a reduction of 57% on the number reported in April 2023).
- **Adult Wards where S25B applies:**
 - The number of pressure damage which developed or worsened in our care on the adult wards where section 25B of the Nurse Staffing Levels (Wales) Act (the 'Act') applies i.e. adult acute medical and surgical inpatient wards; where most of the nursing stabilisation work has focused has remained the same (an average of 25 incidents per month) . However, the number of incidents resulting in avoidable harm has decreased from an average of 11 per month during 2023/24 to an average of 6 per month April-August 2024. The number of incidents reported in August 2024 was 7, a 22% reduction on the number reported in April 2023.
 - The number of pressure damage incidents where a temporary worker was involved has also seen a decrease from an average of 4 incidents per month during 2023/24 to an average of 2 per month for the April to August 2024 period, with no incidents in August 2024 involving a temporary worker.

Falls

- **Across all our services,**
 - The average number per month of slips, trips and falls that affect patients being reported for April-August 2024 remains the same as the average number per month reported during 2023/24 – an average of 223 incidents per month, with the majority of the incidents resulting in no or low harm (post investigation).
 - During 2023/24 the percentage of incidents resulting in moderate and above harm was 3.61% of the total number reported. For the April-August 2024 period, the percentage of those incidents resulting in moderate and above harm had decrease slightly to 2.39% of the total number reported.
 - The number of slips, trips and falls where a temporary worker was involved (across all our services) has seen an increase from an average of 31 incidents per month during 2023/24 to an average of 35 per month for the April to August 2024 period, However, the number of incidents reported in August 2024 was 9, a 78% reduction on the number reported in April 2023.
- **Adult Wards where S25B applies:**
 - The number of slips, trips and falls has seen a decrease across these wards; from an average of 116 incidents per month during 2023/24 to an average of 104 per month

for the April to August 2024 period. The number of incidents reported in August 2024 was 106, a 10% reduction on the number reported in April 2023.

- The number involving a temporary worker has also decreased from an average of 17 per month (range of 8-25 per month) to an average of 15 per month for the April to August 2024 period. The number reported for August 2024 was 2,
- The assessment of harm post investigation was no or low for the majority of incidents. However, the percentage of moderate or above harm has increased slightly from 1.36% of the total incidents reported during 2023/24 being moderate or above harm, to 1.77% of the total incidents being reported for April-August 2024, with two incidents in April 2024 having resulted in severe harm (post investigation).

Medication Administration Errors

- **Across all our services,**
 - The number of medication administration errors affecting patients (closed and open incidents) has seen the number being reported decrease from an average of 52 incidents per month during 2023/24 to an average of 47 incidents per month for the first 5 months of 2024/25. The number of medication administration errors reported in August 2024 was the same number as reported in April 2023 (43).
- **Adult Wards where S25B applies:**
 - The number of medication administration errors being reported on these wards has seen a decrease from an average of 12 incidents per month during 2023/24 to an average of 8 per month for the April to August 2024 period. The number of incidents reported in August 2024 was 9, a 25% reduction on the number reported in April 2023.
 - The number involving a temporary worker has decreased from an average of 5 per month (range of 2-10 per month) to an average of just over 2 per month for the April to August 2024 period.

Incidents involving temporary staff – the average number of all incidents that involved a temporary worker during 2023/24 was 120 per month. For the April-August 2024 period this has decreased to an average of 104 per month, with 64 incidents reported in August (the lowest in-month number during the April 2023 and August 2024).

Complaints/Concerns: Of the 2243 complaints received during 2023/24, 169 were deemed, following the investigation, to be wholly or partly about nursing care (7.53% of the total number of complaints received). Of the 1010 complaints received between 1 April 2024 and 31 August 2024, 22 were deemed, following the investigation, to be wholly or partly about nursing care (2.18% of the total number of complaints received).

The main subject of the complaints which were wholly or partly around nursing care during 2023/24 were those related to clinical treatment and assessment (68 complaints). This was followed by discharge issues (20) and patient care (9 complaints). Clinical treatment and assessment (6 complaints) and patient care (4) continue to feature as the subject of the complaints which are wholly or partly about nursing care, but the number of complaints featuring discharge planning appear to have decreased (2 received for the five month period April-August 2024).

Risk and Limitations:

- The comparison is between all the data for 2023/24 and the first five months of 2024/25 and the pressures linked to the winter period may change the position.
- As more substantive staff are recruited, the number of nursing and midwifery vacancies decreases, however, it is recognised that in a number of our clinical areas we have

inexperienced, newly registered nurses and nurses who are new to the UK Health Service who will need time and support to become established in their registered nurse role.

Conclusion: It is too early to say whether the reduction in use of temporarily staff, particular agency workers is contributing to some of the positive changes seen in the above data and it is unlikely that the reduction in the use of agency workers is the only factor that has resulted in this change. Examples include:

- Continued focus on supporting staff with training and education around the three incident types set out above.
- Teams undertaking EQLiP projects which have focused on reducing patient safety incidents - The Emergency Department in Glangwili have undertaken a project to reduce patient safety incidents in the department which has included pressure damage and the recording of the NEWS scores, the Bronglais unscheduled care wards have undertaken a project focusing on hydration and fluid balance.
- The implementation of 'I' Stumble within Community Hospitals across the three counties, to support assessment of fallen patient outside of medical cover.
- Medication management quality improvement work including the introduction of green transfer bags to reduce medications being left on previous wards, pilot of new intravenous infusion lines, which can be flushed resulting in the full dose of intravenous (IV) medication being given, switching medication from IV to oral being promoted to reduce the number of days patients require IV medication; and single nurse IV medication trial on Clinical Decisions Unit in Glangwili Hospital.

