



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

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

**Dydd Iau, 12 Chwefror 2014**  
**Thursday, 12 February 2014**

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynnddi 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
Mike Hedges	Llafur (yn dirprwyo ar ran David Rees) Labour (substitute for David Rees)
Ann Jones	Llafur (yn dirprwyo ar ran Alun Davies) Labour (substitute for Alun Davies)
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur (Cadeirydd dros dro y pwyllgor) Labour (temporary committee Chair)
Gwyn R. Price	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales

**Eraill yn bresennol**  
**Others in attendance**

Tanya Bull	Unsain Cymru Unison Wales
Dawn Bowden	Unsain Cymru Unison Wales
Dr Kate Chamberlain	Arolygiaeth Gofal Iechyd Cymru Healthcare Inspectorate Wales
Yr Athro Fonesig/Professor Dame June Clark	Yn rhoi tystiolaeth bersonol Giving evidence in a personal capacity
Yr Athro/Professor Peter Griffiths	Yn rhoi tystiolaeth bersonol Giving evidence in a personal capacity

Alun Jones	Arolygiaeth Gofal Iechyd Cymru Healthcare Inspectorate Wales
Anne Phillimore	Bwrdd Iechyd Lleol Aneurin Bevan Aneurin Bevan Local Health Board
Yr Athro/Professor Anne Marie Rafferty	Yn rhoi tystiolaeth bersonol Giving evidence in a personal capacity
Paul Roberts	Bwrdd Iechyd Lleol Prifysgol Abertawe Bro Morgannwg Abertawe Bro Morgannwg University Local Health Board
Peter Meredith Smith	Bwrdd Cynghorau Iechyd Cymuned Cymru Board of Community Health Councils in Wales

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

Siân Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Siân Thomas	Y Gwasanaeth Ymchwil Research Service
Christopher Warner	Clerc Clerk

*Dechreuodd y cyfarfod am 09:04.*  
*The meeting began at 09:04.*

[1] **Ms Madeley:** Bore da a chroeso i gyfarfod y Pwyllgor Iechyd a Gofal Cymdeithasol. Nid yw'r Cadeirydd yn gallu mynychu'r cyfarfod heddiw, felly yn unol â Rheol Sefydlog 17.22, rwy'n galw am enwebiadau ar gyfer Cadeirydd dros dro tan ddiwedd y cyfarfod heddiw.

**Ms Madeley:** Good morning and welcome to the Health and Social Care Committee meeting. The Chair is unable to attend today's meeting. Therefore, in accordance with Standing Order 17.22, I call for nominations for a temporary Chair for the duration of today's meeting.

[2] **Gwyn R. Price:** I'd like to nominate Lynne Neagle as the Chair.

[3] **Ms Madeley:** Rwy'n datgan felly mai Lynne Neagle sydd wedi'i phenodi'n Gadeirydd dros dro ac rwy'n galw arni i gymryd sedd y Cadeirydd tan ddiwedd y cyfarfod heddiw.

**Ms Madeley:** I therefore declare that Lynne Neagle has been appointed temporary Chair and I invite her to take the Chair's seat for the duration of today's meeting.

*Penodwyd Lynne Neagle yn Gadeirydd dros dro.*  
*Lynne Neagle was appointed temporary Chair.*

09:05

**Cyflwyniad, Ymddiheuriadau a Dirprwyon**  
**Introductions, Apologies and Substitutions**

[4] **Lynne Neagle:** Thank you, everyone. Can I welcome everybody to this morning's meeting of the Health and Social Care Committee? Just to run through the usual housekeeping: as you know, the meeting is bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1 or for amplification on channel

2. Can Members please turn off their mobile phones or put them on silent? If there is a fire alarm today, can you please follow directions from the ushers?

[5] We've got apologies from David Rees, and Mike Hedges will be joining us shortly to substitute for him. Ann Jones will be joining us this afternoon as a substitute for Alun Davies, who's unable to attend after lunch. Can I also welcome Peter Black to the meeting, who's substituting for the items on the safe nurse staffing Bill?

09:06

### **Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 6 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 6**

[6] **Lynne Neagle:** Okay, we'll move now then to item 2, which is an evidence session on the Safe Nurse Staffing Levels (Wales) Bill. Can I just welcome our witnesses this morning, Professor Dame June Clark, Professor Peter Griffiths and Professor Anne Marie Rafferty, who is joining us via video-conference from King's College London?

[7] We've all had the papers in advance, so thank you for providing us with them. Can I just remind Members that all witnesses are attending today in a personal capacity and are not representing an organisation? I also remind Members to speak clearly for the purposes of the video-conference. Okay, so we'll move, if witnesses are happy, straight into questions this morning, because we've got a lot of ground to cover. So, can I just invite Members to indicate if they'd like to ask a question? Gwyn Price.

[8] **Gwyn R. Price:** Thank you. Good morning, everybody. Could I ask Professor Rafferty and perhaps Professor Griffiths after to further outline the findings of the RN4CAST project relating to nurse staffing levels and mortality areas? For example, this showed that, whilst England has a higher nurse-per-patient ratio than Sweden, it also has a higher mortality rate. Could you enlarge on that? Perhaps I'll start with Professor Rafferty.

[9] **Professor Rafferty:** So, the question was a little unclear. Can I just add a correction for the record that I'm actually from King's College London and not the University College London?

[10] So, the question was about the association between poor staffing or better staffing and patient mortality ratios.

[11] **Gwyn R. Price:** Yes.

[12] **Professor Rafferty:** This is a finding that has been confirmed, first of all, in evidence from the United States. A study that we conducted in 2007 was the first to confirm a European finding of that kind; in fact, in England. Subsequently, the RN4CAST study, which, of course, covers a much broader range of European health systems—12 countries in total—similarly confirms that association. So, I think we have a very clear and consistent finding of a positive association between poor staffing levels and patient outcomes over a period of time and across different geographies.

[13] **Gwyn R. Price:** Thank you. Professor Griffiths, did you have a comment on that, please?

[14] **Professor Griffiths:** If I understood what you said correctly, you said that England has a higher ratio than Sweden. That is correct: actually, therefore, England has worse nurse staffing. You must be careful drawing comparisons between mortality rates in different

countries, because there are so many different country-specific factors, and the key finding is the consistent association within country between worse nurse staffing ratios and higher levels of mortality. I think that's the important headline finding. But we certainly have worse nurse staffing than Sweden does.

[15] **Lynne Neagle:** Dame June, did you have anything to add?

[16] **Professor Dame Clark:** No, not at this point.

[17] **Lynne Neagle:** Okay. Oh, Professor Rafferty wants to say something.

[18] **Professor Rafferty:** Sorry, can I just say that I didn't quite catch the point on Sweden, so I was just referring to the generic finding that Peter has echoed? I think when we actually rank-ordered England in our studies, it came out seventh in terms of having the poorest outcomes for patients. So, it wasn't one of the highest but one of the lowest-performing countries in terms of its patient mortality rates and how these correlated with nurse staffing levels.

[19] **Lynne Neagle:** Thank you very much.

[20] **Professor Dame Clark:** There are two very quick points that I could add. One is that the body of research that Anne Marie has been talking about didn't start with the European study. The research and the recommendations have been developing for at least a decade, and I think that's relevant to the questions you might want to ask later about the lack of compliance. I think that's quite an important point.

[21] **Lynne Neagle:** Thank you very much. Lindsay Whittle.

[22] **Lindsay Whittle:** Good morning, everyone. We had a debate yesterday in our Plenary session in the National Assembly for Wales about doctors, but some of us, myself included, took the opportunity to talk about a national workforce training plan, partly perhaps to encourage more training for nurses but perhaps to encourage nurses who have retired early to return to the nursing profession. I wonder whether there's any evidence in your valued opinions as to whether this legislation is likely to lead to an increase or decrease in the use of temporary staff, and whether it would actually encourage nurses to return to work, please.

