



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Iau, 15 Ionawr 2015
Thursday, 15 January 2015

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir

trawsgrifiad o'r cyfieithu ar y pryd.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Peter Black	Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar ran Kirsty Williams)
	Welsh Liberal Democrats (substitute for Kirsty Williams)
Alun Davies	Llafur
	Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig
	Welsh Conservatives
John Griffiths	Llafur
	Labour
Elin Jones	Plaid Cymru
	The Party of Wales
Darren Millar	Ceidwadwyr Cymreig
	Welsh Conservatives
Lynne Neagle	Llafur
	Labour
Gwyn R. Price	Llafur
	Labour
David Rees	Llafur (Cadeirydd y Pwyllgor)
	Labour (Committee Chair)

Eraill yn bresennol
Others in attendance

Dan Greaves	Pennaeth yr Uned Alcohol a Chyffuriau, y Swyddfa Gartref
	Head of Drugs and Alcohol Unit, the Home Office
Lisa Salkeld	Gwasanaethau Cyfreithiol, Comisiwn Cynulliad Cenedlaethol Cymru
	Legal Services, National Assembly for Wales Commission
Angela Scrutton	Pennaeth Deddfwriaeth Cyffuriau, y Swyddfa Gartref
	Head of Drugs Legislation, the Home Office
Philippa Watkins	Gwasanaeth Ymchwil, Comisiwn Cynulliad Cenedlaethol Cymru
	Research Service, National Assembly for Wales Commission
Kirsty Williams	Aelod Cynulliad, Democratiaid Rhyddfrydol (Aelod sy'n Gyfrifol am y Bil)
	Assembly Member, Liberal Democrats (Member in Charge of the Bill)

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Amy Clifton	Gwasanaeth Ymchwil
	Research Service
Sian Giddins	Dirprwy Glerc
	Deputy Clerk
Llinos Madeley	Clerc
	Clerk

Sian Thomas

Gwasanaeth Ymchwil
Research Service

*Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.*

Cyflwyniadau, Ymddiheuriadau a Dirprwyon Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members to the first session of this term of the Health and Social Care Committee? I hope you all had a pleasant Christmas and enjoyable new year. Back down to the business of the committee now. The meeting is bilingual. If you wish to use the headphones, please remember that it is channel 1 for translation from Welsh to English, but it is now channel 2 for amplification. Can I remind people, please, to turn your mobile phones off, or any other electronic equipment that may interfere with the broadcasting equipment? If possible, can you please make sure that your iPads and the phones—the ‘pings’ when messages come through—are off? There is no fire alarm scheduled today, so, if there is one, please follow the instructions of the ushers. We have received apologies from Lindsay Whittle for this morning. I haven’t received any other apologies. Obviously, a few Members are running a bit late this morning.

09:31

Papurau i’w Nodi Papers to Note

[2] **David Rees:** If we move on to item 2 on the agenda, we have some papers to note. Can we go through them in sequence? We have the minutes of the previous meeting on 10 December. Is everyone okay with those? The response from the Minister for Health and Social Services to the additional letter we sent regarding the inquiry into the NHS complaints process follows on from the initial response of the Minister. You have all had that. Are you happy to note that? The response of the Minister for Health and Social Services to our letter of 5 November on the follow-up inquiry into the contribution of community pharmacies in Wales. Okay.

[3] We then have the additional information from the Minister for Health and Social Services, which was given to Darren Millar and copied to the committee, on the health services for the proposed new prison in Wrexham.

[4] Then we have the correspondence from the Chair of the Children, Young People and Education Committee in reply to our request about the work on the autistic spectrum disorder.

[5] We have the letter from the Minister for Health and Social Services regarding the Commissioner for Older People in Wales’s report, ‘A Place to Call Home?’

[6] Finally, we have correspondence from the Chair of the Petitions Committee, regarding the petition P-04-570, Inequitable Access to Treatments That Have Not Been Nationally Appraised in NHS Wales. In relation to that particular letter, are you content for me to reply, because we have a situation where we have a very hectic workload—. It refers mainly to individual patient funding requests; we have responded about IPFR in our cancer delivery plan report and during the debate on the cancer delivery plan. The Minister has also, since the original petition, actually announced a review of the IPFR and the review, or the review that will take place, and which we will monitor. Are you therefore happy for me to respond to the Petitions Committee in that light, to state those issues and that we will, as a

consequence, not be undertaking any further work on IPFR, but we will be monitoring? Kirsty.

[7] **Kirsty Williams:** Well, I still regard the situation as unsatisfactory, but the Minister has made it quite clear, his position, and I don't know whether any more work by this committee would be able to change that situation.

[8] **David Rees:** I think my view is that, because we will be partaking in, or looking at the review of that, we will come back to it, throughout the review process.

[9] **Kirsty Williams:** Sure.

[10] **David Rees:** Okay, thank you for that.

[11] That is all the papers to note.

09:33

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Meeting**

Cynnig:

Motion:

y pwyllgor yn penderfynu gwahardd y cyhoedd o eitemau 4 a 5 yn unol â Rheol Sefydlog 17.42(vi).

the committee resolves to exclude the public from items 4 and 5 in accordance with Standing Order 17.42(vi).

*Cynigiwyd y cynnig.
Motion moved.*

[12] **David Rees:** I therefore now propose, in accordance with Standing Order 17.42(vi), that we need to meet in private for the next two items, items 4 and 5 of the meeting. Are Members content with that? In that case, we will move into private and return to the public arena at 10 a.m. this morning.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 09:34.
The public part of the meeting ended at 09:34.*

*Ailymgynullodd y pwyllgor yn gyhoeddus am 10:05.
The committee reconvened in public at 10:05.*

**Ymchwiliad i Sylweddau Seicoweithredol Penfeddwol Newydd ('Cyffuriau
Penfeddwol Cyfreithlon'): Sesiwn Dystiolaeth 8
Inquiry Into New Psychoactive Substances ('Legal Highs'): Evidence Session 8**

[13] **David Rees:** Good morning. Can I welcome Members and the public back to this morning's session of the Health and Social Care Committee? We move on to our next item of business, which is an evidence session with officials from the Home Office into the new psychoactive substances inquiry we've been undertaking. Can I welcome the officers of the

Home Office? Would you like to introduce yourselves for the record?

[14] **Mr Greaves:** Yes. I'm Dan Greaves, the head of the Home Office drugs and alcohol unit, and my team's responsible for co-ordination of the cross-Government strategies on alcohol and drugs.

[15] **Ms Scrutton:** I'm Angela Scrutton. I'm head of the drug legislation team in the drugs and alcohol unit, and likewise, responsible for new psychoactive substance policy.

[16] **David Rees:** Thank you for that, and thank you very much for coming along this morning. It's very much appreciated, particularly as, as we've gone through the inquiry, we've identified there are some areas that are the responsibility of the UK Government and have an influence on what happens in Wales, clearly. We appreciate the fact that you've had a difficult time over Christmas and haven't been able to provide the written evidence, but we are fully aware of the expert panel's work, and that will be focused upon in some of the questions, in that sense. Would you like to give us a short introduction as to, perhaps, where the Home Office are in relation to new psychoactive substances?

[17] **Mr Greaves:** Absolutely. Perhaps I'll kick off with the first question. So, first of all, thank you very much for inviting us to participate in this really timely inquiry. New psychoactive substances have occupied quite a lot of our time as a team over a significant period—really, since 2009, when we saw an explosion of new psychoactive substances, these synthetic drugs that mimic the effects of controlled drugs while being designed to evade controls.

[18] It's a global phenomenon, but one that we've focused very heavily on in the United Kingdom. I think we've acted fairly swiftly, first of all controlling mephedrone in 2010, introducing temporary class drug order legislation in 2011 in order to enable us to respond more rapidly to a very dynamic market. Also, we've been very busy since then, actually. We've used temporary class drug orders and misuse of drug controls to control over 500 new psychoactive substances under the Misuse of Drugs Act 1971. We've also been very active in putting in place a forensic early-warning system to understand which substances are being sold and used on the street. We have had, using the Talk to Frank platform, targeted digital communication campaigns to engage with the public about new psychoactive substances. We've published guidance to operational partners, and also led discussions internationally through the UN and the G7 to encourage collaboration and information sharing, both about the substances and about the responses.

[19] But I think it was absolutely clear to UK Government Ministers that, despite our best efforts, the market was continuing unabated. We were still seeing very open supply of new psychoactive substances through retail outlets on high streets, through websites with a veneer of legitimacy, and often young people were confusing 'openly available' with 'safe', which we were troubled by. For that reason, Ministers felt we needed a step change in our response, and rather than just look at options and press ahead, we thought we needed just to take a step back, actually, and create a space for discussion with the foremost experts in the area. So, we actually commissioned a panel with experts from forensic science, chemistry, social science and the enforcement community—quite a wide range of people—and started from the very beginning, actually. We tried to understand what we know and what we don't know about new psychoactive substances, prevalence and harms, mapping out international models. So, we took evidence from New Zealand, who have sort of created a regulated market in low-risk new psychoactive substances; the Irish Republic, who've got a blanket ban; and the US analogue legislation. Actually, we took evidence indirectly from quite a range of additional countries to understand what international best practice looks like. So, we had a very substantial six-month-long process, and at the end of that the panel made a series of recommendations in its report. I think, actually, one of its main recommendations was that the

UK already has a world-leading response to new psychoactive substances. Actually, in many ways, we need to build on rather than replace what we are already doing. But they also were pretty clear that we needed a step change in our response.

[20] The Ministers set very clear success criteria for the panel. They wanted recommendations that strengthened the law enforcement toolkit to tackle this reckless trade, but equally measures that sent out the clearest possible message that these substances were dangerous. The panel's report and the Government's response were, in many ways, interchangeable, because we accepted the overwhelming majority of the panel's recommendations and set out a very clear action plan in our published response.

[21] The heart of the panel's recommendations and the Government's response to it was to look further at the Irish model of a general prohibition on the sale and distribution of new psychoactive substances, and we can talk a bit more about that in depth. Equally, given that we will need to continue to control drugs where there is significant evidence about their harms through the Misuse of Drugs Act, we're actually looking at ways of enhancing our current response—in particular, banning drugs on the basis of their effects on the brain rather than their chemical structure, which kind of gives a much more sustainable coverage when we're crafting drug controls.

[22] I think it's important to say that our response was not just drug control-orientated. The response, like the Government's strategy, was balanced and multipronged, balancing action to restrict the supply of new psychoactive substances with action around prevention—public education—and equally around recovery, so looking at how we gear up treatment systems. So, there was a range of actions across those themes. Again, we've set out quite a detailed programme of action, which we'll go into a bit more detail on in our evidence.

[23] We're acutely aware that, whilst drug controls are a reserved matter to the UK Government, many of the functions pertinent to the drugs strategy are transferred to Wales, namely around public health and education. For that reason, we've engaged throughout the process with Welsh colleagues and are keen to maintain that dialogue, to make sure that, across the UK, we've got the best possible response. In many ways, actually, the Government's response to the panel was, though, the start of a process rather than the end of a process, and there will be a process of engagement with Welsh colleagues in crafting what I'll call for shorthand the 'blanket ban' and the new legislative responses, and equally, in sharing what we've done in an English context through Public Health England and through a dialogue with Public Health Wales.

[24] **David Rees:** Okay. Well, thank you for that, because I'm sure you've actually probably partly answered some of the questions that are coming towards you anyway. But, Gwyn, do you want to continue with that particular point?

[25] **Gwyn R. Price:** Yes, you did partly answer this question, but what discussions have you held so far between the Home Office and the Welsh Government regarding the proposals for a UK-wide ban on the supply of NPSs, and how will you ensure that the needs of the people of Wales are considered in the development of any future legislation?

[26] **Mr Greaves:** Yes. So, I think it's worth noting that we regularly engage with colleagues from the Welsh Government, in particular through the British-Irish Council, which has a working group on substance misuse, on drugs and alcohol issues, both at ministerial level and at official level. So, there've been a series of discussions, at both ministerial and official level, about the process of the review, and there will be a discussion, I think in early February, of the findings of the review, where we start to exchange information and discuss the forward work programme.