Triangulating the data:

There are other mechanisms and data that we can use to triangulate the impact of reduction in temporary staffing on clinical outcomes. These include:

- **'WalkRounds'**- staffing levels and availability has been a theme raised during the 'WalkRounds' up to June 2024; raised during 15 of the 29 'WalkRounds'. We will monitor the feedback from WalkRounds undertaken from July 2024 onwards to see whether this theme continues to feature. The next thematic report is due to be presented to QSEC in December 2024.
- **Duty of Candour:** During 2023/24, there were 51 closed incidents (across all services) where the duty of candour had been triggered – the incidents included slip, trips and falls, pressure damaged developed/worsened whilst receiving health care and treatment/procedural issues.

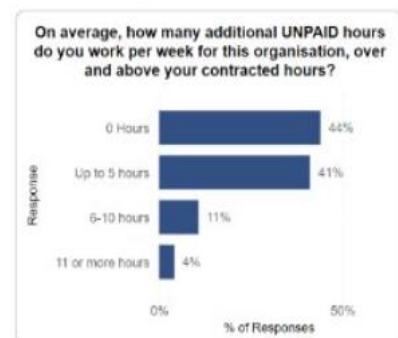
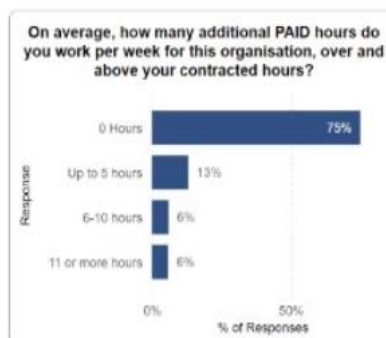
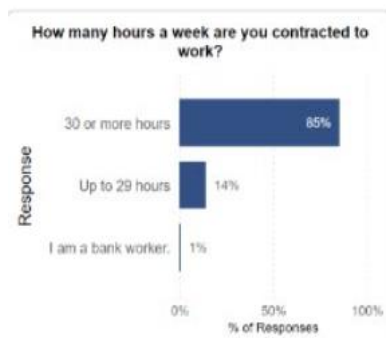
Between 1 April 2024 and the 30 June 2024, there were 63 closed incidents (across all services) where the duty of candour had been triggered - the incidents included patient falls, pressure damage developed/worsened whilst receiving health care, avoidable hospital acquired thrombosis, deteriorating NEWS not escalated and treatment/procedural issues.

- **Public Services Ombudsman for Wales reports** – of the reports received during 2023/24, the themes included:
 - Care/treatment not following appropriate guidance;
 - Lack of reasonable adjustments;
 - Medication;
 - Communication;
 - Documentation / poor record keeping;

- Failures in relation to treatments, test, diagnosis;
- Discharge issues;
- Nutrition / hydration; and
- Complaint handling.

- **NHS Staff Survey** – Whilst recognising that the survey was for all staff groups, the 2023 NHS staff survey initial findings showed that when asked about work pressure, the respondents noted the following.

Morale					
Work pressure					
Question	Never	Rarely	Sometimes	Often	Always
I am able to meet all the conflicting demands on my time at work.	3%	11%	35%	41%	10%
I have adequate supplies, materials and equipment to do my work.	2%	11%	24%	39%	24%
There are enough staff at this organisation for me to do my job properly.	11%	21%	34%	26%	9%



The NHS Staff Survey 2024 opens on the 1 October 2024, and this will be a useful comparator, which will help to inform the impact of reducing the reliance on a temporary workforce on our staff.

Monitoring of Key Quality indicators:

- The number and level of harm of falls, pressure damage and medication errors are considered as part of any nurse staffing level review. At least every six months for those wards where Section 25B of the Nurse Staffing Levels (Wales) Act applies i.e. adult acute medical and surgical inpatient wards and paediatric inpatient wards and for Section 25A areas when a nurse staffing review is undertaken.
- Operational teams have scrutiny processes in place that enable incidents and complaints to be reviewed and consideration given to what actions need to be taken and what learning can be shared.
- There are health board and operational groups which focus on key aspects of care and monitor practice related issues. e.g. the nutrition and hydration and falls groups.

Argymhelliad / Recommendation

The People, Organisational Development & Culture Committee is requested to:

- NOTE the content of the report, and
- SUPPORT the action set out in the report i.e. that we will continue to monitor the impact of the reduction in temporary staff, particularly agency workers, on clinical outcomes and provide an update to the Quality, Safety and Experience Committee in August 2025.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Committee ToR Reference:
 Cyfeirnod Cylch Gorchwyl y Pwyllgor:

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	6. Person-Centred 1. Safe
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care 3. Striving to deliver and develop excellent services
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Data extracted from Datix, Our Performance dashboard and papers presented to Board and the Quality, Safety and Experience Committee
Rhestr Termiau: Glossary of Terms:	RN – Registered Nurse HCSW – Health Care Support Worker
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Diwylliant, Pobl a Datblygu Sefydliadol: Parties / Committees consulted prior to People, Organisational Development & Culture Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	The report sets out the impact on patient safety as reported via datix and those incidents where a temporary worker was involved.
Gweithlu: Workforce:	The report sets out the number of incidents where a temporary worker was involved.
Risg: Risk:	Not applicable

Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	not applicable
Gyfrinachedd: Privacy:	all data is anonymous
Cydraddoldeb: Equality:	not applicable