[23] **Professor Dame Clark:** Would you like me to take that, Peter? I think the fact that so many nurses are coming in through agencies and so on actually demonstrates that the nurses are there. It's really largely a matter of pulling them back into preferred nursing roles within the NHS. The research—and it's for Anne Marie and Peter to comment on this—from other countries, particularly California, shows that their measures were followed by a big return to practise of nurses who had left to go and work elsewhere. Also, in California in particular,—and I've taken the opportunity to talk a bit about California with my colleagues there because my son lives there—nurses are coming to California from other states that haven't yet reached the same levels. So, there is some evidence. It's a bit 'soft' evidence, but it may be that Anne Marie and Peter can comment on that better than me.

[24] **Professor Griffiths:** I would amplify that, and certainly some of the anecdote is reflected in the research findings about California becoming a significantly more attractive labour market, with the nursing profession becoming significantly more attractive, and I can understand the concern about the potential that, actually, we employ more agency nurses to meet the ratios. There's nothing that I've seen in the research literature that suggests that that's the case. The effect appears to be that improving staffing levels on the ward makes it easier to attract and retain nurses in the profession and easier to attract nurses back into the profession, so that, actually, what we get is much more stable nursing workforce as well as a

more adequate nursing workforce.

[25] **Professor Dame Clark:** And there is evidence that stability is also a factor in improving quality.

[26] **Lynne Neagle:** Thank you. Professor Rafferty, did you want to add anything?

[27] **Professor Rafferty:** I've nothing more to add on that point.

[28] **Lindsay Whittle:** I wonder if I could just come back. Thank you, Dame Clark, for enlightening us about the California experience. You're encouraging us all to visit California, but I don't think it'll be allowed. Would that be location, location, location, because clearly California sounds a glamorous place to work, but—

[29] **Elin Jones:** As opposed to Caerphilly? [*Laughter.*]

[30] **Lindsay Whittle:** I was just going to say. [*Laughter.*] Would the Welsh Government perhaps concentrate on not only the professional training that we could offer here in Wales but also location as well? I'm sure that we're promoting Wales as an adventure place for holidays. Surfing off the Gower is very popular. I mean, would that play a part? That is actually a serious question.

09:15

[31] **Professor Dame Clark:** If it were a matter of the climate in California being wonderful, then you wouldn't have seen that change at the time when their legislation was implemented, because the weather in California was always beautiful. I think there have been efforts made recently in the UK, and not before time, to make things more attractive for nurses returning to practice. For example, when return-to-practice courses were first introduced, potential candidates had to pay for them themselves; nowadays, that's not so. I think it would be worth finding out—I don't know the position—what efforts health boards in Wales are making to do that, because that needs to be seen alongside the other issue, which is the number of training commissions in the first place, which is a really, really serious issue. I think Wales is a wonderful place to live and work—perhaps I'm biased.

[32] **Lindsay Whittle:** Yes, of course. Thank you very much—I agree.

[33] **Lynne Neagle:** Professor Rafferty.

[34] **Professor Rafferty:** Thank you. Taking up the point about the attractiveness of Wales, I think that Wales can argue that it should be congratulated for being one of the first within the United Kingdom in moving towards a graduate profession. So, in many ways, it has been in the vanguard of that development. We know that there is a positive association between better-educated nurses and patient outcomes. So, that, in itself, as a policy intervention, should deliver some benefit. There is also another point I'd like to make on the economic side, which is: often the economic argument is one that's used against mandated staffing ratios, but the evidence from California, as far as I understand it, has demonstrated that, actually, this does not, necessarily, cost more, because there are savings that can be made. As Professor Griffiths and colleagues have demonstrated in the National Institute for Health and Care Excellence guidelines, there are savings that can be made and offset against some of the initial outlay in costs of staffing levels.

[35] **Professor Dame Clark:** That's what my colleagues in California told me. They said that, just as here, all the barriers and the problems that have been raised in our debate were raised there, and didn't, in the end, come to fruition at all—that there was an initial rise in

costs, but it was very quickly overcome by savings in other areas, as Anne Marie has said.

[36] **Lynne Neagle:** Okay. Professor Griffiths.

[37] **Professor Griffiths:** In relation to that point, I differ slightly from my colleagues, in that I don't think that the evidence is that clear cut, but I think that some of the more substantive economic analyses that were made around California found it very difficult to attribute any increase to hospital costs that were associated with the change to a mandatory staffing ratio. So, the fears that there would be an economic collapse in the healthcare system resulting from this were not realised, and nobody could clearly attribute increases in costs; although there were increases in costs, it wasn't clear that they were associated with increases in staffing, as opposed to mandatory measures to reinforce hospital buildings to protect them against earthquakes, for example.

[38] The evidence from Australia tends to point to a favourable cost-benefit ratio in relation to the change to a range of mandatory staffing policies. Although that favourable cost-benefit ratio was associated with an increase in cost, it was an increase in cost that, were it for other treatments to save lives, would be recognised as a good investment.

[39] **Lynne Neagle:** Thank you. Peter Black.

[40] **Peter Black:** Yes, thank you, Chair. Personally, I've been to California a few times—I prefer Wales. In terms of the comparison with Australia and the US, clearly, I think that we most probably can make a comparison in terms of return-to-work rates and, to an extent, the financial benefits. How valid are comparisons with the United States and Australia in terms of the clinical benefits of mandatory nursing levels?

[41] **Professor Dame Clark:** The key researchers here are, I think, you, Peter, and Anne Marie—you can take this.

[42] **Professor Griffiths:** I think that, to an extent, it's a reasonable question to ask, but, given that we have seen precisely the same associations between nurse staffing and quality in England, in Europe and in a number of other countries as have been seen in the United States, I think it's very clear that the basic dynamics of that association are the same, and therefore the rationale and the logic behind the policy applies here just as much as it does in the United States.

[43] **Lynne Neagle:** Thank you.

[44] **Professor Dame Clark:** I watched with interest the last session of the committee taking evidence, and there was a debate there about how we define 'safe' staffing. It seems to me that, although that might be an important debate to have, the lines aren't black and white; what is much more black and white is that we do know a lot more about unsafe staffing—what unsafe staffing means—and, of course, the key indicator in unsafe staffing is excess mortality. And that is the key factor that emerges from the research. What we're saying, in fact, is that, unless we do something to improve our ratios, there will be an increased mortality rate. I think the research that has quantified how much is really very important; again, perhaps Anne Marie and Peter can comment on that better than I can.

[45] **Lynne Neagle:** Thanks. Professor Rafferty.

[46] **Professor Rafferty:** Well, I think one of the challenges here is identifying, in terms of safety, a threshold cut-point in overall numbers, and the Safe Staffing Alliance, of course, has identified that as a 1:8 ratio because of the evidence base that they attribute to that level. But I think it's easier, as Dame June has mentioned, to indicate what is unsafe rather than,

perhaps, a more grey zone of what ‘safe’ actually might be. I think some people would argue that even a 1:8 ratio is probably erring on the side of being more unsafe than absolutely safe. But this debate is only necessary in the absence of a responsive system to patient acuity and dependency and something that is sufficiently flexible and pliable to be able to respond to that changing level of demand with the capacity to meet that demand. So, it’s a complex question, but if you have a system that has sufficient elasticity built into it and is actually responsive to these safety parameters, then that can, I think, confer public confidence in a staffing and workforce planning system.

[47] **Lynne Neagle:** Thank you. Peter.

[48] **Peter Black:** Having accepted that we need to have some sort of ratio to reduce the unsafeness of wards, if not improve the safety of wards, given that England and Northern Ireland have both achieved better ratios of nurses to patients without legislation, do we need legislation in Wales to actually achieve that, or can it be done in another way?