[27] I think it's also worth saying that we wrote to the Welsh Government, both at the inception of the panel and at the end of the panel to set out the panel's findings. We've got an ongoing dialogue with colleagues from the Welsh Government, where, in due course, we'll pick up our plans on the legislation. I have to say, although there is a ready-cooked model in Ireland, we're acutely aware that that has its limitations for the UK and we'd want to build on that. We're at the early stages now, thinking we've already started to develop the legislation, and once we've got a clearer shell of that piece of work, we'll start to engage more actively with Welsh Government colleagues, to get perspectives and to start thinking about the linkages between the drug control legislation and wider action, prevention and treatment.

10:15

[28] **David Rees:** Thank you. Alun?

[29] **Alun Davies:** Yes. It's that structured relationship that I'm interested in—you know, the British-Irish arrangements are not internal UK structures, of course. So, in terms of how the Home Office engages with Welsh Government, I'd be interested to understand what those structures are. You've spoken about engagement, which sounds like picking up the phone or writing on an ad hoc basis, but, you know, this is an ongoing issue in terms of dealing with both a policy response but also, then, a more active practical response to dealing with the issue. It would appear to me that there will be a requirement not for letters or telephone calls when you feel that might be necessary, but actually a more structured relationship between institutions in London and institutions in Cardiff.

[30] **Mr Greaves:** Can I just come back on the British-Irish Council? The British-Irish Council is a really kind of useful mechanism for exchange for colleagues across the British isles. In fact, in the margins of those discussions, we do have regular structured open engagement. I wouldn't want to underestimate the value of that exchange, but you are right, that is quite formal in that it's actually—

[31] **Alun Davies:** It's not a UK body either.

[32] **Mr Greaves:** It's not internal to the machinery of Government. We do have regular discussions. We've got, I think, a teleconference scheduled very shortly to explore more fully the current state of our plans and our forward work programme, which in itself is in gestation, on the legislation. I have to say, though, there are kind of multiple layers to our engagement with Welsh colleagues here. Operationally, of course, there is quite deep engagement. We work very, very closely with national policing, where we work with Welsh police forces, alongside English police forces, to inform our response. The drugs early warning system, for example, links health and law enforcement partners. So, I don't think it's just the connections between us and the Welsh Government. Actually, there's connections throughout the system. Public Health Wales and Public Health England have very structured dialogues. So, I think that connection happens, actually, at multiple levels. Is there anything you want to add, Angela?

[33] **Ms Scrutton:** I could just add, to give some further illustrations of that at multiple levels, that the forensic early-warning system that the UK has set up, which incorporates all of the devolved administrations, is one example of where there is information sharing across countries. There are any number of other examples. For instance, you know, we haven't spoken yet, but the advisory council on the misuse of drugs obviously plays a key part in providing advice to Government, and the Welsh officials sit on that and can provide information to that. So, it's all part of that information-sharing system as it processes up into formal advice, to ensure that, you know, we capture a UK situation rather than just a local one.

[34] **David Rees:** Thank you. Lynne?

[35] **Lynne Neagle:** Yes. I just wanted to ask about the legislation, and if maybe you could take us through how you see that developing in terms of timescales, as well. We're all very conscious that we have a general election, so nothing is going to happen in the short term, but how would you see that process being taken forward, and what do you think the likely timescales might be for trying to get this ban in place?

[36] **Mr Greaves:** Perhaps I'll start. I think you're absolutely right. I think the panel has said to us that, although the blanket-ban approach best fits UK Ministers' objectives, there are significant risks and challenges. I think we'll come onto those a bit later on, but actually we recognise this isn't a magic wand. There are real kind of technical issues we need to work through with definitions, and with risks around legal challenge. There are issues around potential unintended consequences as well, with the potential for diversion to other substances, to the internet, and involvement of organised crime. There are real issues to think through. We were quite keen not to act precipitantly. There isn't, therefore, a vehicle for us to work through in this Parliament, so we'll be looking at the next Parliament. I think that'll be a choice. The pace of this procedure will be a choice for new Ministers. That will not just be on the basis of the readiness of this piece of legislation, but relative priorities for new Ministers across Government really. So, it's very difficult for me to talk about the precise timescale. I have to say, though, that both parties across the coalition have set out very clearly their support for this piece of legislation and set out their intention to develop the legislation at the very earliest opportunity, and, in anticipation of that, Angela and her team are already working to understand the Irish example and how we can build on that, starting to talk with lawyers about potential provision. So, work is already beginning, but in terms of when this could come to fruition, that's very, very difficult to say. Anything you want to add, Angela?

[37] **Ms Scrutton:** No. I mean, I can just talk about the various areas that particularly we are taking from the Irish model and looking to unpick and develop, if that would be helpful. So, the obvious one is the basis of a new offence and the scope of that new offence. The Irish offence is effectively distribution, importation, exportation, supply and sale as well as advertisement of new psychoactive substances, which it then seeks to define, where they are known or intended to be used for psychoactive effects. So, that's our first entry point that we need to kind of understand: is that the right type of offence that we wish to pursue? The benefit of that type of offence, as distinct from the Misuse of Drugs Act, is that there is no out and out prohibition, as such; it is based on the purpose for which you are selling them.

[38] We also need, like the Irish have done, to make sure that legislative provisions are robust so that we can very much head off what we have at the moment, which are the selling ruses: 'not for human consumption' and 'research chemicals'. So, whatever we want to kind of pursue needs to adequately deal with that type of selling technique. Also, we know how that selling technique will adjust quite quickly as and when we've deployed other types of legislation, so we want something that's fairly sustainable to deal with that. The Irish, again, have looked to allow the court to make certain assumptions based on how that NPS is sold, the environment et cetera. So, there's some nice learning from that, but, again, as my colleague pointed out, we just need to kind of frame that in something that is suitable for a UK—including English and Welsh—justice system.

[39] Other aspects that we are looking at are the potential escalation in the context of proportional legislation between civil to criminal penalties—again, something that the Irish deployed by all accounts quite well. So, there is a criminal offence there, but equally there is a process to give people the opportunity to change what otherwise is criminal behaviour, and that has its certain attractions, more particularly when we are talking about new psychoactive substances that will be caught by this new legislation and not caught by the Misuse of Drugs Act, where we don't have the fullest body of evidence of harm. So, it's about making a

proportional response there. Who's the workforce going to be? Who is actually going to be given the powers to enforce this type of legislation? In your written questions, you spoke about trading standards. What is their role here as well as the police and border force et cetera? So, there's a huge range of law enforcement officers, and who will be deployed to effectively implement other legislation to the extent it needs to be? And then, equally, reflecting back on the Irish model and their Irish experience, actually, there's been quite a huge level of compliance with their legislation. So, we would hope to, you know, be importing something that would have that type of effect. So, yes, who's the workforce and, consequently, what powers do they need?

[40] As we saw from the Irish model, this legislation can be all-encompassing, depending on the basis on which you define it. So, it's very clear that we need, like the Irish have done, a list of exemptions, and we need to make sure they are comprehensive and that they can adjust as more potentially legitimate products come on the market—products as in foodstuff, medicines, alcohol, tobacco et cetera; those ordinary ones; something that will adjust. Where we're dealing with the Misuse of Drugs Act, effectively you have a blacklist that you are factoring constantly, as has been our experience in recent times; the reverse is the situation on this blanket ban, where we'll actually probably be factoring a white list of those things that are exempt from it. So, that just gives you a flavour of the things that we are starting to kind of grapple with, very much informed by that Irish model, but translating that for our own needs and purposes to ensure that we have robust and proportionate legislation.

[41] **Lynne Neagle:** Can I just ask one other question? We have taken some evidence that, by having this kind of blanket ban, the substances could effectively be driven underground and become more attractive to some users who would get them through informal routes. What assessment have you made of the risk of that happening?

[42] **Ms Scrutton:** This was very much part of the commission to the expert panel, which was looking at the various models and the opportunities that we can speak about and, by all accounts, have come to bear in Ireland and Poland to a certain extent. But they also identified the risks associated with this type of approach. Some of those would be the proportionality of this action, as I spoke about, and how, therefore, we're looking to manage that. On the increased interest from international suppliers, organised crime and street dealers to supply that kind of residual market, there is still going to be a residual issue, I think; it would be extremely naïve to say otherwise. And, also, at the moment, certainly some of the evidence that the expert panel took, to the extent that one accepts it, was on the kind of reasonable and responsible retailer in this area.

[43] **Mr Greaves:** Can I just add to that? I think one really important point to make is that, clearly if you take the blanket ban in isolation as your response to NPS, that would have limited effect. I think, absolutely, we'd agree with that. The Government's drugs strategy and the response to the NPS panel's work really talks about a balanced approach, which is not just about supply reduction, but complementing that with proactive tailored prevention work and focused work with the treatment workforce. So, it is very much a kind of balanced approach, which doesn't unduly focus on supply only. I think Angela has been very open about some of the challenges and risks that we need to factor into our thinking.

[44] I think the case of mephedrone is a really very interesting one. This really took a foothold and became one of the top three drugs amongst the adult population in England and Wales back in 2010-11. It was able to get a foothold because it circumvented our drug controls and we were really grappling with how to deal with this new phenomenon of new psychoactive substances. Following its control, we've seen a very significant and sustained reduction in mephedrone usage across England and Wales, for a whole range of factors, including the fact that we control it, but equally focused on getting some very strong public health messages out.

[45] We hope in future, having proactive, forward-looking legislation will enable us to act and take action before any new psychoactive substances in the future get a foothold as mephedrone was able to back in 2009 and 2010.

[46] **Lynne Neagle:** Thanks.

[47] **David Rees:** Okay. John.

[48] **John Griffiths:** In terms of research and data, do you now feel that you are in a fairly strong position in knowing exactly what the prevalence of use is, what the patterns are and, indeed, what the resulting harms are? Is there enough information there now to give us a clear picture?

[49] **Mr Greaves:** We published an evidence paper on new psychoactive substances alongside the panel's report and alongside the Government's response, which I think sets out our thinking in this area. I think we do have really good evidence on the identification of new psychoactive substances, not just in the UK, but overseas. There is a network of early warning systems, which enables us to know exactly what is being sold on the street. We've invested very heavily in our forensic early warning system. In fact, we were able to spot trends where there were prevalence and harms around synthetic opioids—substances that mimic heroin—in Denmark and Sweden, and were able to control it really before those drugs took hold here. So, I think we're very sophisticated on that front.

10:30

[50] We've got fairly good evidence about the levels of use around some specific NPS that have been around for a while; some good insights also into the number of deaths associated with some new psychoactive substances, both through national statistics and through coroners' reports. We've got a good barometer around a poisoning inquiry to the National Poisons Information Service. So, there's some quite good evidence in some areas, but, actually, there are some real gaps, and I think that we've set that out very openly in the report, and talk particularly about the gaps around both the acute and chronic health harms associated with new psychoactive substances. I guess that that is for two reasons: firstly, often the people taking the drugs, let alone the people who are treating them, don't necessarily know what they are taking; secondly, the chronic harms, by their very nature, won't become known for quite some period of time, so there are some evidence gaps that are out there. I think that we've set out a programme of work to fill some of those evidence gaps.

[51] So, for example, we've revised the questions going into the crime survey for England and Wales 2014-15 onwards to give us a much more complete picture about the prevalence of new psychoactive substances across the general population. We're also exploring with Public Health England collecting data across a whole range of settings around criminal justice, further education and the night-time economy. We're also looking at introducing a kind of yellow-card-type system—an adverse reporting mechanism for new psychoactive substances; where there is an adverse event that is reported, we gather much more data through that front. Equally, the National Institute for Health Research are provisionally looking to fund two studies on new psychoactive substances, and the Home Office's chief scientific adviser, Professor Bernard Silverman, wrote to the research councils, drawing attention to the panel's recommendations and the evidence gaps and helping us to fill those. So, I guess that the short answer to your question is that we don't know everything, but I think that we're heading in the right direction.

[52] **David Rees:** Darren.

