



**Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	09 October 2025
TEITL YR ADRODDIAD: TITLE OF REPORT:	Nurse Staffing Levels: Impact of Reduction of Agency and Bank Staff on quality, safety, and patient experience
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Janice Cole-Williams, Assistant Director of Nursing Helen Humphreys, Head of Nursing, Professional Standards and Regulation Catrin Jones, Nurse Staffing Programme Lead

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA
SBAR REPORT**

Sefyllfa / Situation

This paper provides the Quality, Safety and Experience Committee with an updated on the impact of reduction of agency and bank staff on quality, safety, and patient experience.

Cefndir / Background

Reviewing the impact of reduction of agency and bank staff on quality, safety and patient experience originated from an action from the People, Organisational Development & Culture Committee (PODCC) on 9th April 2024. An update on the stabilisation work programme, the recruitment of internationally educated nurses included a discussion on whether there had been any impact of these changes on clinical outcomes. A subsequent 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 update was provided to People, Organisational Development & Culture Committee (PODCC) on the 29th of October 2024 hduhb.nhs.wales/about-us/governance-arrangements/board-committees/people-organisational-development-and-culture-committee-podcc/podcc-29-october-2024/2-3-workforce-efficiency-update/. The Committee received assurance from the report, but the update highlighted the need for further review of any impact these changes may be having on the quality, safety, and experience of patients and that subsequent updates would be provided to the Quality, Safety and Experience Committee.

An SBAR was presented to the Quality, Safety and Experience Committee on 13th February 2025. hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/qsec-13-february-2025/2-1-nurse-staffing-levels-impact-of-reduction-of-agency-and-bank-staff-interim-report/, and the committee received assurance from the report.

Work currently being undertaken is in line with requirements set out in the Nurse Staffing Levels (Wales) Act 2016 (the ‘Act’) and includes:

- The health board’s 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 Board’s reporting responsibilities (Section 25e). The statutory guidance (2021) published to support the application of the ‘Act’ defines nurse Page 2 of 11 staffing levels as the number of Registered Nurses (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)

Asesiad / Assessment

The data for Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups shows that:

- As of July 2025, the Band 5 vacancy position was 131wte. When compared to the vacancy position in May 2023 (277wte), this is a 52% reduction.

RN Band 5 vacancies:		
July 2025	Sept 2024	May 2023
131wte	166wte	277wte

The vacancy position is expected to reduce further once the September 2025 newly registered nurses commence their employment with us.

- The monthly Whole Time Equivalent (wte) usage of temporary nursing workforce reported through Allocate shows that Registered Nurse (RN) agency usage has seen a reduction and is currently 63.06wte as of August 2025 (although slightly up on the July 2025 position). This compares to 105.36wte for December 2024 (and 341.25wte in January 2023), an overall reduction of 81.5% since January 2023 and a 40.15% on the December 2024 position. Vacancy and short-term sickness are the main reasons for RN agency requests. Agency usage is expected to reduce further over the coming months due to the placement of newly registered nurses starting with us as of September 2025.
- The 12-month rolling sickness for Registered Nurses for August 2025 was 6.7%. The 12-month rolling sickness has been consistent since April 2023 - with a low of 6.4% in December 2024 and a high of 7% in April 2023.

Incident reporting: a downward trend in reporting has been seen across the HB when comparing the number of incidents reported during 2024/2025 when compared to previous years. An exploration of the top classification and categories has been undertaken by the Quality, Safety and Assurance Team which shows that the reduction is in the number of pressure and moisture damage incidents being reported. The reduction in these types of incidents being report is due to targeted work to remove duplicate incidents and improved understanding about reporting of pressure damage identified on admission.

The Quality metrics reviewed for the purpose of this report are as follows:

Patient safety incidents: There was a total of 31,671 Patient Safety Incidents reported across all services within Hywel Dda UHB between 1st April 2023– 31st July 2025 (data from Datix Cymru).