[49] **Professor Dame Clark:** I’m quite clear about this: the defining characteristic of advice is that it doesn’t have to be taken. I learned that a million years ago when I moved from hospital nursing into health visiting, and the evidence has been around a very long time. There is one thing that perhaps I can say because I’m now retired—I no longer work for the NHS—that it would be difficult for the nurse directors that you saw at your last meeting to say, and it’s about the relative powerlessness of nurses in these decisions. Given the organisational structure of the NHS as it is, what the nurse can give at any level is no more than advice. The decision is the chief executive’s, and if we look at the 2012 principles that have been much talked about, for example, I’ve heard you talk about the nurse-patient ratio part of it, but one of the other principles in that, a recommendation by the CNO—who is just as vulnerable to this ‘They don’t listen to me’ as is anybody else—on the principle concerning the skill mix that is recommended was downgraded from the recommended level. So, the recommended ratio is 65:35. The recommended ratio in the chief nursing officer’s principles is 60:40. I am quite sure that that is as a result of financial pressures and negotiations that went on. And it also seems to me that it’s no coincidence that, in that very year, the number of commissions of training was dramatically reduced from a high, some years earlier, of about 1,400 down to less than 1,000—919; I’ve got the figures here. Of course, the bad news is that means that the situation that we’ve got at the moment is not as bad as it’s going to get, because the number of trainees—the number of commissions that were begun in that year—will only be coming through this year and next year.

[50] So, this is another reason why I think legislation is necessary. I am very sad to say that nurses aren’t always listened to—and that’s at all levels: from the chief nurse level down to what happens in boards. And, of course, the directive that provided the context for those principles came from the director of the NHS in a letter to all chief executives of boards.

[51] **Lynne Neagle:** Thank you. Professor Griffiths.

[52] **Professor Griffiths:** Going back to the question, underlying that England appears to have achieved better staffing than Wales without legislation rather implies that the situation in England is something to be aspired to. I think we need to be very clear that, within England, there is unwarranted variation in nurse staffing—that nurse staffing on hospital wards in England is frequently dangerously low. So, in a sense, the situation in England is one that might also be remedied by similar legislation to this. I think that England has essentially the same problems that Wales does; if the average staffing is slightly different, I think that’s a somewhat secondary issue, because I think neither has a staffing level that should be aspired to.

[53] **Lynne Neagle:** Thank you. Professor Rafferty.



[54] **Professor Rafferty:** Yes, I just want to follow up those points, really, and echo the word ‘vulnerability’ that Professor Dame June Clark has also mentioned, because we see the longer-term economic trajectories of workforce planning in nursing following largely the economic cycle of the country. It does seem to be a particularly sensitive barometer, as I mentioned in my written evidence, to the economic fluctuations and fortunes of the country—i.e. when pressure is on budgets, it’s often the nurse training and education budget that is the first that is raided and reached for, because it’s perceived as a soft target for making savings, and making those quickly. We do not see the same trends impacting medicine or the workforce planning of doctors. Therefore, this boom and bust cycle is something with which educators have to contend in dealing with radical shifts and shocks to the commissions that are actually generated by workforce planners. I am speaking here not just as someone who has researched the area of workforce, but also as a former dean of the Florence Nightingale Faculty of Nursing and Midwifery and an elected member of the executive of the Council of Deans for Health in the UK. It was a constant running sore with which we had to contend—we had no control over the planning of those numbers and our budgets could stabilise or drop like a stone depending on where we were in that particular cycle, and it certainly had no relationship with the continuing demand for healthcare in the community, in the acute sector or across the health system more generally.

[55] So I think that vulnerability is something that really needs to be taken very, very seriously, and the stability point, I think, that Professor Dame June Clark was making earlier is very, very well made. If we take the comparison with medicine, we’ve had a report recently from Health Education England in its strategic plan, which, actually, does identify the processes around which medical workforce planning happens, and they train for the longer term.

09:30

[56] They also train for training and education and that’s a pipeline that takes 13 years to produce a consultant. There’s training factored into that experience, from the medical student experience to the consultant experience, at every stage in career progression. In nursing, we only train for the entry point into registration. That is far too short term a horizon in order to workforce plan, because it takes no account of the experience of the qualified staff upon whom we are reliant for training and educating the next generation of nurses. So, it’s an extremely short term and myopic view, in my view. That’s something that really needs to be radically overhauled and looked at in terms of the long-term horizon. If we are going to fix this problem, it’s not just a question of fixing it at one point in time and at one point in the career cycle.

[57] **Lynne Neagle:** Thank you. Elin Jones.

[58] **Elin Jones:** Yes. You’re all advocating legislation over guidance. I wanted to ask you whether you think the Bill is explicit enough on the actions that would be taken on health boards if they fail to comply with the statutory duty. On the whole, it seems to be quite silent on that, saying that there should be annual reports by the health boards, and then, if they’re failing to meet the statutory duty, or the minimum staffing levels, that they produce a detailed plan to prevent recurrence. I was wondering whether you think the legislation would benefit from being more explicit as to what actions the Minister would take against health boards for failing to comply with the legislation.

[59] **Professor Dame Clark:** In my first and, I think, my second evidence too, this was the one point in the Bill that I picked out as something that needed to be strengthened. I wouldn’t know how at all, because I’m not an expert in that field, but I understand that when the first draft was put together in the first place, there was some discussion about keeping it

simple and short and putting as much as you needed to put into the guidance. But I do agree that sticks are needed as well as carrots, and the evidence is that less than sticks hasn't worked so far. I don't know what sanctions might be available, but, yes, I tend to agree with you that they do need to be strengthened in some way.

[60] **Elin Jones:** Okay.

[61] **Lynne Neagle:** Professor Griffiths.

[62] **Professor Griffiths:** It is, perhaps, a worthwhile observation, because it's an interesting point. I was wondering what I thought about that and I don't actually have an answer. But, looking back at the Californian legislation, it was quite interesting that there was an economic sanction against hospitals that did not comply. So, on one hand, there was a more forceful element of the legislation, but that economic sanction was actually extremely weak, and while that was not sufficient to rein in every single hospital, some hospitals, for a short period of time, traded taking that loss, because they saw it as being worth while. But, actually, that very weak economic lever did appear to be sufficient, eventually, to get hospitals into line. So, it's a difficult judgment that, in US terms, the sanction was actually a very weak one; it was a very small fine per patient day, where staffing was low.

[63] **Lynne Neagle:** Thank you. Professor Rafferty.

[64] **Professor Rafferty:** Well, I do think money talks and that's a major currency that chief executives, who are major targets, I think, here, for this intervention—. I think, getting the attention of the board and trying to lever up the voice of nursing and amplify the voice of nursing at board level, I think, the sinews would be stiffened markedly by some powerful sanction. Whether that's economic or whether that's the loss of certain privileges, it's not really for me to say, but I think, definitely, a strengthening—and perhaps not just financial; perhaps there could be other penalties that would really help to add in an incentive to adhere to these regimes in a win-win formulation, not in an utterly punitive kind of way.

[65] **Lynne Neagle:** Elin, is that okay? Okay, thank you. Can I just ask, in relation to the previous answer about workforce planning, whether the witnesses feel that we should be looking at workforce planning as something that should be on the face of the Bill, then?

[66] **Professor Dame Clark:** Absolutely. I've just got in front of me—I'll just run off a list of figures for the committee. I'm not expecting you to pick them up. Just to give you a feel: starting in 2003, that year, there were 1,387 commissions. In the years from 2003, it went like this: 1,247; 1,265; 1,271; 1,079; 1,095; 1,179; 1,070; 1,035. 2012 was the dip. That was obviously a year of financial straits. It dipped to 919. It started to go up, and I was pleased to see in the *Western Mail* this morning that there has been a decision to increase. It didn't say the figures in the *Western Mail*; it said an increase by 20%. Using the figures that the two nurse directors gave at your last meeting, those 919 who should be coming through now, even if there were absolutely no drop-out and if they all agreed to work in Wales, they would fill the vacancies identified by just Rory Farrelly—that's just one of our boards. That's the seriousness of the situation.