[53] **Darren Millar:** Thank you, Chair. One of the things that concerns Members, when we've been receiving evidence on the use of NPS, has been the prevalence of NPS in the prison system and the availability of NPS in the prison system. In fact, some of the people who we have spoken to—those who have encountered NPS and use them for personal recreational use—have been people who have become addicted to some of these substances as a result of exposure in the prison system. What research have you done regarding the prevalence of the use of NPS in the prison system and what specific actions is the Home Office planning to take in order to combat this? Mr Greaves, you mentioned earlier the desire to stamp out the use of NPS before it gets a foothold and before it gets as prevalent as, you know, substances like methadone—not methadone—

[54] **Mr Greaves:** Mephedrone.

[55] **Darren Millar:** Mephedrone—early on. But, one thing that we don't know or that we haven't received a great deal of evidence on is whether there's a piece of work being done in order to stamp out use in the prison system. So, where are you with that?

[56] **Mr Greaves:** Do you want to kick off?

[57] **Ms Scrutton:** This is obviously a piece of work that the Home Office is more than happy to assist and is able to assist but is largely driven by the Ministry of Justice and the National Offender Management Service, but we've been working very closely with them. Obviously, the first point to make is, you know, we, the Government, recognise this as an issue in this particular setting as well as one that's in the community. To make the basic point: it is already an offence to convey or possess controlled new psychoactive substances and, as we mentioned earlier, we've controlled an awful lot. The particular group of new psychoactive substances that we understand to be used in the prison service is the synthetic cannabinoids. I think, of those 500, at least 200 at the moment are synthetic cannabinoids. We've recently received advice from the Advisory Council on the Misuse of Drugs and we will be updating our group definitions, which will cover all of those synthetic cannabinoids that we've got now and are likely to get. Then, obviously, one of our, kind of, longer term actions is this different way of banning synthetic cannabinoids based on the effects on the brain rather than the chemical structure. That is our kind of long-term goal—to have a complete position on synthetic cannabinoids.

[58] Just to add, the police can, obviously, investigate where there has been a suspected offence, and seize, et cetera, and prosecute. But your question, really, is what action is, further, being taken. I think that there is a sense that, you know, there is more that needs to be done and should be done. So, the National Offender Management Service is working with health partners in England and Wales to improve understanding of the risks of new psychoactive substances that are used among staff, offenders and visitors. This month, they've initiated an internal communications campaign to increase front-line staff awareness and knowledge of new psychoactive substance effects and treatment, to increase prisoners' understanding of the risks and to empower staff with knowledge of the legal framework, testing and options for punitive action. Underneath that, there is monitoring activity—so, public health monitoring has commenced in 10 prisons in the north west, screening up to 10,000 samples for an extensive range of drugs, including NPS, illicit drugs and prescription medication. I think that this is part of a sense of getting an understanding of the scale, as well as, you know, what the response is. Prisoner-user samples are being tested under the Home Office forensic early warning system, so this is, again, where the Home Office has offered its assistance to NOMS, based on our technical experience and, also, the funding that we do have to undertake this sampling at no cost to NOMS.

[59] We are also, under FEWS, doing some collection plans on those seizures, and this not only informs the National Offender Management Service what type of substances they've got

in their system, but informs our broader picture in terms of our bigger response. NOMS are continuing to develop testing for new psychoactive substances. The issue with synthetic cannabinoids is that there are so many of them that the testing mechanisms need to be developed to identify this huge range of substances and continue to work to prevent new psychoactive substances entering prisons. We are, obviously, in discussions with the Ministry of Justice around our intentions for the new legislation and the general ban. At first sight of that, it is a piece of legislation that is very much, kind of, aimed at the community kind of concern and need for an enhanced response, but part of those discussions with the MOJ is to see to what extent, and how, our proposals there might assist and deal with the problem in the prison estate as well.

[60] **Darren Millar:** So, a piece of work has been commissioned, effectively, to try to establish the scale and prevalence—

[61] **Ms Scrutton:** The scale and, also, raising awareness.

[62] **Darren Millar:** —and the harms that are being caused. There is some work going on in terms of prison population education and prison officer education. What's the timeline on that piece of work? When are you expecting to see outcomes from it?

[63] **Ms Scrutton:** Well, the internal communication plans, obviously, are already kicking in this month, and, as far as the testing is concerned, and, certainly, the work that the Home Office is doing with the forensic early warning system, that is happening now; that is a live activity, and we expect those samples and the testing, you know, to happen over the next few weeks. So, the response and the returns will then be returned to us by the forensic providers—by the system—and then shared across the estate.

[64] **Darren Millar:** In terms of the collation of that knowledge, if you like, so that it can inform the legislative process going forward, and any action that might be taken, going forward, when and where would those data be published?

[65] **Ms Scrutton:** We are looking, as a wider piece of work, at information sharing and to what extent we put this information in the public domain. To the extent that this is, obviously, something that is run by the National Offender Management Service, I'm afraid, probably, it's in their gift to answer your question rather than mine.

[66] **Darren Millar:** You'll be aware that, obviously, here in Wales, there are a number of prisons—a small number of prisons. There's a new prison proposed, as well, in north Wales. Of course, the burden of prison healthcare lies with the Welsh Government, and not with the UK Government. So, it is absolutely critical, of course, that that information is shared directly with the Welsh Government, particularly in terms of offender management when they return to the community, or a community, in Wales, as well, in terms of outcomes. So, can we take it that you will certainly be advocating for that information to be shared as early as possible?

[67] **Ms Scrutton:** I would imagine that National Offenders Management Service are already thinking about this and how they disseminate their information, but you may take it that we will go back with that message, and we will make that clear to NOMS—your representations, which seem perfectly fair.

[68] **David Rees:** Thank you for that. You've both mentioned this morning, obviously, working across various departments and this covers not just the single Home Office, but other departments in the Government. Is there a lead department on NPS in any way, because I want to ensure there is co-ordination existing between some of the actions that are being taken?

[69] **Mr Greaves:** So, the lead department for the drug strategy is the Home Office, working in partnership with the Department of Health, Ministry of Justice, Department for Education, Department for Work and Pensions and many others. Within that strategy, the lead on new psychoactive substances is very clearly the Home Office. We published the action plan previously, we commissioned the expert panel, we co-ordinated the response to the Government's panel and we shall be programme-managing the series of actions that fall out of that in conjunction with a range of Government departments and agencies. Insofar as it relates to legislation, of course, we'll drive that forward and want to consult with devolved colleagues, but equally, we understand from colleagues at Public Health England there are established relationships between Public Health England and Public Health Wales to enable an exchange of information and expertise about areas that we're taking forward in relation to England but would need to be taken forward by Welsh Ministers in Wales.

[70] **David Rees:** Thank you for that clarification. Alun.

[71] **Alun Davies:** Sorry, Elin.

[72] **David Rees:** Elin.

[73] **Elin Jones:** Yes, I wanted to ask you about the legislation and enforcement of legislation, if there is to be legislation. Obviously, banning sale and promotion is only going to be effective if there is a degree of enforcement on those plans. What response are you receiving from those people who may ultimately be responsible for enforcement—the police, trading standards and others—on the ability and the capacity to be more actively involved and have powers to enforce on this? And then, something I don't think has been touched on yet—the complicating factor of legislation and enforcement on internet sales. I wonder if you'd like to comment on the challenges that are posed by looking at any legislation on internet sale and promotion.

[74] **Mr Greaves:** Well, perhaps I'll start. I think it's important to, kind of—in answering both of your questions, both around the local enforcement workforce and also around the internet—consider what we have in place at the present time, and what enhancements and changes the new legislation will bring about. I think it's important to say that there is a range of existing legislation, which is already in place in relation to a range of products, but can be used against new psychoactive substances, which are being enforced against now, which is probably worth explaining very briefly, by way of context. So, for example, there are the General Product Safety Regulations 2005, which aim to ensure that products that are offered for sale are safe, with the duty of care being placed on the manufacturer, the Consumer Protection from Unfair Trading Regulations 2008, which are all about misleading descriptions, the Intoxicating Substances (Supply) Act 1985, which really is in relation to substances that are sold for the purposes of inhalation for intoxication. The anti-social behaviour powers, again, give local partners a range of powers to deal with anti-social behaviour and deal with premises that are causing anti-social behaviour. I think those are being used, and being used to some extent to good effect. I think there are some examples in Kent, around so-called head shops being closed using the General Product Safety Regulations, in Northampton, again, taking action against under-age sales through the Intoxicating Substances (Supply) Act, both in Lincoln and in Exeter, using the new anti-social behaviour powers to take action against premises causing anti-social behaviour. So, there are existing web pieces of legislation that local partners, whether it's trading standards or police, can use for disruptive effect.

10:45

[75] The feedback that we received from local partners was that that toolkit was incomplete—none of that was really designed for the purposes of new psychoactive

substances. And although they were using those as an interim measure for good disruptive effect, they weren't a long-term sustainable solution. We took evidence from a range of local partners—in fact, the Local Government Association, the national policing leads and trading standards all gave evidence to the expert panel. They concluded that a more sustainable response was required, and that's part of the reason we plumped for a general prohibition on the sale of, and supply of, new psychoactive substances.

[76] I think the experience from Ireland—and we can't guarantee it being replicated here—was actually that that was quite—. It wasn't as resource and enforcement-intensive as one might have thought. Actually, they did a proactive programme of engagement with NPS suppliers to explain the legislation, explain the consequences, and they were able to issue orders and point out that failure to comply with those orders was a criminal offence. And, actually, what we saw, off the back of that, was quite significant patterns of compliance. Almost all of the so called head shops and .ie domain-name websites were closed down. Actually, a lot of that was done via compliance rather than via enforcement, so, actually, in aggregate, I recognise there's going to need to be a workforce and there are some questions for us to work through about who and how and some choices to be made about resources locally. But, actually, in the here and now, communities across England and Wales are concerned about new psychoactive substances—I get that message in very many communities—a lot of action is being taken and that can actually be incredibly resource-intensive when you're using legislation that isn't designed for that purpose. So, in many ways, although there will be a new task, we hope, in aggregate, it will be more effective and less resource-intensive than many of the kind of web of existing powers that are there. Is there anything that you wanted to add?

[77] **Ms Scrutton:** No

[78] **David Rees:** Elin, are you okay?

[79] **Elin Jones:** Just on the complexity of enforcement for internet sales and promotion. Do you have any views as to the capacity that will be needed for that particular piece of work?

[80] **Mr Greaves:** I think there are two aspects to the web. There's the so-called kind of clear net, and what is often referred to as the dark web, with the clear net being kind of openly visible websites with a veneer of legitimacy selling openly new psychoactive substances, often with a kind of Amazon-style user experience, and there's the dark net, where sophisticated tools are used to conceal the action of both sellers and purchasers. In relation to the blanket ban, that strengthens our existing powers to take action against not only bricks and mortar retail outlets but, equally, .co.uk web domains. There are existing powers and an existing programme of activity that is being strengthened within the National Crime Agency, which has, for the first time, created a cyber command. And, of course, the general ban will enable us to, kind of, strengthen that set of powers.

[81] There is, of course, a risk that what we do is merely displace that activity to websites in other countries and other jurisdictions where legislation may be less developed than our own. WE acknowledge openly that risk. I think our view is that there's probably a category of new psychoactive substance user who is happy to purchase from websites with a certain user experience or openly from retail outlets but who'd be much more anxious about purchasing from overseas or accessing criminal markets. So it would choke off some of the supply.

[82] Equally, we can and do work very closely with enforcement partners across the world through the International Narcotics Control Board, through Europol and through Interpol, to make sure that we have a joined up, international response. So, for example, where substances are being sold or supplied from other jurisdictions, which are illegal here, we are asking

countries like China, India and other jurisdictions to take action. There is provision, through the International Narcotics Control Board's Project ION, or international operations on NPS, to kind of build that pattern of co-operation. So, I recognise—I think we openly recognise—that the blanket ban will not be a panacea, but we understand some of the risks, and we hope we've got a range of actions to mitigate some of those risks.

[83] **David Rees:** Okay, Elin?