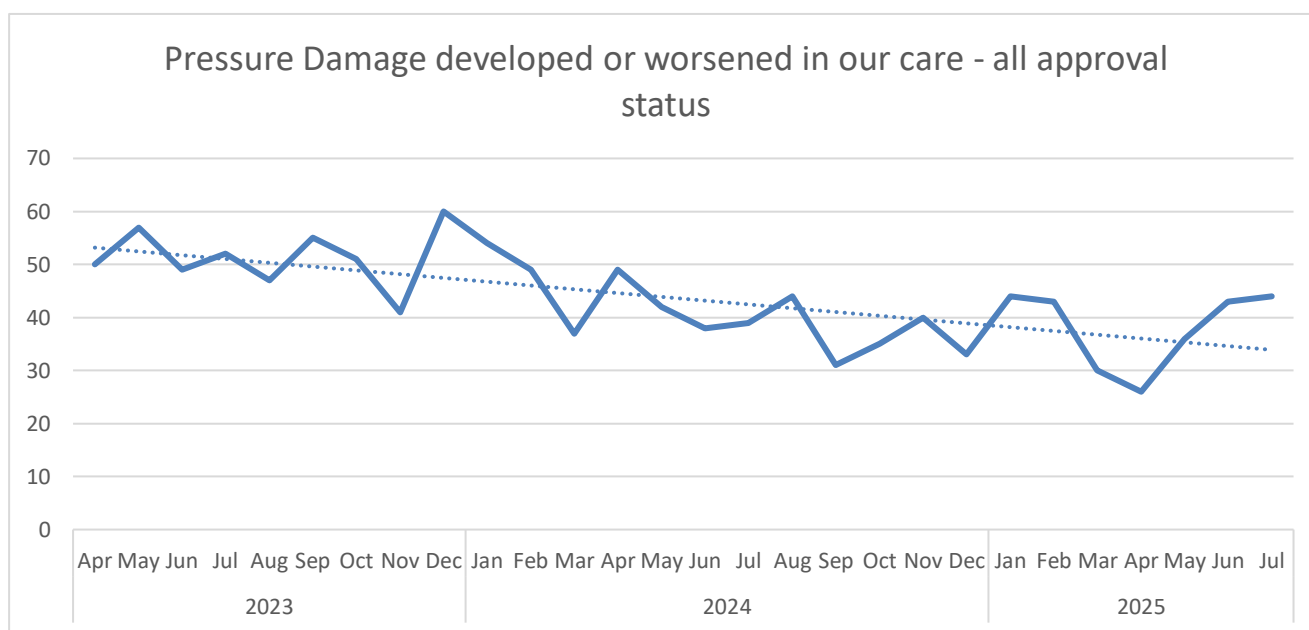
The incidents referenced below are for the Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups and is for

those areas where bank and/or agency staff are predominantly utilised. The incident data in this SBAR may therefore be different from the incident data referenced in other reports.

Pressure Damage which developed or worsened in our care (including pressure damage from medical device which developed or worsened in our care)

All our services (Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups): There continues to be a downward trend in the number of pressure damage which developed or worsened in our care since 1st April 2023. Some of the reduction in these types of incidents is due to targeted work to remove duplicate incidents and improved understanding about reporting of pressure damage identified on admission (since November 2023) mentioned previously.

Time period	Average number of incidents reported per month
April-December 2023	51.3 incidents (range a high of 60 in December 2023 to a low of 51 in November 2023)
January-December 2024	40.9 incidents (range a high of 54 in January 2024 to a low of 26 in April 2024)
January-July 2025	38 incidents (range a high of 44 in January and July 2025 to a low of 26 in April 2025)



- **Avoidable harm:** The number of incidents of avoidable harms across these services has also decreased.