[67] The other point that Anne Marie made that is important about the timing—. We're told that the numbers that are centrally agreed are based on the plans of the nurse directors in the board areas for how many nurses they will need in three years' time. That is far too short a timescale. I agree with everything that Anne Marie has said. I don't see the purpose of pre-registration nursing education as being simply to staff the wards three years from now. It's to prepare nurses for a career of 40 years, where they may be working in any one of a variety of settings. This short-termism and this boom and bust is something that really has to be tackled.

[68] **Lynne Neagle:** Thank you. Professor Griffiths, did you want to add anything?

[69] **Professor Griffiths:** I'm not a legislative expert, and the wisdom of including this issue in this Bill is well beyond my expertise, but it clearly is an issue that needs addressing, and I think, maybe, legislation such as this provides a lever to force people to look at the issue as an alternative mechanism.

[70] **Lynne Neagle:** Thank you. Professor Rafferty?

[71] **Professor Rafferty:** Yes, I think there's an opportunity here, as I mentioned in my written evidence, to implement a natural experiment where Wales did, actually, adopt legislation and then compare the outcomes of that with England, for example, which has not. So, I think there are opportunities to analyse and evaluate the impact of this legislation over the course of time. I think it would help to really stop the leaky bucket phenomenon that characterises workforce planning across our different jurisdictions. We pour a lot of resource in at the front end of bringing nurses into the profession, and then we don't do them a great service by asking them to work in what are poor and parlous conditions.

[72] I think, one final point I'd like to make on this is that, as far as I understand, the Welsh Assembly has actually been progressive in its appointment or election of women to the Assembly. It has the highest percentage of women—I think it's about 50%—as its Members. We're talking about nursing, which is a female-dominated profession. This is something that would benefit the female workforce and, of course, the families and communities that rely upon that workforce, too.

[73] **Lynne Neagle:** John Griffiths.

[74] **John Griffiths:** If we could move on, Chair, to unintended consequences, which has been a major area of concern, I think, in the evidence that we've taken to date: it's always something that legislators have to consider very carefully, as to whether legislation will result in unintended consequences, which would be adverse and counter-productive to the aim of the legislation, and we've had concerns from other health professionals. For example, there are concerns about community nursing and concerns from support staff who operate on the wards that, in establishing particular ratios for nursing, the impact might be to adversely affect ratios elsewhere—you know, support staff, associated health professionals and community nursing. Given that it's a complex business, delivering health services, and it's very much a team effort, I think the worry is that it could be counter-productive, including for nurses, who may find that they've got an increased workload in having to do tasks that are currently performed by others. So, I think this is a major area of concern for many in terms of this proposed legislation, and I think we'd be very interested, as a committee, in terms of the evidence that you're aware of that would point in one direction or another on these issues.

[75] **Lynne Neagle:** Shall I take Professor Rafferty first, if that's okay?

[76] **Professor Rafferty:** Yes, I didn't quite catch all of that, but if the question is about skill mix, I'd really like to come back to the cost element of this—the yo-yo effect that we've seen over time in terms of workforce planning, and the evidence base on support staff and skill mix. I know that this was part of Professor Griffiths's evidence to NICE guidelines. I think there are clearly different ratios—proportions of support staff to registered nurses—currently in the workforce. I hear the 70:30 ratio bandied around as being the optimal, and I think there is some evidence historically to support that. But, overall, I think that the longer term benefits to be gained in actually being transparent about what a staffing policy actually is, both at the local and at the national level, will produce benefits in the longer term.

[77] Now, I think we've also got to recognise that the role of nurses is not just to support

support workers, who, in turn, support patients; it's also to provide support and expertise to enable other professions to work: allied health professions and doctors as well as operating, you know, in more autonomous kinds of roles. I think we have to confront the double standards that do exist in terms of workforce planning for medicine vis-à-vis nursing. We don't actually talk about the impacts of the crisis in medicine adversely impacting on patients. What we've seen happening over time is an increasing divergence in workforce planning numbers, of doctors in relation to nurses, which is going orthogonally like that. That, I think, is a scary prospect that we must fasten our attention on for the future, because doctors create demand in a system: they diagnose patients; they throw patients into the health and social care system, and if there are just not enough nurses there to meet that demand to support patients and their families and communities, then that, and that widening gulf, I think, is a very, very anxiety-ridden prospect for the future.

09:45

[78] **Lynne Neagle:** Thank you, and Professor Griffiths on unintended consequences, and I think John was particularly thinking whether it might have an adverse effect on other members of staff that are working on a ward.

[79] **Professor Dame Clark:** And I'd like to come in on that afterwards.

[80] **Professor Griffiths:** I think it's worth just stating, before we begin, that I think, if we were sitting before this committee saying that we felt that one important aim of this legislation was creating jobs for registered nurses for the sake of it, you would quite rightly tell us to leave immediately. That can't be the purpose here. I think there is some evidence from the United States that there was a marginal rebalancing of the workforce on wards, so a slight balancing towards registered nursing and away from healthcare support worker or equivalent roles. It is very difficult to judge whether or not that was to the direct benefit of patient care or not; the evidence really isn't there one way or another. I note, and I think it's an important consideration, that this Bill also mentions the ratios of healthcare support workers. So, from that point of view, I think there is an inbuilt protection in the way that this legislation is being framed.

[81] The consideration of knock-on to other professions—and you mentioned district nursing—I think that's a more difficult one to address in that, on the face of it, there is no reason within organisational boundaries that that should actually happen, and I think there does come a point where one cannot advocate maintaining unsafe nursing in hospitals in order to protect district nursing. It's a very different service, it's very important, and I think consideration of proper district nursing staffing levels also needs to be given, but I can't see that becoming an inhibiting factor for this legislation, although I very much doubt that there would be a direct knock-through; I can't quite see the mechanism, although you may be more aware of that than I.

[82] **Lynne Neagle:** Just before you come in, can I just say that we did take evidence last time, which you may have heard, from the physiotherapists, who were very concerned about the impact on other people who would come in to work in the ward setting?

[83] **Professor Dame Clark:** A couple of points: first of all, about the issue of the deployment of nurses between hospitals and community, my clinical background is in community nursing, and I fought for years and years and years for more investment in that area, in line with the policy that we've had about transferring more care to the community. The problem that we've discussed about training commissions shows that the planned intake for district nurses—I've just got it in front of me—in 2014 has dropped to 24. That's all.

[84] One of the areas that I think nurse directors do have more control in is the

deployment of nurses within the workforce, so this is nothing new; they have always had to plan their nursing resources across the nursing services. And, as far as I know, there is no evidence that sees this as a problem. Of course, the problem with looking at the States' evidence is that they don't have much by way of community services anyway, so there's not much to compare it with.

[85] On the evidence given by the physiotherapists, I was, frankly, quite shocked. I've never heard an argument that says because you can't do everything for everybody right now, you shouldn't do anything for anybody. And I personally do hope that this Bill—. One of its, if you like, unintended consequences—a good unintended consequence—is that it has raised awareness, and people are now starting to think that maybe we ought to be collecting the data that we need to support this evidence. And my advice to the physiotherapists, and I've shared conference platforms with them, is: 'For heaven's sake, start collecting your data now', because there are no data, as far as I know, around physiotherapy that would provide the kind of evidence base that we are bringing forward around nursing.

[86] **Lynne Neagle:** Thank you. Professor Rafferty.

[87] **Professor Rafferty:** I just wanted to—not make a point about physiotherapists, but to return to the community nursing workforce, and I agree with Peter's point. It's difficult to see exactly what the knock-on consequences would be, but one thing immediately in question is whether you are starving one area to feed another. I don't think that's the way the dynamic would work. What we've seen, certainly in England, is that, over the last decade, the numbers of district nurses have dropped dramatically from something in the region of 12,000 to fewer than 5,000 at a time when we're supposed to be moving care into the community—of course, a policy that we've been pursuing for nigh-on 69 years, and still not quite succeeded. That's within our gift to actually engineer effectively, and, again, it's part of this myopia around career planning and the planning horizons, so that it just doesn't look beyond the immediate point of intake into the profession, and focuses quite obsessively on that to the detriment of looking at the career cycle, and, with that, the qualified workforce of which district nurses are a crucial and important part for policy implementation.