[84] **Elin Rees:** Yes, that's fine.

[85] **David Rees:** I'm conscious that time is now catching up on us, so we've got one last question on the EU proposals. Alun.

[86] **Alun Davies:** Yes. I'm interested in the commission's draft legislation. I understand that the commission has been preparing some legislation for the EU on these matters and I was wondering if you could outline to us the extent to which the Home Office has been engaged with this and whether it is yourselves or the Foreign and Commonwealth Office through UKRep that's been taking the lead in determining the UK approach to this, and whether there has been any debate or discussion between the UK institutions and the Welsh Government on this matter.

[87] **Mr Greaves:** So, first of all, to take a step back, I think what we've acknowledged through this session is that drugs really are a transnational phenomenon. There is no such thing as a UK drugs market; that sits within a global market. For that reason, we support proportionate EU-level action on NPS, which enhances information sharing and helps us to reduce the illicit supply of new psychoactive substances within the EU. Actually, there are some really important mechanisms already in place, including the EU early-warning advisory, which is a kind of joined-up network of forensic early-warning systems to understand which substances are prevalent and to conduct risk assessments and make recommendations about how those are controlled and help to prioritise action. We think that there is a kind of, you know—. That really is quite valuable and something we want to preserve and participate in. We've publicly—or, rather, Home Office Ministers have publicly—expressed concern about the current EU Commission draft regulation, which we think is, in some respects, a backward step.

[88] To answer one of your questions, we, in the Home Office, take the lead in engaging in European negotiations. In fact, a colleague of mine has been in those negotiations throughout this week through what is known as the horizontal drugs group. Equally, the Home Office leads through the Justice and Home Affairs Council.

[89] There are a number of reasons that we are concerned about that proposition. Firstly, we think that, in its current formulation, that draft measure could undermine the UK's well-developed drugs system and, in fact, fetter our ability to implement pre-emptive controls on substances we think pose a risk to public health. At the heart of the European Union is the principle of subsidiarity and we don't think, in this instance, the principle of subsidiarity is met. Nonetheless, we are engaging closely in those negotiations and looking to influence that proposal so that we can preserve the core of things around information sharing that we think are really useful and actually shift some of the aspects of the proposition that we don't like.

[90] I guess there's also one other kind of more abstruse technical point, that we fundamentally disagree with the legal base on which this measure is taken. The measure is being taken through a free trade, a single market, legal base, on the basis that new psychoactive substances, in the view of the commission, are largely substances that have other legitimate uses in manufacture and medicine and so forth, but that's absolutely not our experience. In fact we think it is, on the advice of the Advisory Council on the Misuse of

Drugs, a vanishingly small number of new psychoactive substances that have uses outside of medicines, which are captured by other legislation. So, we also have a principle problem with the legal base that they're using, which, of course, would influence the UK's ability to shape that proposal.

[91] I can't answer your question in terms of detailed engagement with devolved administrations. I'm happy to consult with colleagues who are running those negotiations and come back to you on that. I do know that's been discussed on a range of occasions, but I can't say any more than that. I'll pick that up with a colleague and come back to you in writing if that's okay.

[92] **David Rees:** That'll be okay. Thank you very much.

[93] **Alun Davies:** Can I ask why the United Kingdom Government believes that the current proposals would fetter the ability within the UK to move more quickly or move further forward on these things?

[94] **Mr Greaves:** Yes, there are two principal reasons. Essentially, the premise of this is a tiered system. So, no action, then, equally, taking action on the sale of a substance openly for psychoactive effect, or completely controlling a substance in all its uses. If the Commission took the view that, actually, it was a fairly low or medium-risk substance, that would, we think, preclude the UK Government from taking more stringent measures and, if a judgment were made that a substance, after we'd controlled it in the UK, was less harmful than we had thought, we'd be bound by that decision.

[95] Secondly, enshrined in the proposal is that, because this is under a single market legal base, any time the United Kingdom Government acts to control a drug, that is interpreted as a technical standard, and we would need to notify the European Commission, as one does with technical standards notifications, to leave an elapsed period for views from other member states. Although there are derogations from that, those are very, very tightly circumscribed within the gift of the European institutions, and ultimately judged by the courts, and we didn't think that was satisfactory. Actually, we've controlled, since 2009, over 500 substances, and we want to maintain the discretion to do so on the basis of our own expert advice, which we think is world leading, and at our own pace, which is, generally, one of the quickest in Europe. That's not to say that we're in any way arrogant or denigrate the important role of the European Commission. We think that they can be tremendously valuable, through facilitating information sharing and sharing risk assessments, and we don't rule out the possibility that further legislation may be required. We think it should just take a different shape and more closely respect the principle of subsidiarity.

[96] **David Rees:** Okay, thank you. Can I thank you for your evidence this morning and thank you very much for coming along? You will receive a copy of the transcript for any factual inaccuracies you may be able to identify. So, once again, thank you very much, both, for attending this morning.

[97] Just to remind Members, this was the final evidence session in this inquiry, and we will now move on as a consequence of that and prepare our draft report. I propose that we now have a break until 11.10 a.m. We were scheduled for a 15-minute break, but if we have a break until 11.10 a.m.—. Okay? We can commence at 11.10 a.m. and then have the first evidence session on the Safe Nurse Staffing Levels (Wales) Bill.

*Gohiriwyd y cyfarfod rhwng 10:58 ac 11:11.
The meeting adjourned between 10:58 and 11:11.*

Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 1
Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 1

[98] **David Rees:** Can I welcome back Members to this morning's session of the Health and Social Care Committee? Can I welcome Peter Black, who is substituting today for Kirsty Williams, and will be continuing to substitute during the evidence sessions on this particular Bill? Welcome. Can I welcome Kirsty Williams, the Member in charge of the Bill? Kirsty, would you like to introduce your team?

[99] **Kirsty Williams:** Thank you very much, Chair. Obviously, I'm Kirsty Williams, the Assembly Member for Brecon and Radnorshire, and I had the good fortune to have my name drawn out of a hat, and this is the piece of legislation that I have chosen to pursue. I'm very grateful for colleagues' time this morning—I know this committee has a great deal of legislation that it has to deal with, and I'm grateful for colleagues' time. I'm supported this morning by Philippa Watkins on the policy side, who has been an immense help in putting together what we have before us, and Lisa here from the legal team who has been able to advise me on legal drafting, which in itself is a whole other craft.

[100] **David Rees:** Okay, thank you for that, and obviously thank you for both the Bill and the explanatory memorandum for the Safe Nurse Staffing Levels (Wales) Bill. Obviously, this process is where we undertake Stage 1 and we inquire as to the reasoning and purpose of the Bill. We will have various evidence sessions and you're here to introduce the Bill, but you'll also be coming back towards the end on that. If we start questioning, in that case, because—. Gwyn.

[101] **Gwyn R. Price:** Good morning. What evidence is there that there are unsafe nursing staff levels in Wales, given that the explanatory memorandum says:

[102] 'it is clear there has been considerable progress between March 2013 and April 2014'

[103] in meeting the Chief Nursing Officer for Wales's guidance around safe staffing?

[104] **Kirsty Williams:** Thank you, Gwyn, for that. I think it's important to set the legislation in the context of the last couple of years, where, both inside and outside of Wales, there has been a great deal of focus and indeed concern around nurse staffing levels in the NHS as a whole. The idea for the Bill came out of the Francis inquiry into the scandal of Mid Staffordshire NHS Foundation Trust where there was a great deal of attention paid to that situation arising out of poor levels of staffing. That subsequently had been followed up in England by the Keogh review into mortality figures. We've seen work done by the Berwick review.

[105] In a Welsh context, of course, we have seen concerns raised around staffing ratios and staffing numbers in the Commissioner for Older People in Wales's inquiries into Welsh hospitals. There have been a number of inspection reports published by Healthcare Inspectorate Wales that have drawn attention to issues around staffing numbers. Concerns were expressed about staffing numbers in 'Trusted to Care', which looked at the situation in some of the hospitals in the Abertawe Bro Morgannwg health area, and, indeed, by the Royal College of Nursing in their staff survey, as well as, in the end, Gwyn, the admission by both the chief nursing officer herself and information supplied by local health boards that clearly demonstrate that the recommendations that were published by the chief nursing officer were not consistently being adhered to.

11:15

[106] I think it's really important as well to recognise that we have seen improvements. I

don't want to give the impression that either the Welsh Government or individual local health boards have been sitting back, doing nothing about this particular area. I think that it's important to recognise that, following the Francis review, Welsh Government did make moneys available specifically for the recruitment of more nurses and to ensure better staffing levels in hospital wards. Local health boards, in the three-year plans that they have subsequently submitted to Welsh Ministers, demonstrate how they want to try to move to full compliance, but the chief nursing officer herself would admit that we're not there yet. Therefore, I believe that it's necessary to move forward with this legislation to ensure that those plans are fully realised, and that the principles of safe staffing are underpinned in legislation.

[107] **Gwyn R. Price:** Thank you for that answer. So, it is the consistency as well, across the board, that you are concerned with. There have been improvements, obviously.

[108] **Kirsty Williams:** I'd be the first person to admit that, in the last year, we have seen significant improvements in compliance with the chief nursing officer's recommendations, but we are not there in all local health boards. Where some local health boards have improved staffing numbers that have yet, for instance, to take into consideration the uplift needed to take into consideration staff training needs, authorised absence and sickness, we are not there yet. We've got issues continuing on ratios overnight; we've got some local health boards that are meeting the ratio, but they include the senior nurse in charge, whereas the chief nursing officer's quite clear that that post should be supernumerary. So, whilst we're making progress we're not there yet.

[109] **Gwyn R. Price:** Thank you.

[110] **Alun Davies:** I'm interested in the need for legislation.

[111] **Kirsty Williams:** Sure.

[112] **Alun Davies:** I think that legislation involves a great deal of resource within the National Assembly here, within Government and, if agreed, within health boards. Of course, that resource is something that is of great value. In your answer to Gwyn, you just said that there has been significant progress over the last period in terms of meeting different objectives and ambitions for nursing numbers. Doesn't that seem to argue that that is being achieved without legislation and, therefore, further progress can be made without legislation?

[113] **Kirsty Williams:** I think that what's important to recognise is that the guidance from the chief nursing officer has now been around for a number of years—three years—and yet, we're still not there. So, we have certainly given the opportunity for local health boards to respond to her calls and yet, a number of years down the line, although we've made progress, we still haven't achieved what the chief nursing officer has advised the Government would be regarded as safe staffing levels. The question is: are there other mechanisms by which this could be achieved? We could sit back and take the local health boards at their word that they will continue to work towards this, but you and I have been in this institution long enough to know that, with the best of intentions, that doesn't necessarily mean delivery. We did look—and you will see this in the explanatory memorandum—to see other options, for instance, making safe staffing a tier 1 priority, but again we know here that things like waiting times are tier 1 priorities and yet, routinely, local health boards aren't able to meet those tier 1 priorities. Also, this is legislation not just for the here and now; this is legislation that underpins this important principle for years to come. We don't know whether the next health Minister that sits here in Welsh Government will be equally committed to driving this agenda forward. We don't know the next Westminster Government and what financial decisions they will make that will impact here in Wales. So, this is an opportunity to use legislation: one, to hold local health boards' feet to the fire—I'll be blunt about it: to hold their feet to the fire—

to ensure that they continue to make progress and they make good on the recommendations that the CNO has come up with. It's to safeguard that into the future and to establish here in Wales, in legislation, underpinned by statute, the principle of safe staffing within hospitals. And we know, by looking at other areas, that it's been statute that has been the final push that has been needed to achieve that goal.

[114] **Alun Davies:** I accept your argument that we require safe staffing. I don't think there's any disagreement with that. My concern is: what is the most proportionate way of achieving that? You talk about holding health boards' feet to the fire. Now, I'm quite happy with that, and you're right that we both try to do that in different ways. But that's not what we're doing here: we're legislating, and that's different. What we are doing is creating a new statutory function—a new statutory framework, I'm sorry—for the delivery of services within that setting, and that's different to holding people's feet to the fire. That's very different. My concern is that this could be achieved by other means, by the Minister providing more—how shall I put it—by the Minister saying very clearly to health boards, 'You need to achieve these ratios by this time'. That could be achieved very easily, I would argue, without the need for legislation.