Time period	Average number of incidents reported per month
April-December 2023	18.8 incidents (range a high of 24 in Sept 2023 to a low of 14 in May 2023)
January-December 2024	17 incidents (range a high of 25 in February 2024 to a low of 11 in December 2024)
January-July 2025	13.4 incidents (range a high of 18 in January 2025 to a low of 9 in April 2025)

- **Temporary worker:** The number of pressure damage incidents which developed or worsened in our care where a temporary worker was involved (across all our services)

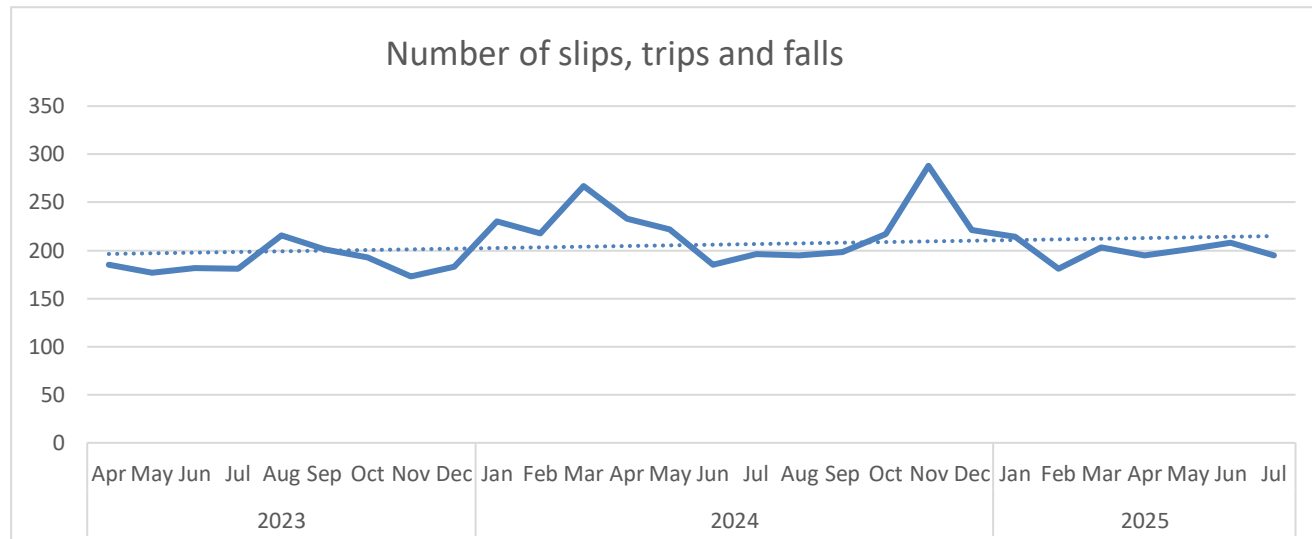
has also seen a decrease from an average of 7.2 incidents per month during 2023 to an average of 5.08 per month for 2024, and to 2.2 per month for the period Jan-July 2025.

Adult Wards where S25B applies: The number of pressure damage cases 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, has reduced from an average of 25.44 per month in 2023 to an average of 22.25 per month in 2024 and an average of 16.7 per month for the period January to July 2025.

- **Avoidable harm:** The number of incidents of avoidable harms across our S25B adult wards has also decreased. An average of 8.1 per month in 2023, 7.8 per month in 2024 and an average of 6.1 incidents per month the period January to July 2025.
- **Temporary worker:** The number of pressure damage incidents which developed or worsened in our care where a temporary worker was involved (across S25B adult wards) has also seen a decrease from an average of 1.7 incidents per month during 2023 to an average of 0.66 per month for 2024, and to 0.1 per month for the period Jan-July 2025.

Falls

Across all our services (Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups) - There was an increase in the total number of falls being reported across these services between 2023 and 2024 (from an average of 118.7 falls per month in 2023 to an average of 222.5 incidents of falls in 2024) but a decrease between 2024 and 2025 with an average of 199.57 falls per month for January to July 2025.