[88] **Lynne Neagle:** Thank you. Can I just ask Professor Griffiths, in relation to the work that you've been doing reviewing the NICE guidance, whether there are any lessons that you'd like to draw out for us as we look at this legislation in Wales?

[89] **Professor Griffiths:** I think that the NICE guidance, or the evidence behind the NICE guidance, in many ways really amplifies the underlying issue that we know that there are significant issues and problems in patient care that are associated with low nurse-staffing levels. Although there has been some quibbling about that evidence, and about whether evidence from the United States applies to this country, it seems really clear that that is a very well-established finding. NICE explicitly excluded the consideration of mandatory ratios from their evidence review, so, from that point of view, the presentation of evidence around that that's in my submission and that we've spoken about is based on a somewhat more informal review of the evidence. But I think it's very important to remember, I suppose, the key alternative policy that has been very strongly advocated by NICE in their guidance, which is to emphasise primarily local planning and local determination using so-called validated workforce planning systems—which is included in this legislation, but with a much stronger emphasis on the mandatory ratio. In reviewing evidence for NICE, we found absolutely no evidence for the effectiveness of such systems in terms of their impact upon patient care. If you look at the situation in California prior to legislation, the use of such systems was mandatory, and yet there was significant and apparently unwarranted variation between hospitals, and staffing improved considerably after their legislation. So, the focus on local workforce planning systems in isolation, without an underpinning of a ratio, is not supported by any evidence whatsoever. So, although there are questions around the evidence on ratios,

without a shadow of a doubt, the alternatives that are being proposed have absolutely no evidence and, actually, the one natural experiment that we have suggests that, in California, there was a move, as they went from a mandatory use of local workforce planning systems to a system with a minimum ratio and the mandatory use of such systems—which is, essentially, the legislation that you’re proposing—that we saw improvements in staffing. We didn’t see clear and strong improvements in patient outcomes, but I think there is a very compelling argument behind that, which is that the case mix of patients in California changed dramatically over that period of time. So, had nothing changed with staffing, you would have anticipated that patient outcomes would have worsened, because the patient profile in Californian hospitals changed to a much more acute one and what wasn’t seen was a change in the frequency of adverse events, which you would expect if you had a much more acute patient population.

[90] So, I think, while the evidence is not 100% clear-cut, it’s actually a much stronger evidence base for a policy such as this than the evidence for the alternative that’s being proposed by NICE, for which there is actually no evidence.

[91] **Lynne Neagle:** Thank you.

[92] **Darren Millar:** So, you’re asserting that the evidence from California was unclear in terms of benefits to patient outcomes as a result of the legislation. I mean, the whole premise on which this legislation’s been brought to us by the Member in charge is that it will deliver improved patient outcomes and I think all of the evidence we’ve heard so far says that, you know, the evidence is very clear, very conclusive; patient outcomes will improve with minimum staffing ratios. Of course, it depends where those staffing ratios are set, I suppose—

[93] **Professor Griffiths:** Indeed, yes.

[94] **Darren Millar:** —but that legislation is necessary to enforce those minimum staffing ratios. You seem to be muddying the water a little with your suggestion there.

[95] **Professor Griffiths:** I perhaps talk with appropriate academic caution. The evidence from California—I mean, if one had a will to find evidence of improved patient outcomes, there is, but, in all honesty, as an academic appraisal of it, it’s not compelling. If you look in other legislations—the evidence from Australia is actually much stronger, in Australia, they had a slightly different policy, so the reason that that point was emphasising California was that there you have a natural experiment that was effectively comparing the alternatives that are on offer within the UK. The movement in California was very specifically from a policy where they had mandatory local workforce planning tools to one where such tools were used in conjunction with mandatory staffing. So, that was the reason for emphasis on that. Taking a step back more broadly, policies that improve nurse staffing, there is a compelling evidence base that says that that will lead to improvement of patient outcomes.

[96] **Darren Millar:** But, whether it’s the legislation to enforce—the statutory basis in terms of enforcement or not—is unclear.

[97] **Professor Griffiths:** Well, no. This is where, if we come back to the evidence from California in relation to the effect of the legislation on staffing, it’s very clear. So, we have compelling evidence from California that the legislation did indeed lead to improvements in nurse staffing.

[98] **Professor Dame Clark:** Just to add to that, I wanted to reinforce a point made by Rory Farrelly last time. He used the word ‘triangulation’, in other words, that there is no one single all-magic bullet, but that each of the three bits—the nurse-patient ratios, the use of an acuity tool and professional judgment—each of those three is necessary but not alone

sufficient, it's when you put those three together—. At the moment, we do have some work on the other two, we do have nurses who try very hard to give their professional judgment, we do have a range of acuity tools, including the one that the chief nursing officer here has been using; it's the third piece that's missing. It's when you put the three pieces together that, I think, we're moving forward.

[99] **Darren Millar:** Of course, Mr Francis though, suggested that this legislation was unnecessary, didn't he? I mean, he talked about triangulation, in fact, I think he mentioned the word more frequently than most other words that he used. But he suggested that we didn't need this legislation in order to deliver the improved staffing ratios, didn't he?

[100] **Professor Dame Clark:** Mr Francis?

[101] **Darren Millar:** Rory Francis.

[102] **Elin Jones:** No, it's not Francis.

[103] **Darren Millar:** Pardon me. Rory Farrelly.

[104] **Professor Dame Clark:** Oh, Rory Farrelly. I didn't hear him say that.

[105] **Darren Millar:** Okay, well I think the evidence from the health boards has been very clear, certainly the written evidence, that they do not feel that there's a need for this legislation in order for them to improve the staffing ratios.

[106] **Professor Dame Clark:** I'm reminded of the famous quotation from, who was it, Mandy Rice-Davies: 'He would say that, wouldn't he?'

[107] **Lynne Neagle:** Okay, thank you. Can I just ask one final question? We have had some evidence that perhaps the focus of the Bill is too narrow in just applying to adult acute wards, and we've had evidence that maybe we should be looking at applying it to the community, also, maybe, to nursing home settings and settings like that. Can I just ask the witnesses for their comments on that point of view, please?

[108] **Professor Griffiths:** I think that's a very difficult question to answer, because, in terms of the scope for, then, developing the guidance behind the Bill, I think there's a much firmer grounding for what that might look like in adult acute settings, but, equally, it's very clear that the same or similar issues apply in other settings, and so the logic for extending it to those other settings seems to be very clear. Whether or not we have the knowledge in order to identify the ratios—and the attempt to do so might actually bog down progress, because it would take so long—I'm unsure.

[109] **Professor Dame Clark:** How do you eat an elephant? One bite at a time. Around the California legislation and other states too, there is work that has been done about the differing ratios that are required for different specialties.

10:00

[110] I think we should look at that and build on it. One of the sub-issues that I'm passionate about—but it's a bit of an obsession with me and I've discussed it with individual members of the committee on other occasions—is how, in the UK generally, but in Wales in particular, we do not collect the right kind, or enough of the right kind of data about nursing. We need to start now to collect that evidence, so that we can expand the provision—and the Bill does make provision for expansion into other areas—so that, gradually, we will get sensible staffing and workforce planning right across the board, across disciplines and across

specialties within nursing, but you have to start somewhere.

[111] **Lynne Neagle:** Thank you. Professor Rafferty, have you got any comments?

[112] **Professor Rafferty:** No, nothing further to add, but I do agree that that seems like a sensible position to try this out in one area and then, if successful, to roll it out into other areas. It would be very useful, I think, as the Bill makes provision for, to have a review at an appropriate time and to evaluate through an impact analysis its efficacy.