[115] **Kirsty Williams:** With all due respect, the Chief Nursing Officer for Wales, a number of years ago, said very clearly to hospitals and local health boards, backed up by Welsh Government, 'This is what you need to do'. It can't be any more clear than that, you know, than the chief nurse of this country saying, 'This is what I regard in my professional opinion is a safe way to staff Welsh hospital wards' and we're still not there. We're still not there. So, we've tried that. We've tried issuing advice. We've got acuity tools that have been introduced, which are very welcome, but we've still not achieved this goal. You know, we've got tier 1 priorities, which could be a way forward, but we know in other areas that that doesn't necessarily lead to delivery.

[116] So, in my honest opinion, Alun, all that is left to us, to ensure that local health boards have due regard to safe staffing principles in all their services, and to create a system that uses minimum ratios, the professional opinion of nurses on wards and acuity tools that have been developed by Welsh Government to create that environment, is for that to be underpinned by statute. Otherwise, we could still be sitting here in a few years' time knowing that advice from the chief nursing officer isn't being achieved in Welsh wards, and the failure to do that—. Let's be clear what that means if we don't do it: for every extra patient a nurse has to look after, there is an increase in potential mortality rates. That's what we're talking about here. This is about mortality rates in patients. This is about preventing falls. This is about preventing mistakes with medicines. This is about proactive discharge planning. It's about reducing lengths of stays in our hospitals. That's the opportunity cost if we continue to let the situation develop, just sitting back and waiting for those goals to be achieved.

[117] **Alun Davies:** I accept part of what you've said there, actually. There is clearly a requirement to have nursing levels at a particular level within an individual ward. However, you've also said—notwithstanding what you've just said—that great progress has been made. Had no progress been made, then clearly the case would be unanswerable, but progress has been made using means and mechanisms that are non-legislative and non-statutory. So, progress is being made. What you're saying is that progress isn't fast enough or quick enough, or it needs to be made in a more comprehensive way and that, therefore, statute is the only way of achieving that, surely.

[118] **Kirsty Williams:** Yes, well—

[119] **David Rees:** Yes, you've answered the question previously, so there wasn't a question there. Elin.

[120] **Elin Jones:** Just to follow on from that, if this Bill and the statutory guidance were in place in a year's time and health boards failed to meet, and were in breach of, the guidance, there's nothing that's described in this Bill on how any penalty or enforcement would be placed upon any health board to meet the guidance. So, we could have an effect that we would have annual reports from health boards just saying that they've been in breach of the guidance for four fifths of the year, and I'm not sure how much further forward we would be, because there is no mechanism other than, possibly, an individual who'd been on a ward in Glangwili taking some kind of legal case against the health board there for being in breach of the guidance. So, how do you see that the legislation—? What pressure is there on the local health board, other than being in breach of legislation, to actually comply with legislation?

[121] **Kirsty Williams:** I think I would refer to the words of Dame June Clark, who, in the consultation, said that the reason why she thought legislation was so necessary was because it does bring a different mindset and a culture to the organisation. So, this isn't just a target anymore; this is about complying with the law of the land, and that is a different level of focus than, perhaps, other expectations that are placed on the local health boards. Local health boards would have to be able to demonstrate that they had taken all reasonable steps to account for safe staffing in the planning of their services. Ultimately, yes, a case could go to court and create case law, which, I think, would again help to build a feeling of how important this is for local health boards to achieve.

[122] The explanatory memorandum, on page 22, explains the escalation procedure that is available. What we've tried to do is not to create a system that is so overburdensome that we end up spending a lot of time and resources creating a system to monitor all this, so we would use existing QDM—quality data model—procedures and reporting mechanisms to highlight any potential breaches. That procedure sets out very clearly intervention powers that Ministers have available. Ultimately, that is the final sanction, that the Minister has the power to intervene in the running of the local health board that is in breach of this legislation, which would be a very serious step for a Welsh Minister to take, I would suggest.

[123] **David Rees:** Okay, Elin?

[124] **Elin Jones:** Yes.

[125] **David Rees:** I have questions now from John, then Darren and Lynne.

[126] **Darren Millar:** Sorry; it was just on this point.

[127] **David Rees:** On this particular—? Okay, I will go with Darren then, in that case.

[128] **Darren Millar:** I'm very sympathetic to the need, potentially, for legislation, but I'm just a bit concerned that we're replacing one form of guidance from the chief nursing officer with guidance from a Minister. We know that there are existing mechanisms in terms of ministerial intervention in boards when things go wrong, but, in spite of the existence of that ministerial intervention arrangement, very rarely do we see Ministers intervening, in spite of tier 1 targets being missed, in spite of guidance not being adhered to, and in spite of services being under continued and maintained pressure. So, how can this committee have confidence, unless you're more specific about the intervention that might be possible or the penalties that might be incurred by health boards or other health bodies or organisations within the NHS for not meeting these standards—the standards, or the 'recommended guidance' is how you describe it in terms of recommended ratios in the Bill not being met?

[129] **Kirsty Williams:** First of all, the guidance that we have at present does not have a statutory underpinning.

[130] **Darren Millar:** I understand that.

[131] **Kirsty Williams:** So, what this legislation does is provide a statutory underpinning to the guidance issued by Welsh Government, which makes it stronger than what we've got at present. The explanatory memorandum sets out very clearly the escalation process that is available to Welsh Ministers. Now, Darren, I'm not the Welsh Minister; I can't tell the Welsh Minister when he or she should intervene in the running of the local health board. There have been examples in recent years when I wish he or she had have done just that, but there is a mechanism available if there is consistent breach of the law, which, again, I think, you know, focuses the Minister's mind that this isn't just a breach of non-statutory guidance anymore; this is a breach of the law passed by the democratic institutions of this country that would allow them to intervene, and that is set out in the explanatory memorandum.

[132] As I said, in being mindful of establishing this system, I want to use, wherever possible, existing mechanisms so that we're not creating a whole industry that takes time away from what I think we all want to do, which is to focus on delivery on the wards, and therefore, you know, powers are available for Ministers.

11:30

[133] It would be a matter for the Assembly to scrutinise and judge the Minister on whether he or she uses those powers appropriately. But again, I think it does represent a change in culture. This isn't just missed targets anymore. This isn't just missed guidance anymore. This is breach of the statutes of this land.

[134] **David Rees:** John.

[135] **John Griffiths:** As we've rightly heard already, Chair, there is a basic starting point with legislation, which is that you do not undertake it lightly because of all the resource and implications of legislation, unless there is an absolutely compelling case. There are many desirable objectives, I think, that we'd all share, but whether legislating is the best way of achieving them or not is another matter. Obviously, we've already discussed some of those issues, but another important aspect of legislation is unintended consequences. I know that was raised by Mark Drakeford when the Bill was initially discussed in the Assembly, and he stated his view that the one thing uppermost in his mind in considering the proposals is the potential for a series of unintended consequences. I just wondered, Kirsty. Obviously, you will have given a lot of thought to the impact of this legislation if it is passed and implemented. In thinking about it, and giving it in-depth consideration, as I know you have, have you considered potential unintended consequences and, if so, what are they and how, in your view, would they be avoided?

[136] **Kirsty Williams:** Well, you are asking me to give the game away, but you're right: I think it is incumbent upon us all when examining legislation to have cognisance of what might happen. So, you will be aware that, when I first came to this debate, the focus was very much on minimum staffing levels. As a result of consultation and widespread discussion with people in the field, the emphasis has changed, because it seemed to me that, potentially, bare minimum staffing ratios on their own might not give us the desired effect that we wanted, and could indeed have some unintended consequences. So, first of all, how have we tried to account for that? We have put on the face of the Bill an overarching requirement to consider safe staffing in all settings, so that is the overarching principle that local health boards will have to adhere to and account for. In looking at the reality on a ward, we've tried to create a triangulated—it's not a very elegant way of saying it—three-cornered approach for establishing what safe staffing looks like. The name of the Bill has changed, to try to move the emphasis away from minimum staffing ratios on to safe staffing. So, what the Bill has done, what we are trying to achieve in the Bill, is, yes, create the ratio, but recognising that a

bald ratio on its own does not necessarily lead to safe staffing. So, we have provision for the use of the Welsh Government's acuity tools.

[137] So, it's about recognising that you have to look on a ward not just at the number of patients you have in your ward, but actually how ill those patients are. On any given day, you could have a wide range of demands on a hospital ward, from people who perhaps don't need a lot of care to people who, at this time of year—lots of elderly people in hospital with lots of comorbidities. You know, we have to raise the complement then to cope with that situation, as well as a requirement on allowing for the professional judgment of the nurse in charge to make a judgment as to what kind of nurse complement they need on that ward at the time. So, we've tried to create a triangulated approach to ensure that the focus isn't just on numbers, which could be an unintended consequence, but the focus is on, yes, bald numbers, but also the nature of the patients in the ward, and the professional judgment of the senior nurse who is in charge of that particular shift. So, we've tried to—. Part of the consultation would be, 'Oh, it will all become about a numbers game. It won't reflect the nature of the people in the hospital beds', and we've tried to account for that in section 2, when we say to the Welsh Government, 'When creating the guidance, these things have to be a part of that', and that has to help dictate the numbers of staff that are on a ward at any one time, as well as the overarching principle around safe staffing. That's how we've tried to account for it. We've also clearly stated in the legislation that the ratio is a minimum, rather than a maximum, because some people have said that their concern would be that, if you set a minimum ratio, that becomes the default position, but that isn't necessarily safe. So, that is why we've got the provisions in about professional judgment and the use of acuity tools as well. So, that is how we've tried to identify those problems.

[138] **David Rees:** That was actually included in the Andrews report; she talked about the ward level being the driver for any safe levels.

[139] **Kirsty Williams:** Yes, absolutely. As I said, in the beginning, when I first came to this, I was thinking simply in terms of numbers and, as a result of the consultation and as a result of talking to people who have to do this on a daily basis, it was clear that numbers alone don't necessarily deliver you safe staffing. So, we've changed the name of the Bill. It's not about minimum staffing anymore; it's about safe staffing, and you'll get to that by, yes, having a minimum number, below which you know if you drop you're beginning to potentially compromise care, but it is about recognising the acuity of the patients on the ward and the professional judgment of the nurse at that particular time, and allowing them to be able to make a judgment on how many staff he or she needs to provide that safe staffing.

[140] **David Rees:** I may come back to unexpected consequentials afterwards. Lynne.

[141] **Lynne Neagle:** Thanks, Chair. As you know, Kirsty, I'm supportive of what you're trying to achieve with this Bill and I also fully recognise and sympathise with the concerns you've expressed about delivery and the gap between policy and implementation. I just wanted to pick up on the unintended consequences a bit more, really. One of the concerns that has been expressed is that the Bill doesn't take a multidisciplinary approach to staffing and, in particular, the physiotherapists have expressed concerns. Do you think there's a danger that an unintended consequence is that all the resources will be poured into nursing, and that may distract from the other disciplines that we've got trying to provide that joined-up approach on a ward?

[142] **Kirsty Williams:** Thank you. I understand why the physiotherapists have responded to the two previous consultations in the way that they have, and I can understand that they're doing their job on behalf of their members. I think, first of all, the important thing to recognise is that nurses are in a unique position—different to any other professional group that we have working in the NHS—in the fact that they are responsible for the care of patients

24 hours a day, seven days a week. They have the greatest contact with patients, far greater than any professional group. We know from the reports that have been carried out into services here in Wales and in England that it is the lack of nursing staff, qualified and unqualified, that has the potential to cause significant problems in terms of compromising care on wards. We know that. We know that the guidance that the chief nursing officer has given isn't being adhered to. So, we know that there's a particular problem in this particular group of people.