- **Level of Harm:** for those incidents that have been investigated and closed the number of falls resulting in no or low harm (post investigation harm assessment) increased between 2023 and 2024 (an average of 184 per month in 2023 and an average of 216.66 per month in 2024) but has decreased between 2024 and 2025 with an average of 171.14 per month for January to July 2025. There is also a downward trend in those incidents that have been investigated and closed that have resulted in resulting in moderate, severe or catastrophic harm (post investigation harm assessment) (an average of 3.3 per month in 2023, an average of 1.9 per month in 2024 and an average of 0.42 per month for January to July 2025).
- **Temporary worker:** The number of falls where a temporary worker was involved (across all our services) increased between 2023 and 2024 from an average of 28.55

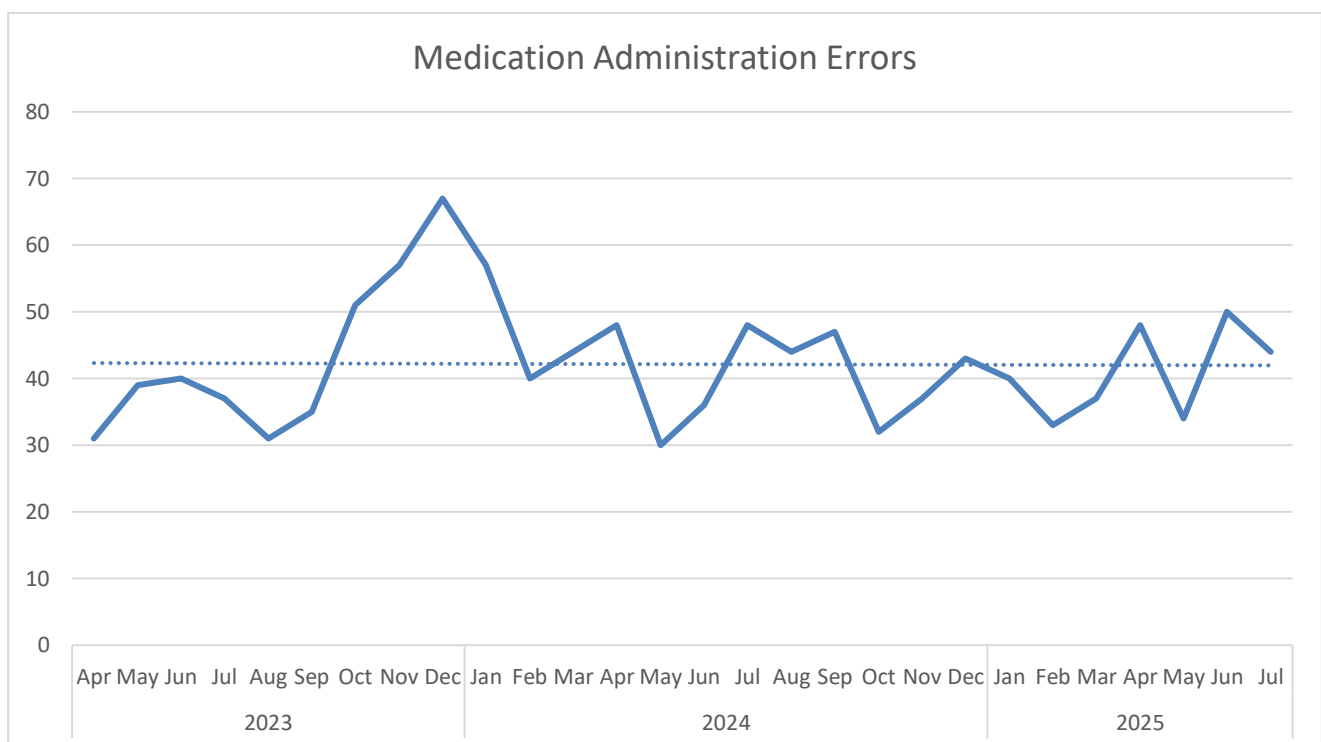
incidents per month during 2023 to an average of 29.25 per month for 2024. The number of falls where a temporary worker was involved has decreased to an average of 5.85 incidents per month for the period Jan-July 2025.

Adult Wards where S25B applies: The number of falls reported across the wards where S25B applies increase between 2023 and 2024 (an average of 103.22 per month in 2023 to 111.16 per month in 2024) but has decreased between 2024 to 2025 with an average of 108.57 per month for the period January to July 2025.