[113] **Lynne Neagle:** Okay, thank you. Well can I, on behalf of the committee, thank Professor Dame June Clark, Professor Griffiths and Professor Rafferty for their evidence this morning? I'm sure all Members have found it really informative. You will be sent a copy of the transcript to check for accuracy, so if there are any issues, you can come back to us. But, thank you very much for your time this morning; it's much appreciated.

[114] **Professor Dame Clark:** Thank you for listening.

10:03

### **Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 7 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 7**

[115] **Lynne Neagle:** Good morning. Okay, we'll move on, then. Can I welcome Peter Meredith Smith from the Board of Community Health Councils in Wales? Thank you for coming this morning and thank you for the written paper you provided. If it's okay with you, we'll go straight into questions, or did you want to say anything at the start?

[116] **Mr Smith:** I guess the only comment that I would make, it's not quite a declaration of interest, but some members of the committee will be aware that, in terms of my current post, I'm seconded into this post from the Royal College of Nursing, and I have previously been involved in this agenda as a registered nurse, but the views that I represent today are the views of the CHCs. Just to be clear about that, so that there's no—. I'm not batting for the RCN or anybody that has that sort of vested interest in it.

[117] **Lynne Neagle:** Okay, thank you. Okay, we'll take questions from Members now then. I've got Gwyn Price first.

[118] **Gwyn R. Price:** Good morning.

[119] **Mr Smith:** Good morning.

[120] **Gwyn R. Price:** Could you tell me the main barriers that currently prevent safe nursing staffing levels being in place?

[121] **Mr Smith:** In terms of the evidence that I'm presenting, just to be clear, you've had some very astute academic evidence this morning, but what I give is perspective in terms of the CHCs that I'm representing this morning. The sorts of barriers that we hear about relate to issues around what we see as deficiencies in terms of workforce planning itself, in terms of chronic problems not being addressed. The message that we're getting back from nurses that we talk to in terms of our scrutiny visits is that not enough nurses have been trained to fill the posts needed. The biggest issue, I guess, is—. What's reported to us is the emphasis on the financial difficulties of the organisation rather than focusing on the needs of the patients. The message that we're getting is that's the case. The evidence that we see in terms of scrutiny visits are nurses who seem to be very busy. There's an impression of being understaffed. That's the sort of information that we're getting back from the patients that we're engaging



with, as well. I think we set out in the evidence the view that the patients are giving us in terms of their experience in these clinical areas.

[122] **Gwyn R. Price:** So, do you believe they're understaffed?

[123] **Mr Smith:** I do, yeah. The tension I've got, which is why I made the initial point, is that, quite clearly, the evidence that we're getting back from the CHCs—and I had a meeting on Monday with the chief officers to sort of validate this opinion that they're giving—is that there are significant issues of short staffing on the wards. They've seen some improvements, but that's largely been achieved through the use of long shifts, agency staffing and overtime, which is an issue in itself, isn't it? There's clear evidence that the service is responding to the pressure. There is that sort of change. I think, in terms of the issues that we look at during the scrutiny visits, in fairness, it has to be said, in terms of giving a balanced perspective on some of the issues that I referred to in the report relating to our complaints information, real efforts have quite clearly been made by the LHBs in terms of improving issues around dignity and fundamentals of care. In terms of our last round of scrutiny visits, things are definitely improving, but the observation is, 'At what cost?' 'How is that being achieved?', I think, is the observation that we're getting from both the people who are undertaking our scrutiny visits and the patients we're engaging with.

[124] **Lynne Neagle:** Thank you. Darren Millar.

[125] **Darren Millar:** Yes. Can I just ask you about the role of CHCs perhaps in being able to enforce such legislation? There's very little information on the face of the Bill about how this legislation will be monitored and enforced. It talks about the need for annual reports. But, where do you see the role of community health councils fitting in to the assurance mechanisms? In fact, perhaps you can tell us now that, given the guidance that is already out there in Wales, which has been given by the Welsh Government through the chief nursing officer, what role the CHCs have in helping to ensure that there is compliance against that.

[126] **Mr Smith:** Clearly, we have a legal responsibility to scrutinise the health services on behalf of the public and service users. The two main mechanisms for doing that, I guess, are engagement with the providers of health services and holding them to account and asking them difficult questions. I guess the second issue is the issue of our announced and unannounced visits and our scrutiny visits; all the CHCs have a programme of scrutiny visits.

[127] Our ability to scrutinise the issue of nurse staffing is very limited at the moment. In terms of the tools that are used across Wales, they're very variable, and part of the agenda that I'm trying to lead is to get some consistency in terms of the way we deal with this issue across Wales. Notwithstanding, efforts have been made, particularly on the back of the ambulance review, the Francis report, and so forth, to try and modify the methodologies that CHCs use. So, they're beginning to attempt to get a more quantifiable understanding of what the pressures are around staffing, but it's very rudimentary at the moment, I must say.

[128] But, something like this would help us, because, effectively, we go to clinic areas, or our members go to the acute wards, and they see what's going on—people rushing round, patients often not being able to get interventions done in a timely manner, nurses looking tired, and so forth—but you get different views fed back to you when you question that. Managers might have one view; the nurses delivering that care might have another. If we were in a situation where there was absolute clarity in these areas about what should be happening—and we've talked in our paper about the need for patients to have information in real time—that would assist us. I think that could assist us in terms of our scrutiny work. It would inform work that we're doing at the moment.

[129] The committee will be aware that our regulations are being reviewed at the moment,

and at the heart of that is a desire to standardise the way that we undertake our work. One of the key standards that we will want to look at, assuming that the regulations proceed as consulted upon, is this standard on the way that we undertake scrutiny. Something like this would be really helpful to us, because, at the moment, it's a bit like the nature of our paper, it's very much giving a view—this is the opinion of the members that are visiting these. The hard evidence isn't as firm as perhaps some of the other speakers that you've heard this morning, but this would be really helpful. For our lay members, who are, after all, volunteers—two thirds of our human resource in terms of the work that we do are volunteers; they're not experts, they bring a lay perspective—this would be very helpful in terms of giving some framework to scrutinising our health services.

[130] **Darren Millar:** And, given the evidence that we've heard about the impact of guidance elsewhere in the UK, in Scotland in particular, and indeed in England, driving up the staffing ratios without this legislation, do you know why it appears to be more difficult for Welsh health boards to meet the guidance of the CNO here than is the case elsewhere?

[131] **Mr Smith:** I mean, I can't comment in terms of what's happening across the border, but the impression that we get is that it's about some of the stuff I've already said: you know, not enough nurses in the system. I think you'll be aware that there are high levels of sickness in the system. The workforce planning doesn't seem right, and the fixes actually are very often sort of shifting nurses round like widgets in the sense of, if we highlight a problem, that can be fixed, and then we're hearing about another problem elsewhere. So, the impression that that gives is that we've got a bit of a whole-systems problem. I guess that we've indicated some of our concerns in terms of where this might take us in terms of unintended consequences. It's this issue of, you know, if you've got legislation relating to one particular area, there is a real worry that we will have problems elsewhere, which is our experience in terms of service change.

[132] **Darren Millar:** So, how do CHCs monitor workforce planning at the moment?

[133] **Mr Smith:** We don't robustly do that, it has to be said. I mean, all you can do is look at the limited information that's available at board meetings. We look at what workforce information is available. I mean, it's very limited and I don't think that the stuff in terms of this agenda, that's most relevant, is scrutinised in the public domain. It is available. I mean, if you look at things like spend on bank, agency and overtime for nursing over the last six years, my personal view is that that's an exceptionally good proxy measure of the deficiencies in the system. I think that the issues in terms of agency spend in the last 12 months are well publicised. You'll be aware of those, and I suspect that that is a direct consequence of some of the service failings that you will all be familiar with that are very high profile. I think you could probably cross-reference them.

[134] **Darren Millar:** But what you're suggesting is that CHCs don't routinely or consistently challenge the boards in terms of that workforce planning.

[135] **Mr Smith:** No. I would say it's in an ad hoc way really. I mean, if you're aware of an issue, you challenge, but I think what this would give us some structure around is a more systematic way of doing that.