[143] I must say, and I've searched and searched and searched—because I would not want to do down another professional group in bringing this legislation forward; that's not my intention—there is no evidence that I can find anywhere that would suggest that, in doing this, it has a detrimental effect on other professional groups. There is international evidence that doesn't suggest that. Although we don't have it in England, there's at least one trust in England that has decided on its own to implement minimum ratios, and there's no evidence that I'm aware of there that it has had a detrimental effect. Actually, some of the international evidence, especially from Australia, has suggested that, actually, having the right number of nurses on your ward is of benefit to other professional groups who have to interact with those patients. For instance, people in the ward have been fed and washed and cared for before they have to go to their physiotherapy appointment somewhere else in the hospital. They actually get to their physiotherapy appointment somewhere else in the hospital. So, actually, a well-run, well-resourced staffed ward—there is international evidence to suggest—rather than being problematic for other professional groups, actually makes it easier for them to do their jobs. It's also clear as well that, in submitting three-year plans to the Minister for approval, local health boards have set out their plans to try to meet the CNO's recommendations. There is no evidence that they're doing that to the disadvantage of other professional groups.

[144] If you flick it on its other side, Lynne, what we're saying is that in order to potentially—because I don't believe it would happen—not disadvantage another professional group within the NHS, that we're willing to sit back and accept staffing levels that we know potentially are not safe. That has to come to the forefront, I think—that's the building block that our Welsh NHS should be based on.

[145] **Lynne Neagle:** Okay. Can I just ask two other question then, focusing on the nursing side of it? Are you confident that if this became law that we wouldn't see health boards doing things like maybe employing lower grade nurses in order to meet the minimum staffing ratios, and that we might see a shift in that direction? How confident are you that we wouldn't see cost cutting and things like that happening in that regard?

[146] **Kirsty Williams:** Sure. What the legislation sets out is not only statutory guidance with regard to nurse-patient ratios, but guidance on qualified to non-qualified staff ratios, because we do know that the CNO already makes recommendations to local health boards about what the ratio of qualified to non-qualified staff should be. There have been problems in meeting that, and therefore the legislation requires Welsh Government to make statutory guidance with regard to qualified to non-qualified staff. Again, the guidance requires the acuity tool, which then gives guidance on the nature of the qualifications of the staff on that particular ward, so I think we've covered that.

[147] **Lynne Neagle:** Okay. Just finally in relation to bank nurses, you highlighted in the EM the huge cost of bank nursing to the Welsh NHS. Did you consider putting anything on the face of the Bill to predispose the delivery of this towards permanent staff?

[148] **Kirsty Williams:** That's come up in consultation subsequently, and I'm not averse to considering recommendations from the committee if the committee felt that that would be a welcome addition to the draft that we've got. Undoubtedly, one of the aims of this legislation is to create an environment that has substantive posts on hospital wards that are filled by

permanent members of staff. We know that, at the moment, the Welsh NHS is spending an awful lot of money on an expensive way to staff our wards, and, of course, a bank or an agency nurse is better than no nurse at all, but not only is it a very expensive way to staff our wards, again from academic evidence, we know that those nurses simply aren't as efficient as a full-time member of staff on the wards. So, the actual efficiency you get for your investment in that member of staff is less than for a permanent member of staff. Often, bank or agency nurses are prevented from doing certain tasks on a ward if that's not their permanent place of work. So, actually, it's an expensive way but it's also an inefficient way. A lot of the consultation responses that we've had have talked about the need for continuity of care for patients in driving up standards of care. That's very difficult to achieve if you've got a constant churn of temporary staff on a ward.

[149] What we saw in Australia was that, when they moved in Victoria to this system, they literally saw thousands of nurses who had left the profession come back into the profession because they knew they were going to be working in an environment that was properly staffed and that allowed them to do their job. We hear often from nurses that they've gone to bank or agency work because they find it less stressful, or people have left the profession altogether because of the pressures. There is evidence to suggest that moving to this system actually creates an environment that brings nurses back onto wards because they know they're going to have better working environments and an environment that allows them to do what they want to do, and the time to do what they want to do.

11:45

[150] **David Rees:** Peter.

[151] **Peter Black:** Thank you, Chair. Kirsty, in your response to John Griffiths, you set out a fairly complex set of decisions that a ward manager would have to make in terms of determining not just how many nurses would have to be on a ward, but also the mix of those nurses, taking account of the patients and the needs of the individual patients et cetera. Given that a lot of that is going to depend on professional judgments of the ward manager on the day, and given that no ward is going to be the same and you're going to have a whole range of different decisions depending on which ward you happen to be involved in, how confident are you that it's possible to produce regulations that can take into account the whole range of those decisions that a ward manager has to take on a daily basis, and that gives them guidance to actually make sure that those nursing levels are safe?

[152] **Kirsty Williams:** Let's be clear. Nurses in charge of wards are making those kinds of decisions every day. That's the reality of their job on a ward every day. I think what sometimes, anecdotally, we hear, and certainly evidence that we've received, is that, sometimes, they have a frustration that concerns about staffing are fed up the food chain, you know, to managers higher up above them, to directors of nursing, into board levels and that doesn't get acted upon. One of the strengths I think that the legislation brings is a new sense of power and back-up to those nurses working on the ground to be able to use this legislation to demand action on behalf of managers and executive boards.

[153] One of the things that I found so heartbreaking about the 'Trusted to Care' report was that everybody in that hospital and in the management of that organisation knew about the concerns. They were being flagged up, they were being raised, and yet no action was being taken. That's one other reason why I think legislation is needed, because we need to strengthen the arms of directors of nursing who sit there at executive boards—and nursing, because they are the biggest staff complement and that's where the money is going, so that's where the pressure is to cut costs when you've got to balance your budget. I want to strengthen the arms of nurses in wards and nurses sitting at executive boards to say, 'No, I'm sorry, you can't cut back on those things; we have to respond because the law says we have to

have due regard for it.’

[154] So, I hope that this legislation strengthens the arms of senior nurses on wards to be able to say, ‘This is what you need to do to respond to the situation’, and it gives them a statutory basis to raise concerns if their requests aren’t being met. Also, the acuity tool’s already there; the Welsh Government has already published that. Electronic rostering is already there, so all the mechanisms are in place to allow somebody to do it. Also, the important thing is the senior nurse will have the time to do it because she is supernumerary to the complement on the ward. Often, what senior nurses tell me is that they’re dragged in to doing the actual hands-on nursing and they’re not given the time to provide the leadership on the ward that they need.

[155] **Peter Black:** Often—and we’ve got an election coming up now—politicians like to go out on the stump and talk about the number of nurses they’re going to recruit, the number of doctors et cetera, because people relate to that and in terms of that, but we know when we come to look at it in detail here in committee that what really matters is the outcomes for patients. Is there a danger here that this legislation is focusing too much on inputs and not actually on the patient outcomes?

[156] **Kirsty Williams:** Oh, no, absolutely not, Peter; absolutely not. We’re doing this to improve patient care because from everything that we’ve read, from Francis, from Keogh, and all the reports that we have, we know that nurse-patient ratios, the number of staff you have on a ward, have a direct effect on the outcomes for those patients: reduction in mortality, reduction in the number of falls, reduction in the number of medicine mistakes—practically every kind of measurement you could possibly come up with is assisted by having safe staffing levels on the ward. That’s the ultimate outcome. That is exactly what this legislation is about. Ultimately, it’s providing better outcomes for patients, in the first instance, and better working environments for our nursing staff.

[157] **Peter Black:** You’re aware, of course, of the King’s College London national nursing research unit, which found that, whilst international evidence suggested nurse staffing ratios could improve nurse staffing, recruitment and stability in the workforce and staff workloads, the impact on patient outcomes is less clear. How would you respond to that?

[158] **Kirsty Williams:** I don’t agree. If you look at the work of Linda Aiken, of Rafferty, all that academic study—the report into *The Lancet*, which is probably the most applicable to the situation that we find ourselves in, demonstrated that mortality dropped. So, I would argue that the evidence for patient outcomes actually isn’t disputed. I think you can have a debate—you know, I believe strongly that legislation is the way forward—but I don’t think actually there is any dispute that safe staffing levels don’t have a positive impact on patients, and if you drop below a certain level, that’s when you begin to compromise care.

[159] **David Rees:** We understand you believe positively, and that’s why you’ve put the Bill forward. We fully understand that. Can I take a quick opportunity, before I call Elin in, to ask one quick question on that particularly? You’ve talked an awful lot about international research and international examples, and I suppose the healthcare systems in those areas are totally different, necessarily, from the healthcare system we see in the UK. Have you undertaken any evaluation as to how applicable the research is to the UK system compared with the systems that they are based upon?

[160] **Kirsty Williams:** Sure. I would argue that actually it’s probably easier to introduce a system of this kind in an NHS that is organised in the way that it is, for instance, than in a situation like California, where you have private hospitals and no NHS—no national healthcare provision. I would argue that it’s probably easier to introduce such a system here. The evidence is the CNO’s evidence—the Welsh chief nursing officer’s evidence. She has

come up with figures that she believes represent safe staffing on our wards and, ultimately, whilst the evidence from Australia, California and Japan is helpful, to look at the consequences of introducing the legislation, what we're trying to do here is actually implement principles that have been established by our own chief nursing officer. The National Institute of Health and Care Excellence, which published, back in the summer, issues around staffing—it's England-only and non-statutory, but, again, those are very applicable to our systems here.

[161] **David Rees:** Okay, we'll be looking at NICE and others in the coming sessions. Elin.

[162] **Elin Jones:** I've got three quick questions. I agree that the detail of staffing ratios shouldn't be on the face of the primary legislation, but you've chosen to give Welsh Ministers powers to issue guidance, rather than powers to bring forward subordinate legislation, or secondary legislation. So, I wanted to know why you chose that particular route.

[163] Just for me to understand how you interpret the practical implementation of this, in the legislation you say that it should be required duty to be met on a shift-by-shift basis, and then you also say that there should be provision about publication to patients and information to patients. So, is what you're envisaging almost like a real-time, per-ward, 'The staff ratio here should be, by legislation, 1:8, but today it is 1:5'? Is that where you think this goes or takes us?

[164] Just to follow quickly on, on the unintended consequences, local health boards employ nurses in a number of different settings, and you've chosen not to include here, for example, community nurses, where the issues of safe staffing levels and time to care are just as relevant as they can be on a ward setting. So, I just wanted to understand from you why you chose not to include them at this stage, only to give Ministers powers to consider doing that at a later stage.

[165] **Kirsty Williams:** Sure. On the first question—regulation versus statutory guidance from Welsh Ministers—the reason why I've taken that approach is similar to the reason why we haven't put them on the face of the Bill in the first place: to allow for greater flexibility, and therefore, not need to constantly come back to a legislative process. So, for instance, we do know, in the last five years, the acuity of patients on wards has changed dramatically. If we were to put a figure, either on the face of the Bill, or indeed, in subordinate legislation, that would require quite a lengthy process to come back and amend that. So, what we're trying to do is create flexibility in the system, but underpinned by some kind of statute. So, therefore, statutory guidance seems to offer the flexibility but also the legislative underpinning that we're looking for to drive the agenda forward.

[166] With regard to information from the public, this could be done in a number of ways and I've left it to Welsh Government to issue guidance on the best way of achieving that. Interestingly, Welsh Government already—well, individual local health boards already provide a limited form of information on the MyHealth website, because they've got nurse-to-bed figures on that website. So, you know, you could have a situation where we're looking at information like that. It's difficult, because, of course, the wards might change on a daily basis or a weekly basis. So, it's impossible to have a situation that says, 'Legislation says you should have this today', because, of course, we're going for that triangulated approach. There'll be—

[167] **Elin Jones:** But, you do say 'shift-by-shift basis' in the legislation.

[168] **Kirsty Williams:** Yes, and that's what we're trying to do. So it's quite difficult. For instance, you know, you could have a sign that says, 'The legislation says this'. Well, the legislation, yes, would have a minimum ratio, but the legislation also says that you need to

bear in mind the acuity of the patients on the ward and the professional nurse judgment. The Royal College of Nursing in their evidence have suggested information, you know, at the front of the ward to give patients and relatives. They suggest that's one way of doing it, but I'm not dictating to Welsh Government the best way in which it could display that information. It's clear that having information that's made available to members of the public is empowering to them.