- **Level of harm:** For those incidents that have been investigated and closed there was increase in the number of falls resulting in no or low harm (post investigation harm assessment) between 2023 and 2024 (an average of 101.66 per month in 2023, an average of 106.91 per month in 2024) but there has been a decrease between 2024 and 2025 with an average of 97.28 per month for January to July 2025.
- For those incidents that have been investigated and closed that have resulted in moderate, severe, or catastrophic harm (post investigation harm assessment) there was an average of 1.44 per month in 2023, and an average of 1.16 per month in 2024. There are no closed incidents of falls resulting in moderate, severe, or catastrophic harm for 2025 but there are three open incidents for 2025 which are currently being investigated.
- **Temporary worker:** The number of falls where a temporary worker was involved (across S25B wards) has decreased from an average of 16.5 incidents per month during 2023 to an average of 12.75 per month for 2024 and 3.2 per month for the period January to July 2025.

Medication Administration Errors

Across all our services (Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities Clinical Care Groups): The number of medication administration errors affecting patients (closed and open incidents) is reported as seeing a small decrease from an average of 43 incidents per month during 2023 to an average of 42 incidents per month for 2024 and an average of 41 incidents per month for January to July 2025.



- **Temporary worker** - The number involving temporary staffing has seen a decrease from an average of 12.6 incidents per month in 2023 to an average of 13.5 incidents per month in 2024 to an average of seven incidents per month for the period January to July 2025. In 2024, a robust monitoring process was introduced to support temporary staff to orientate to new areas.

Adult Wards where S25B applies • The number of medication administration errors affecting patients has seen a decrease with an average of fourteen incidents per month reported in 2023 compared to 12.5 incidents in 2024 and 12.4 incidents for January to July 2025.

- Temporary worker - The number involving a temporary worker has seen a decrease from 5.55 incidents per month in 2023 to an average of 3.9 incidents per month in 2024 and an average of 2.85 incidents per month for January to July 2025.

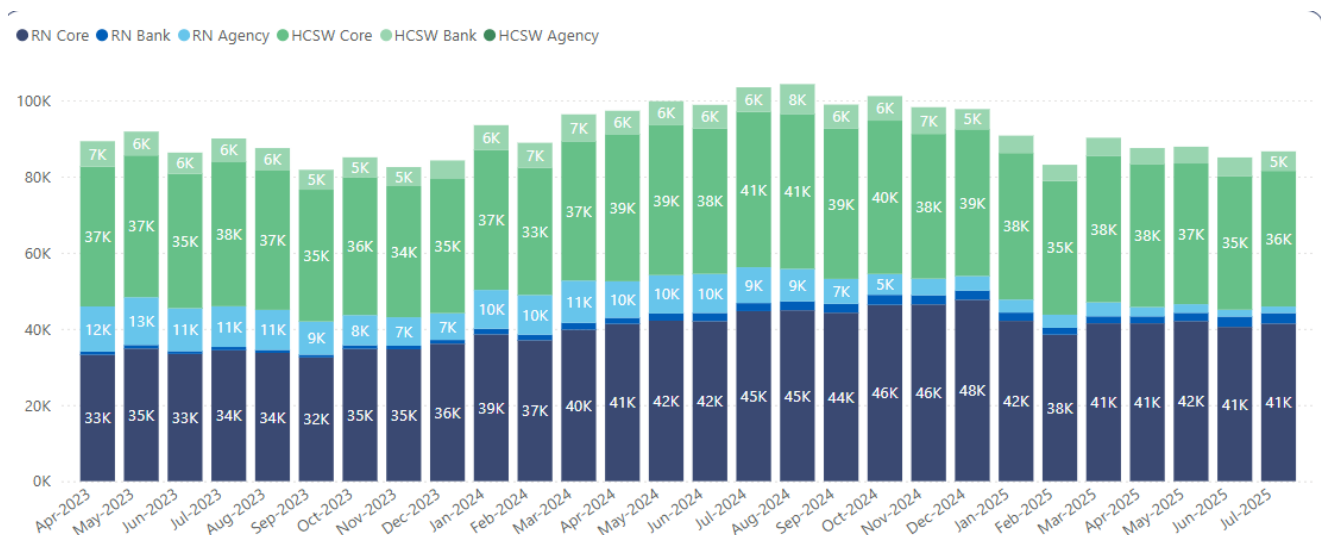
The HB will be shortly rolling out an Electronic Prescribing and Medicines Administration (EPMA) system. It is anticipated that the roll out of EPMA will reduce medication errors linked to illegibility, multiple or missing drug charts and incorrect dosing or frequency. However, EPMA will not reduce errors linked to human factors, communication breakdowns or adverse drug reactions. [Medication-Related Incidents and the Potential Impact of EPMA Systems](#) (2024)