[136] **Darren Millar:** Okay. Thank you.

[137] **Lynne Neagle:** John Griffiths.

[138] **John Griffiths:** Just drawing on the experience that you have, Peter, I wonder whether you could expand on the evidence that you've already provided in terms of things going wrong and nurse staffing being an important factor in those things going wrong. In

terms of adult acute wards, is there anything further you could tell us in terms of, you know, the staffing ratios that exist and how they've been a part of the problems that have taken place?

[139] **Mr Smith:** Okay. I mean, there were a couple of high-profile cases that were referred to me in terms of preparing this evidence that it wouldn't be appropriate to talk about. Some of them, you're probably aware of through the press, really.

[140] In general terms, as I referred to in the paper, we don't collect—. Well, there are no data available in terms of the concerns and complaints database, because they're two separate issues that sort of say, 'Nursing staffing is an issue; we want to complain about it'. But in terms of those issues that I've sketched out in this evidence, you know, the view of the lay visitors and the view of the CHC staff is that, when you follow through some of these complaints, it is often the case that nursing staffing issues are very pertinent, if you look at the issues that go wrong.

[141] Interestingly, in terms of the data that I have provided for you, just to give a bit of clarity on that, I said that we did that review of the data, that was a full review of all the concerns and complaints data that we held from April 2010 to August last year. I've done a bit of validation work to look at that. We looked at the last year's figures in preparation for the meeting today, and the situation has not largely changed in terms of the percentage of problems that relate to nursing in terms of secondary services and in-patient services. There have been some shifts that are quite interesting. There's a positive shift in terms of the fact that issues around dignity of care have actually fallen out of the top five now, but that's been replaced by issues of complaint around the care of elderly people, which I think is really quite interesting. I mean, this is very skewed information. It's because, generally speaking, the people that we engage with, as I've said in the paper, to give balance, are generally content with the service that they receive, and these people that we're talking about are obviously a very skewed sample, aren't they? But, it is nonetheless significant when you look at some of these failings, you know.

10:15

[142] **Lynne Neagle:** Okay, John? Elin.

[143] **Elin Jones:** In your response to us, you do come out in favour of the duty needing to apply to a wider range of health places than just adult in-patient wards, such as other clinical environments, then. One of the concerns that we've heard in this committee, and it's a concern I have, is that with health boards running nursing services in a variety of scenarios—in the community, in community hospitals, as well as on acute in-patient wards—with the budget pressures as they are, in order to meet this statutory requirement, they may well end up shifting the nursing population that they have, or their current workforce. Do you think that that would be a realistic danger as a result of confining this just to adult in-patient wards?

[144] **Mr Smith:** I think it's clearly stated. The view given quite consistently by the eight CHCs that have contributed to this is that that is a risk that they worry about, but I would better describe it as an issue. You can't pretend it's not happening. I think part of the difficulty that we've had in terms of the nursing staffing agenda for many years is that we spend a lot of time managing symptoms not addressing the problems, and that is an issue. If we don't acknowledge that as an issue, we've got a problem. You know, we already have evidence, as I've said, that when issues are raised in terms of the scrutiny process and remedial action is taken, there is usually an opportunity cost somewhere.

[145] My experience in terms of the job I'm doing and other experiences is that the Welsh public are pretty sensible generally, actually, and what they most desire is honesty in terms of

what we're dealing with. I think there's no misunderstanding about the pressures of the services, and I don't think there's any misunderstanding about—there's no blank cheque to sort that. But they are often confronted with a situation, I think, where there's a pretence that the NHS is able to deliver on all things, and this does cross-reference with others of our functions in terms of the role that we have in enabling the public to engage with consultation. You know, we know what happens behind this. You know, we get problems, emergency closures and all that sort of issue as a consequence of trying to put right problems.

[146] The fix to this has to be acknowledging that these issues exist: you can't ignore the problems that have been highlighted in the evidence that you received that arise because of poor staffing, can you? I mean, we can't sort of say, 'We'd better ignore that because it could cause a problem in primary care or mental health'. I think it needs to be flushed out, and I think that that's why they wanted to raise that issue. It may be that things will have to stop in other areas to ensure safety and quality of services, but what we wouldn't want is for the legislation to be used to solve a problem in one place at the expense of service users in another place—often more vulnerable service users, as is the case, isn't it?

[147] **Elin Jones:** There's a very clear part of the NHS that is excluded here, putting aside the possibly more complex issues in undertaking a statutory duty in the community setting. Community hospitals are excluded from here, so they're adult in-patient, but they're not acute hospitals. It would strike me that that scenario especially could benefit from having this duty upon it as well.

[148] **Mr Smith:** Basically, I mean, if you get the workforce planning right, the starting point is that we have some notion of what we're here to do, and then we need to think about what resource is needed to do that, rather than rolling on from year to year, trying to react to things. Community hospitals, the example that you've given, are key to the whole healthcare system, aren't they? I would suspect that community hospitals going forward will have a very important role to play in terms of easing the pressures in the system, if we use the total system properly, and if we have a more sensible view of the workforce as a resource across the healthcare system.

[149] That's another problem that we see is that you've got sort of a bunker mentality very often. The organisation of the NHS is such that you have directorates, or whatever you choose to call them, that have pressures to balance the books to deal with these workforce issues. It's the responsibility of the boards quite clearly to ensure that there is a more sort of holistic approach to solving those problems, which is, again, why some of the stuff in this legislation is very important, isn't it, in terms of clarity and in terms of your responsibility to the public to reassure them that the workforce that is delivering their healthcare is fit for purpose, and being honest with them when there are difficulties? Because there will be difficulties. You know, I think we've mentioned in our evidence that we appreciate that you can't have too black-and-white and hard-and-fast rules—there needs to be tolerance, but you do need this whole-systems approach with clear accountability and a clear understanding of the limitations of what people can contribute to the solution. I think that's another problem. In terms of our experiences in talking to clinical staff, there's an assumption that there's a lot of empowerment at the bedside, shall we say, to solve this problem. I don't know whether you've heard that in your evidence, but that isn't the case. There's a lot of assumptions that ward managers have more control and autonomy than they do and have more of an involvement in workforce planning than is the case. Similarly, at board level, I think there's an overstatement of the authority that nurse directors have in that situation.

[150] **Elin Jones:** I think it was described to us in the last evidence as the 'powerlessness of nurses' in the system, and nursing directors on the boards. That was, you know, quite an accurate way, I think, probably, of describing the role of nurses in workforce planning—

[151] **Mr Smith:** What's described to us is very much the predominance of a general management model, you know, in terms of hitting the objectives and balancing the books and all that. Very often, you know, the reality is, in terms of the consequences of that approach, the people at the bedside, particularly the clinical staff, I guess, bear those consequences because those are the people whose registrations are at risk. When we have seen service failures that are in the public domain, it usually relates to very low-grade staff, doesn't it? They are the casualties in terms of this situation, very often. I think the point that I would make, which I hope we've, sort of, conveyed in the report, is it's quite remarkable how understanding the public that we engage with are. They're very appreciative of it and when things go wrong, they don't generally say, 'Well, it's that individual nurse's problem'.

[152] **John Griffiths:** Sorry. Can I just ask on that? One issue that's been involved in the discussion and debate around the legislation is to what extent you would have, you know, minimum staff ratios becoming a sort of default setting, and to what extent we're not actually talking about that; we're talking about safe staffing levels, and other factors come into play—the particular conditions on the ward at any one time. You know, when you're talking about where decisions are made, how does that relate to that question as to, if this legislation comes into place, will it be safe staffing that drives what happens, rather than this sort of default—

[153] **Mr Smith:** I mean, that's been acknowledged, again, as a consequence that we're worried about: in terms of the ceiling, as it's described, or what have you. So, again, we flag that, not because we're saying this shouldn't be done because of that, because that's a risk, isn't it, you know?