[169] Why this setting? First of all, it's important to recognise that it's an overarching safe-staffing duty that covers all settings in the Bill, but you're right; the guidance refers to what would be acute wards in district general hospitals. The reason for that is, one, because that's where there have been significant difficulties to date, so that's where the pressure has been, and that's where we've had the problems. Secondly, that's where we have the evidence at present.

[170] We know what the causes and effects are of unsafe staffing levels in those particular settings. We know what safe staffing generally looks like in those particular settings, because of the work that's already been done by the CNO and others. We are not there yet with regard to levels in the community. What we do know is that the Welsh chief nursing officer is looking at developing a set of tools to look at staffing numbers in community settings. NICE is also looking at a set of tools as to how you would evidence-base and how you would come to be able to set ratios in those particular areas. The Bill is drafted in such a way as to, as and when that information becomes available, give Welsh Government the ability to bring forward regulations for those settings as well. So we've tried to futureproof the Bill by making it able for Welsh Government to bring forward regulations in those settings when that evidence becomes available—and I'm confident that that evidence will become available, because Welsh Government officials, NICE officials, and individual local health boards are working on those data sets now to be able to come up with the evidence that we need to be able to move to that.

12:00

[171] I've heard the Minister say many times in this Chamber, you know, let not the perfect be the enemy of the good. We need to start somewhere. We've got the evidence for acute wards in DGHs. Let's start there but create a Bill that, like this does, allows the Welsh Government to move further when the evidence arises. That's what we've tried to do.

[172] **David Rees:** Can I clarify, on that particular point, that it's obviously adult acute wards and so it's focused on adults?

[173] **Kirsty Williams:** Yes. It is.

[174] **David Rees:** You said 'in DGHs'—and it's not all wards, therefore, in DGHs.

[175] **Kirsty Williams:** No.

[176] **David Rees:** So, it will be specifically identified, and definitions of 'acute wards' will be clear.

[177] **Kirsty Williams:** Yes. The definitions that we are basing it on are the definitions that the CNO uses to issue guidance already to local health boards.

[178] **David Rees:** Okay.

[179] **Elin Jones:** Just on the practicality, the shift by shift basis—

[180] **Kirsty Williams:** Sure.

[181] **Elin Jones:**—and how that's worked out, I'm still unclear in my own mind as to whether I've understood this correctly. The guidance would set a particular figure—a recommended minimum registered nurse to patient ratio.

[182] **Kirsty Williams:** Yes.

[183] **Elin Jones:** Then, depending on the acuity and on the view of the nurse in charge, or whoever is organising shifts, there would possibly be a different ratio; one could be 1:8 and the other could be 1:9 because there were particular issues. Then there's the—

[184] **Kirsty Williams:** It would be 1:7 maybe, or 1:6. You'd go up, rather than down, because that's the minimum.

[185] **Elin Jones:** Ah, yes, working the other way.

[186] **Kirsty Williams:** So, you've got a ratio that is the minimum by which you can't drop behind—

[187] **Elin Jones:** Yes, the other way.

[188] **Kirsty Williams:**—but you might well need to have extra staff, depending on the acuity of the patient, and—

[189] **Elin Jones:** So, we could end up with having three sets of ratios to compare. One is what the legislation says, one is what the acuity and the professional view of the particular circumstance of an acute ward is on a shift by shift basis, and one is what's actually delivered by the local health board.

[190] **Kirsty Williams:** What we're trying to do is that there is a minimum. So, yes, there is a minimum ratio by which people should not drop, but, in trying to move away from just a broad numbers game to better reflect what safe staffing actually looks like, we know that, if you drop below a certain level, then you are compromising care, but that level alone might not be enough to deliver safe care, depending on the patient. So, what you would have is guidance that will be given to local health boards that says, 'This is the minimum', but, in establishing the complement for that ward, you need to take into account the acuity tools for what you would normally expect patients to look like on that particular ward, when you are setting your complement for the ward, and then on shift by shift basis you have the professional judgment of the nurse that says, 'The minimum ratio is eight, the establishment on this ward is nine, because we know, from our acuity tools, that that is the nature of the patients we usually would have on this ward, but actually, it's January, we've got a flu virus, we've got very dependent people in, so, today I'm saying we need this level of staffing on the ward to make it safe'. That's how it would work in reality. So, you've got the underpinning, you have the usual establishment, and then the professional judgment of the nurse on a shift by shift basis. There are systems in place for e-rostering to allow the planning for that. Most hospitals already have it. It's a high priority, for those hospitals that don't, to have it in place already to try and move things forward.

[191] **David Rees:** Okay. Darren.

[192] **Darren Millar:** Yes. Thank you, Chair. Isn't there a potential for this to create risk as a result of the imposition of minimum staffing levels?

[193] **Kirsty Williams:** Safe staffing levels.

[194] **Darren Millar:** I'll explain what I mean. We have this situation often in the NHS that beds are closed and wards are closed because of insufficient numbers of staff sometimes to man them. If there's an increase in the staff complement going into some of the acute wards in a hospital, isn't there a potential that the capacity of the NHS will be reduced and therefore people will not be able to access in-patient beds, as is already the case in so many of our hospitals, and therefore the risks of an individual patient might increase?

[195] **Kirsty Williams:** No. I don't accept that. Actually, if anything, having proper complements of staff in hospitals will make hospitals more robust to fluctuations in demand. If you look at the evidence from the pilot in Nye Bevan, where they looked at putting perfect wards—perfect patterns in wards—actually, what that allowed them to do was to have greater resilience to demands being placed upon them, because they had a wider complement of staff to call on, because they were adequately resourced. So, actually, what it did was make the system more resilient. That is the feedback from the Nye Bevan experiment, that, actually, it made it more resilient to fluctuations—

[196] **Darren Millar:** So, you don't accept that, because of potential risk of litigation, for example, if this was on a statutory footing, that a hospital might say, 'Well, actually, we've had two nurses call in sick. We can't get people from the bank or agency at such short notice, so we will have to close a ward' and therefore it will reduce capacity.

[197] **Kirsty Williams:** No, this system is not designed to do that. I mean, we have this—

[198] **Darren Millar:** I know it's not designed, but is that an unintended consequence that you could foresee arising?

[199] **Kirsty Williams:** No—

[200] **Darren Millar:** I certainly can.

[201] **Kirsty Williams:** Well, I think in those circumstances—so this is the nurse-stuck-on-the-Britton-Ferry-bridge-Mike Hedges example—

[202] **David Rees:** [*Inaudible.*]

[203] **Kirsty Williams:** No, no. Not stuck on the bridge so much, as stuck on the road because the junction's been closed. What that would do—. If you had an adverse incident like that, and you felt that staffing had not met the safe staffing regulations, that would be flagged and you'd have an escalation policy. What we're looking at is not somebody jumping down the neck of an LHB because it's had an incident like that, but it's actually looking for patterns, over time, of a ward that is constantly not meeting the requirements, that is constantly being flagged, or a hospital that is constantly being escalated, rather than a one-off incident. So, the system is designed not to penalise people. Some people said we should be fining people. Some people said that we should be shutting down wards. This is not the system we are trying to create. It allows for the flagging up of incidents like that, which then can be reflected on, and, if you have a pattern of them, then you know you've got a problem in that particular ward or hospital. But, I don't envisage a situation that you say, Darren.

[204] **Darren Millar:** Okay. You've suggested that the introduction of the Bill may allow for, or lead to, a reduction in the use of agency and bank staff, and therefore have a positive financial impact, in some part, in terms of—

[205] **Kirsty Williams:** I don't claim that.

[206] **Darren Millar:** Well, we've had suggestions that there may be a reduction in the use of agency and bank staff.

[207] **Kirsty Williams:** Uh-huh.

[208] **Darren Millar:** Okay. Isn't the reverse more likely—that there would be an increase in the use of agency and bank staff and the cost per nurse, if you like, on average across the NHS, might actually increase?

[209] **Kirsty Williams:** No. First of all, with regard to financial savings, we don't claim that this legislation will make any financial savings—

[210] **Darren Millar:** The point I'm making is that you do suggest that there'll be a reduction in the use of agency and bank staff.

[211] **Kirsty Williams:** Yes, we do, because—

[212] **Darren Millar:** I've seen the table.

[213] **Kirsty Williams:** Yes, I do, and we say that because what you would be doing is creating substantive posts to meet the requirements, because, as the LHB, you would be required to demonstrate to Ministers how you had planned your services, your workforce planning and your recruitment and retention to meet the statutory guidance. So, the hospitals should be planning on the basis of recruiting a full complement to meet the guidance. It doesn't necessarily rule out altogether that there'll be circumstances in which bank or agency staff would never have to be used again. But the international evidence suggests that, actually, it moves away from the use of that type of nursing, because you have a proper complement of staff planned for in your workforce planning and submitted as part of your business plan. If you look at the plans that have been submitted to the Welsh Government, those plans that have been improved do actually say, 'This is how we're going to staff our wards. These are the complements. This is how we're going to meet the chief nursing officer's plans.' So, actually, they should be planning on that basis. They should be planning their staffing on the basis of meeting the statutory requirements.

[214] **Darren Millar:** Yes, but, of course, they would plan to meet the minimum statutory requirements, wouldn't they? If the acuity levels changed, because a patient came in who was particularly ill and was admitted into a ward, because it's monitored on a shift-by-shift basis, and worked out on a shift-by-shift basis that they needed two or three extra members of staff, for whatever reason, then the only place to go would be the bank or the agency, wouldn't it?

[215] **Kirsty Williams:** The—

[216] **Darren Millar:** Unless you're constantly planning for an oversubscription, you know—unless you're constantly planning for more than the minimum levels.

[217] **Kirsty Williams:** Well, the minimum is the minimum, obviously. So, what the acuity tool allows the Welsh—. That's why the Welsh Government have introduced the acuity tools to actually help you ensure that your establishment on a ward is the correct type of establishment, and there should be an uplift—the CNO recommends planning on the basis of an uplift—for increases in demand or because people go off sick. That's not happening at the moment. So, actually, what the legislation does is to ensure that, in planning their establishments, actually there is an uplift to take account of some of those issues. And, as I said before, what you're creating is a more resilient system because you've got more, you should have more, nurses on your ward anyway and in any one ward you might find a situation where the establishment allows you to move staff around.

[218] **Darren Millar:** Okay. Just in terms of the care settings, the Chair has already mentioned that, at the moment, the legislation is drafted in such a way that it would only apply to acute inpatient adult wards.

[219] **Kirsty Williams:** Uh-huh.

[220] **Darren Millar:** What about children's wards? What's the evidence base for not applying it to children's wards and other care settings, not just in the community, but perhaps outside of the NHS as well in terms of private hospitals, in terms of nursing care homes? Is there any reason that you haven't looked at its applications more immediately, if you like, to those care settings?

[221] **Kirsty Williams:** With regard—

[222] **Darren Millar:** Children's and independent, particularly—

[223] **Kirsty Williams:** Children's, yes. With regard to children's wards, there is guidance already. There seems to be, from what I can see from the RCN, better adherence to that guidance already in a way that we haven't got in the wards that we are referring to. It's a question of scale. Again, within the scope of this Bill, we're trying to solve a specific problem that has arisen in recent years. That doesn't mean that the principle can't be extended to other settings in the NHS. The Bill tries to allow the opportunity for the Government to do that, if it felt that the evidence was there and it was necessary to do so. With regard to children's wards, don't forget that there is an overarching principle at the forefront of this legislation that the LHB has to have due regard to safe staffing levels throughout its organisation. So, the children's ward is caught in that particular provision, and, as I said, there is an opportunity, if Welsh Government felt it was advisable, to be able to make specific recommendations to children's services, but my understanding is that there is Royal College guidance that is better adhered to in those settings. It's these particular settings where we've had the problems, and that's at the forefront of what we're trying to address in this piece of legislation, but allowing Welsh Government to bring forward recommendations in other settings. Underpinning it all is a catch-all requirement on the LHB to have due regard to safe staffing wherever in whichever wards.