Number of RN and Health Care Support Worker (HCSW) staffing Hours on S25B wards - this data is captured via safecare for those areas where section 25B of the Act applies. The data sets out the number of hours worked by:

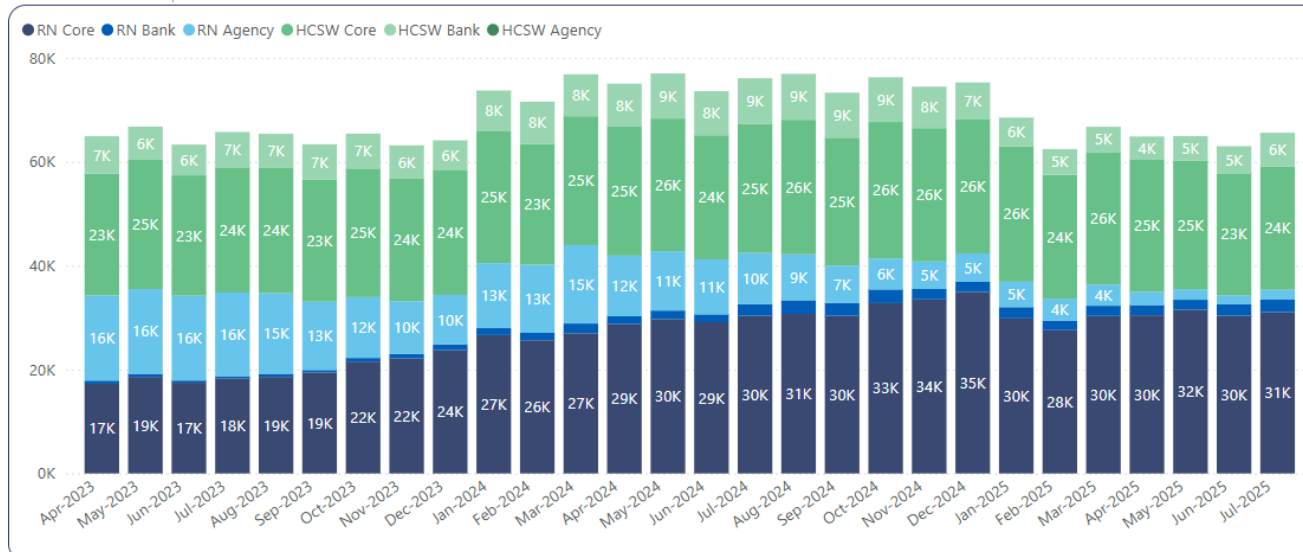
- RN core (substantive staff)
- RN bank
- RN agency
- HCSW core (substantive staff)
- HCSW bank
- HCSW agency (if applicable)

For the adult S25B wards, the data shows that although agency staff were being deployed on both day and night shifts, most of the agency usage was at night (most agency staff indicated that they would prefer to work night duty rather than day duty). The data does show the decrease in agency usage since April 2023, which is particularly noticeable on the graph for the night shifts (the lighter blue in the two graphs). the data also shows the corresponding increase in RN core hours (the darker blue in the two graphs).

Day - Number of RN and HCSW staffing Hours.



Night - Number of RN and HCSW staffing Hours.



Falls – the times of the incidents of falls have been reviewed and where the time of the incident is record, the average numbers of falls that occurred between 730pm and 730am for 2023 was 99.66 per month. This increased to an average of 107.16 per month for 2024 but has decreased to 94.28 per month for the period January-July 2025.