[224] **Darren Millar:** But you accept that there are minimum guidelines already out there in terms of children's wards regarding patient-to-staff ratios that legislation could—. There may be benefit, potentially, of introducing that via amendment into the Bill.

[225] **Kirsty Williams:** I am not averse to that at all if the committee felt that it wanted to extend it to children's wards. Then I would be happy to see the evidence and to respond to that appropriately.

[226] **David Rees:** Can I just clarify that point? You mentioned that you were informed that the RCN indicates that they are actually being staffed appropriately at this point in time.

[227] **Kirsty Williams:** The evidence seems to suggest that there is better adherence to the guidance that's available at present. There have been some notable exceptions where there've been concerns, haven't there, about neonates? I'm aware of that and previous committees have done work on that area, but, generally, there seems to be better compliance with guidance in those settings. And it's a question of scale as well. We're talking about the majority of patients here caught by this legislation, because this is where the majority of patients are.

[228] **Darren Millar:** And, sorry, just on independent hospitals or care homes?

[229] **Kirsty Williams:** I haven't thought about the private sector. Again, I'm thinking about the—. I mean, there are regulations and there's an inspection regime for the private sector—

[230] **Darren Millar:** As there is for the NHS.

[231] **Kirsty Williams:** Yes. I'm trying to focus legislation on the largest group of patients that we can, where we know there is a problem, that's been identified, where we know we're not meeting the guidance issued by the chief nursing officer.

12:15

[232] With regard to other settings outside of the NHS, I think you're right. I think we should be looking at all sorts of staffing ratios for other sectors, but within the scope of a private Member's Bill, and what I was given permission to bring forward by the Assembly, it wasn't in the scope of social care, it was in the scope of the NHS.

[233] **Darren Millar:** But there is no reason why, through amendment, the Bill could not be used to require minimum staffing levels to be introduced for the independent hospital sector, for example.

[234] **Kirsty Williams:** Potentially. As I said, that has not been the focus of my work, because the vast majority of people in Wales are not treated in private hospitals. The private sector is infinitesimally small in Wales.

[235] **David Rees:** Elin.

[236] **Elin Jones:** But in nursing homes—. You prompted me to think, when you mentioned healthcare inspection, why there's nothing on the face of the Bill in terms of the healthcare inspectorate having a responsibility to monitor, as part of their inspection processes, reliance—the ability of the health boards to meet the requirements of the Bill. It strikes me that the process you have in place for the health boards to report to Ministers and Ministers to lay reports on adherence to this Bill is quite a cumbersome process. Wouldn't it have been easier just to make it a requirement for healthcare inspection, as part of its overall regime of inspection? We've talked a lot about that in this committee, I know, and you will probably say that in your answer to me. Why not just give them they duty to spot-check and to inspect on the adherence by local health boards to the guidance, rather than an annual, reasonably complicated reporting mechanism by the health boards on the Bill?

[237] **Kirsty Williams:** First of all, in terms of whether it's a complex mechanism for the local health boards, we're not asking them to collect new data sets that they're not already collecting. It's about asking them to present that information in a way that has reference back to this particular legislation. So, we've been very, very careful not to expect local health boards to start collecting lots and lots of extra data that they don't already have. They should, if they are properly managing their quality assurance within their institutions, have access to all of these data. They should have. If they haven't, then that's a warning sign straight off about the quality regime within that particular institution.

[238] Secondly, there is nothing to stop Healthcare Inspectorate Wales reporting back on staffing levels. They already do, in their reports, and it's a source of concern to them in many of the reports that they carry out. The question is: what are the consequences for that? As we know, at the moment, they highlight it, but there are no subsequent consequences. There's nothing in this legislation that will prevent HIW commenting on that, and actually it would strengthen their work, because they would be able to have a statutory basis on which to judge

the performance of the local health boards.

[239] **David Rees:** Elin?

[240] **Elin Jones:** No.

[241] **David Rees:** Okay. You've talked a little bit about costs, and you indicated that there were no financial benefits expected from the Bill.

[242] **Kirsty Williams:** No, I said I didn't claim any. If you look at NICE's work in England, it says that it's inconclusive that there are benefits, but what it actually also then goes on to say, in the NICE work for England, is that there are opportunities for the avoidance of harm. So, for instance, the numbers of falls and medicine mistakes, and they can put a figure to that.

[243] **David Rees:** I understand that. I'm looking more at the fact that you've also mentioned substantive posts being identified, and that more are needed. I suppose I want to clarify what you mean by 'substantive posts'. Are we talking about band 7s, and so on, or are we talking about a larger number of nurses? Betsi Cadwaladr and other health boards are concerned about perhaps the increase in complement as a consequence, and the costs of that. Have you done any analysis as to what you expect the increase in costs to health boards to be?

[244] **Kirsty Williams:** It's quite difficult to do that because, of course, the ratios are not on the face of the Bill, so it's very difficult to come up with exact costings because of that. What we have tried to do is to cost what is in the Bill, so, the costs associated with data collection, publication and communication between Welsh Government and the local health boards, and the annual report. That is detailed within the EDM. Of course, we have made an attempt to look at the costings of the consequence of the policy objective. So, my policy objective through this is to have adherence with CNO guidance. That is outlined on pages 45 and 46. The calculations are based on using the University of Bath cost calculator. We have referenced those back to chief nursing officers in local health boards and they say that it is a realistic and robust way of doing it. What we've identified in that is that the cost is on page 44 of what meeting the CNO's recommendations are. What's important to note is that the local health boards have submitted plans that are included in their three-year budgeting forecasts to try to meet the CNO's recommendations, and Welsh Government has made moneys available for them to do that. The question is whether we can ensure that the plans become a reality. I think this piece of legislation aids us in that attempt to make sure that those plans that are written down on paper actually happen on the ground, and that we don't have a rowing back from those plans.

[245] **David Rees:** Okay. Darren, you have a question on this.

[246] **Darren Millar:** Yes, it is just a very brief question on cross-border issues. Obviously, lots of patients from Wales are cared for through commissioned services in England.

[247] **Kirsty Williams:** Yes, sure.

[248] **Darren Millar:** Is there any mechanism for health boards being able to ensure compliance with these ratios? I can't see anything in the Bill specifically. How would you envisage that Welsh patients will still derive a benefit if their services are commissioned elsewhere?

[249] **Kirsty Williams:** I only have competence to legislate for Wales.

[250] **Darren Millar:** I understand that.

[251] **Kirsty Williams:** I appreciate that, and, Darren, I know it more than anybody, because a cohort of my constituents goes across the border into England for their hospitals, but I have no competence to legislate for staffing levels in the English NHS. What I would hope, Darren, what I would really hope, is that, by moving forward in this way in Wales, we can be at the forefront of this agenda for the NHS across the UK. I would hope that the benefits derived from introducing this system in Wales will actually allow us to lead the debate in this area in a way I would hope the NHS in England would follow.

[252] **Darren Millar:** If I might help the Member in charge, Chair, would you be averse to coming forward with an amendment that required commissioning arrangements to consider staffing ratios where Welsh patients are being cared for in settings outside of Wales?

[253] **Kirsty Williams:** There is a debate to be had about whether that is possible and/or desirable.

[254] **Darren Millar:** Well, it is possible; it happens in the north.

[255] **Kirsty Williams:** What's clear, Darren, is that, if you look at RCN figures about nurse-patient ratios, England is already doing better than Wales. So, I would argue that, actually, patients who are going across the border into English hospitals are probably, as a result of the Francis report and the investment in district general hospitals in England, enjoying a better staff-patient ratio than they are in Welsh hospitals. I can only legislate for Wales. I think there is a debate to be—. You can have a discussion about what influence commissioning could have, but the reality is that figures from the RCN show that, in Wales, our nurses are probably looking after more patients than they would be if they were across the border.

[256] **David Rees:** It will also include the NICE guidelines, as well, which have been introduced.

[257] **Kirsty Williams:** Yes. In England, of course, the NICE guidance has been made available this summer with regard to what English NHS organisations should be doing for safe staffing levels. I think the weakness in this system in England is that it is guidance only—it is not statutory—and there are no minimum ratios, because it was not part of NICE's terms of reference to do that. I think we can have a better system in Wales, and I think we can lead. Where Wales leads, I hope England will follow.

[258] **David Rees:** I've got two minutes, basically, to conclude one point. We've focused very much on section 2 of your Bill; we have not discussed, really, section 3, which is the reviews and report. For example, you've listed a lot of things there that you would want to report on. I just wonder where they came from, because some of them have very complex inputs into them and maybe are not clearly focused upon pure staffing levels, for example.

[259] **Kirsty Williams:** Sure. The list that is included in section 3(5) is a combination of outputs that are asked for currently by the Chief Nursing Officer for Wales, outputs that were listed in NICE's work this summer with regard to staffing levels, and consultation responses.

[260] **David Rees:** We may, obviously, explore some of those as well.

[261] **Kirsty Williams:** So, that's where that list has come from. It's existing guidance from the CNO, NICE's work and consultation responses.

[262] **David Rees:** Would you be able to identify for me, on a personal basis, in a note, which ones come from where?

[263] **Kirsty Williams:** Yes, of course; we can supply a note that identifies which documentation those come from.

[264] **David Rees:** All right. Last one then.

[265] **Alun Davies:** I apologise that I had to go to meet constituents during this session. When I read this—. You know, I don't think that many people in this committee have a problem with the principle of what this Bill is seeking to achieve. If I have a concern about it, it's the level of bureaucracy that might come as a consequence of the legislation. When I read this—. I understand the points you're making, Kirsty; I think it's a good point. Would it be possible to achieve the same results—because I think that the review and reporting is important, actually, to answer Elin's earlier point about making the legislation work—in your view, but with a far reduced level of reporting and review?

[266] **Kirsty Williams:** I think it's really important when legislating to ensure there is a mechanism by which we can judge the outcomes. We had questions earlier today about, 'Isn't this all about inputs not about outcomes?' So, section 3 is about trying to establish a mechanism by which we can judge the outcomes, and we can see whether the policy intent of the legislation is achieved. So, I think it's an important section.

[267] My understanding of what is already required of local health boards is that they are reporting on this—they are collecting this evidence anyway. Therefore, we have tried very hard not to create a system where we are asking them to report on stuff that they're not already measuring, but we're asking them to present it in a report specific to this legislation, so that we can demonstrate whether the policy intent has worked or not. If it doesn't work, then there's an opportunity for Welsh Government to review. There should not be any organisation that isn't already collecting these data and that these data should not be available to them. So, that's why the list is there. I mean, if people feel that the list is too long, or there are elements there that they don't feel are particularly relevant to the issue of a connectivity between safe staffing levels and outcomes, then there's a debate to be had. But, I don't think it's fair to say that we're asking them to do things they're not already doing. They should have these data available, and if not, that brings into question the quality assurance systems that they are running in their institutions.

[268] **David Rees:** I'm going to call it to a halt there. Can I thank you for your evidence? You will receive, as you know, a copy of the transcript to check for any factual inaccuracies or errors you may identify. Clearly, if there's something you feel, as you go on, that you need to inform us of, please let us know, because, as the Bill progresses, you will be keeping an eye on this stage, I'm sure. You will be coming back at the end of Stage 1 to conclude and put forward your final points on that matter. So, we look forward to seeing you then.

[269] **Kirsty Williams:** Thank you very much. We will ensure that the Chair receives a letter outlining where those parts of section 3(5) derive from and that you get that as quickly as possible. Can I thank Members for their time this morning?

[270] **David Rees:** Okay. Thank you.

[271] I'll move on to item 8.

12:29

**Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r
Cyfarfod**
**Motion under Standing Order 17.42 to Resolve to Exclude the Public from the
Remainder of the Meeting**

[272] **David Rees:** I propose that, in accordance with Standing Order 17.42(vi), we resolve to meet in private for the remainder of this meeting. Are Members content with that?

Cynnig:

Motion:

y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

*Cynigiwyd y cynnig.
Motion moved.*

[273] Okay. Thank you. We'll wait for the gallery to be cleared.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 12:29
The public part of the meeting ended at 12:29.*