Risk and Limitations for this paper:

- it is recognised that the data for 2023 and 2025 is part year data (9 months and 7 months respectively) whereas the data for 2024 is for the full 12 months and this may impact on some of the analysis.
- As more substantive staff are recruited, the number of nursing and midwifery vacancies decreases, however, it is recognised that in several of our clinical areas we have inexperienced, newly registered nurses and nurses who are new to the UK Health Service (particularly in BGH) who will need time and support to become established in their registered nurse role.

Conclusion:

The data does suggest that there have been positive changes in terms of patient outcomes since April 2023 and whilst some of this is down to the reduction of bank and agency usage, it is unlikely that the reduction in the use of bank and 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.
- Changes in the way we report, for example the targeted work to remove duplicate incidents relating to pressure damage which develops or worsens in our care mentioned in this paper.

Triangulation of date

“Walkrounds” – the ‘walkrounds’ undertaken during 2024/2025 included both positive observations and areas for improvement. The positive observations included staff commitment, compassion, teamwork, and morale. The areas requiring improvement included workforce pressures including staff shortages in several areas particularly in Mental Health and Community nursing and reliance on temporary staff in those areas.

There has been work undertaken to review the nurse staffing levels on the Mental Health inpatient wards and the additional finance requirements have now been transacted into the budgets., with a recruitment plan in place to recruit the additional staff required.

There has been work undertaken within the community teams to consider the National Community Nursing Specification: Overarching principles, characteristics, and functions of Community Nursing in Wales (2022) and work towards the staffing principles set out in the document.

Health Inspectorate Wales (HIW) reports: one visit undertaken by HIW during 2024/2025 and two visits undertaken by HIW during 2023/2024 noted concerns around staffing levels. There has been work undertaken to review the nurse staffing levels in these areas which includes the mental health inpatients staffing review noted above. There has also been work undertaken within our Emergency Departments with the nursing workforce increased in both WGH and GGH, and work ongoing in the Emergency and Urgent Care Unit (EUCC) in BGH.

Duty of candour –During 2024/25, there were 132 patient safety incidents that triggered the duty of candour. There were 104 recorded as moderate harm, 19 as severe harm and 9 as catastrophic/death [hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/qsec-10-june-2025/4-4-duty-of-candour-report-2024-25/](https://www.hduhb.nhs.wales/about-us/governance-arrangements/board-committees/quality-safety-and-experience-committee-qsec/qsec-10-june-2025/4-4-duty-of-candour-report-2024-25/). There is no comparable data for previous years as the Duty of Candour came into force on 1st April 2023. The themes of the patient safety incidents included in-patient slips, trips or falls (20% of the incidents) ; pressure damage that developed or worsened whilst receiving healthcare (11% of the incidents); inappropriate monitoring and/or escalation (8% of the incidents) and medication error/delay/omission (4% of the incidents).

The learning identified included:

- ensuring that required training has been completed and competency assessed,
- introduction of peer review of pressure damage to confirm grading,
- Use of body map for pressure damage
- the use of the cannula bundle and recording Visual Infusion Phlebitis (VIP) score
- importance of environment and patient safety huddles.
- Importance of assessing overall clinical picture
- Importance of completing NEWS correctly and escalating accordingly.

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 most demanding workloads were more likely to report job dissatisfaction exacerbated by missed breaks; poor compliance with mandatory training; emotional exhaustion and their intention to leave their job, Having the right number of staff, however, leads to an increase in people wanting to join the profession and improved 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). Data we do have is shown below.

Staff Survey – whilst the positivity score for the theme patient safety increased from 48.5% in 2023 to 57.1% in 2024 (an increase of 8.7%) , the theme highlighted that staff feel unsafe in reporting errors, near misses or incidents and there is a perception that those that do report are treated unfairly and there is little feedback after doing so. Whilst the survey included all staff groups, this has implications for nursing. The Quality Assurance and Safety Team are:

- Considering additional areas for inclusion in newsletters and 7-minute briefings.

- Reminding investigation managers of the importance of documenting within the relevant section in the Datix Incident Module the feedback to the reporter which shows that the time taken by the reporter is valued.
- Working with Clinical Service Groups (where reporting levels are lower than expected) to develop trigger lists for incident reporting.
- Working with Clinical Service Groups to refocus the Scrutiny Panels to become Learning from Events Panels.
- Working with acute hospital pharmacy colleagues to consider how medication prescription errors identified before administration (near miss incidents) can be captured as these are captured within pharmacy systems rather than in Datix Cymru.

Percentage of staff how had had a Performance, Appraisal and Development Review (PADR) in the last 12 month – The data for Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities shows that as of August 2025, 82% of registered nurses and midwives have had a PADR, this compares to 72.6% in April 2023, 76.6% in April 2024 and 82.6% in April 2025.

Percentage staff compliance with the Core Skills Training Framework - The data for Community and Integrated Medicine, Planned and Specialist Care and Mental Health and Learning Disabilities shows that as of August 2025, 92.7% of registered nurses and midwives are compliant with the Core Skills Training Framework, this compares to 90.3% in April 2023, 91% in April 2024 and 91.5% in April 2025

Patient experience –

- **Complaints/concerns** - there was one complaint received in 2023 which was managed though PTR were the failure to maintain the planned roster was deemed to be a contributory factor to the nature of the complaint, this increased to six complaints in 2024. For the period January-July 2025 there has been one complaint were the failure to maintain the planned roster was deemed to be a contributory factor to the nature of the complaint.
- Feedback from the walk arounds included comments about the kindness and professionalism of staff.
- For the period April and May 2025, 203 compliment were received direct to wards, departments, or the Chief Executive/Chair’s office and these highlighted the professionalism and compassionate care provided by healthcare teams.

Monitoring of key indicators

The number and level of harm of falls, pressure damage and medication errors are considered as part of any nurse staffing level review. Reviews are undertaken as a minimum of six monthly for those wards where Section 25B of the Nurse Staffing Levels (Wales) Act applies i.e. adult acute medical and surgical inpatient wards, paediatric inpatient wards. and for any 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. Scrutiny & Assurance Meetings are held for each acute site (with representation from community teams) to monitor and scrutinise inpatient falls, identifying causal factors and sharing learning to prevent recurrence.
- Outcomes from the Scrutiny & Assurance Meetings feed into the Clinical Care Groups Governance arrangements
- The Adult Inpatient Falls Reduction Improvement Group (AIFRIG) was established as a group of the Quality, Safety and Experience Sub Committee in May 2023. The role of the Group is to “review and analyse claims, learning from events and performance reports which will help inform operational direction and contribute to the reduction and

improvement of inpatient falls. This group will now report into Integrated Quality, Financial Performance and Delivery Group.

- There are health board and advisory groups which focus on key aspects of care and monitor practice related issues. e.g. the Nutrition and Hydration Group, Falls Group and Medication Errors Review Group (MERG).

Argymhelliad / Recommendation

The Quality, Safety and Experience Committee is requested to take assurance that a review of the reduction of agency and bank staff initiative has not identified any adverse impact on the quality, safety, or experience outcomes of patients, however, this will continue to be closely monitored.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1 Scrutinise, assess, and seek assurance in relation to the patient impact, quality and health outcomes of the services provided by the Board
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)	1. Safe 6. Person-Centred Choose an item. Choose an item.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	3. Data to knowledge 4. Learning, improvement and research Choose an item. Choose an item.
Amcanion Strategol y BIP: UHB Strategic Objectives:	1. Striving teams Choose an item. Choose an item. Choose an item.
Amcanion Cynllunio Planning Objectives	1 Workforce Stabilisation Choose an item. Choose an item. Choose an item.
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 Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Data extracted from Datix, Our Performance dashboard and papers presented to People Organisational Development Culture Committee
Rhestr Termâu: Glossary of Terms:	RN – Registered Nurse HCSW – Health Care Support Worker

Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	Not applicable
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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 Impact of Reduction of Agency and Bank Staff on Quality, Safety and Patient Experience
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	All data is anonymous
Cydraddoldeb: Equality:	Not applicable