[154] I think I can reflect on my experience as somebody who's been a ward manager and worked as a nurse, and link it into the stuff that we're using from the start. For me, the minimum standard stuff is about the fundamentals of care that you'd expect. It isn't rocket science, you know. In terms of my time as a ward manager, you don't need a sophisticated workforce tool to realise that you've got 20 patients on the ward, and you know the make-up of the sort of patients that we're dealing with now, who not only are requiring support and very sophisticated treatments and therapies, but essentially are requiring really intensive help with, you know, the skills of daily living. It ain't rocket science.

[155] I've managed a ward and you've got policies that say if there's a fire, you need this many nurses to evacuate it, if you've got drugs procedures, that needs this many nurses, if you've got this many ward rounds running, or if you've got half the patients on the ward that require assistance with feeding—and I don't know how we'd feel in terms of having to have our food rushed in 10 minutes. To me, it isn't rocket science. I think that, on the minimum staffing issue, this is about safe staffing issues. It isn't rocket science. We've got a good understanding of what's going on on the wards. It's analysed enough now in terms of the problems at the front door of the hospital and so forth, isn't it, you know? So, we know what's going on on the wards, and common sense would—. You know, the people on the CHCs are lay people, so they can see it, you know. If you've got this population of patients that need assistance with toileting, feeding, having a drink, getting some exercise, plus the therapy, plus the nurses participating in the multidisciplinary ward rounds and so forth, I didn't have too much trouble when I was working on a ward to have an understanding of what I needed, to be going home on a Friday night thinking that those staff are safe. It didn't need a sophisticated tool.

[156] I think that there has to be some commitment to get the basics right, but the legislation has to be flexible enough to understand that expert opinion is really very important, and things change. Ultimately, we should be delivering care to patients as individuals—and individual need might be quite intensive, mightn't it, you know? But I think it's pretty shocking really if we say that we can't come to some estimate of what's needed to take care of 20 patients who are vulnerable and need to be looked after properly.

[157] **Lynne Neagle:** Okay, thank you. Can I just ask, linked to Elin's question, obviously the legislation doesn't apply to children's wards? Have you got a view on that, as a body of CHCs? Is it an area where you've noticed any particular problems?

[158] **Mr Smith:** I can't say, in terms of the evidence that we've garnered for this, that that's been highlighted specifically as a problem, other than this general issue that, you know, we would be worried about what's going on in other areas. The other thing that's featured—I mean, I've not given you any evidence on it—when I've talked to chief officers, members and chairs of boards, is that they have flagged this issue, which is a broader issue for the CHCs, in terms of the services that LHBs commission in other sectors, as it were, in terms of the nursing home sector and so forth. They can be a forgotten population, can't they?

[159] The other thing that's relevant—I don't know if it's part of your question, but it's relevant to a question that was asked earlier on—is there's a real concern that some of the consequences of this are more easily—perhaps 'hidden' is the wrong word, but they become more invisible in the community environment. All the high-profile stuff in terms of the press and in terms of the stuff that comes to our attention is inevitably in the buildings of the NHS, isn't it, you know. I guess there's a risk, given that the population that we largely serve in Wales are an elderly population, that there's a lot of unrecognised or unsighted stuff that can, potentially, go on in a community environment that doesn't generally get the same attention that the failures in the in-patient service have.

[160] **Lynne Neagle:** Okay, thank you. We have had evidence that one of the unintended consequences of the Bill could be that it would have an adverse effect on the multidisciplinary approach taken in a ward, so that maybe other professionals would be disadvantaged by having this safe staffing ratio. Have you got any comments on that?

[161] **Mr Smith:** I think a personal comment that I would give is that it's really sad that the pressure in the system has led to those concerns from people who should be pulling together. But the reality is, if there's an opportunity to fix part of this, as far as I'm concerned, it should be done, and I think that that gets the ball rolling, then, doesn't it? If you're saying, 'This is a good enough thing to do for good reasons' and if, on the basis of the evaluation that's indicated in this, it proves that things improve in terms of safety and quality, I think that's a very compelling argument to look at other elements of the multidisciplinary team. But I think it's an awful situation where you've got people in other professions thinking, 'Crikey, we don't want this to happen because...'. It's the opportunity cost then, isn't it? You'll have to cut physios or occupational therapists to pay for this. That's the reality of how this plays through, isn't it?

[162] **Lynne Neagle:** Okay, thank you. You did mention bank nurses and temporary staff. Some witnesses have said they think this Bill could lead to an increase in the use of temporary and agency staff. Is that a concern that you share?

[163] **Mr Smith:** I mean, the way that it's looked upon in terms of the conversations we've had, that's part of the fix, in a sense, because you know how much is being spent on it, and there's a suspicion. I think reference is made in the paper that it isn't solely about the workforce planning; it's the workforce management as well. Some of the feedback that we get from clinical staff indicates that that spend on agency and so forth is, sometimes, to do with the way that the HR processes are run. There's a bit of a paranoia about it, in the sense that there can be a sluggishness in terms of replacing posts that exist for financial reasons, but then, when you hit safety and quality issues, you're spending on the agency. That is a view that I've heard personally and other people have reported to me.

[164] **Lynne Neagle:** Okay, thank you. The Bill would require information to be published

for patients on the staffing ratios, and also the role of the staff on duty in any particular shift. Do you think that's realistic and are there any challenges, you think, in communicating that information to patients that you want to flag up with us?

[165] **Mr Smith:** It's a thing that you want to get right, because I've said before that people are very tolerant if they're communicated with. It's pretty important in terms of the anxiety that's around, because much of the anxiety in terms of the public is generated because of the press around this, isn't it? The transparency and the communication of this are very important. We need to know, as I've said, in terms of strengthening our scrutiny functions, undoubtedly, but if you want to reassure the public, put something in real time in the clinical areas that they're in that says, 'This is what we believe should be necessary in this ward, and this is where we're at at the moment', and have people available to reassure people that if you're not quite hitting the target, it's okay, you've got a fix for that. This is the reason. If you link that with the broader reporting scenario and the accountability of the board, that needs to be linked into the reporting, as well. That's about the accountability, isn't it? So, you've got the day-to-day stuff, which is very important, I think, to the public—or to any of us. You know, it seems busy here. Is it okay, given what I'm reading in the paper?

10:30

[166] If you can quite clearly read, 'We're green in terms of the staffing today', that's good. But also, we need that reporting from the accountability framework to the public, sort of saying, 'Over the past year, this is what we aimed to do in terms of staffing, and this is what we did; if it doesn't hit the green light, this is why it didn't hit the green light; this is what we did about it, and this is what we're doing to prevent this being a problem going forward'. If you want to reassure the public, you need to convey a culture that you are letting them know about things, and we're putting things right, not having to front the press and to front the public when things go wrong.

[167] **Darren Millar:** Is it okay to ask a question? It's about potential unintended consequences. If you've got this live information on the screen at any one time, and it dips into red—there's an untoward incident or someone passes away—isn't it likely to lead to the unintended consequence of more complaints, more litigation, and more problems, perhaps, for CHCs and the national health service in general?

[168] **Mr Smith:** I have a view that complaints to the NHS are not a problem. Certainly, it wouldn't be a problem—

[169] **Darren Millar:** Litigation is, though, isn't it, if things get to litigation?

[170] **Mr Smith:** There can be. In terms of—. I'm trying to get a sense of the complaints that we support in terms of the litigation issue, and I've got a feel for that in terms of—

[171] **Darren Millar:** Essentially, I'm asking: is this going to drive an increase in litigation against the NHS?

[172] **Mr Smith:** Well, in terms of representing the view of the public, I don't care, really. I mean, if you've got a situation where the staffing is not right and people's dignity is being compromised because of that, their safety is being compromised because of that, that's not a worry, in terms of representing the public, is it? We want services that are safe and of decent quality that we can all, as citizens of Wales, have confidence in. So, it may be a consequence, but maybe.

[173] **Darren Millar:** Okay.

[174] **Lynne Neagle:** The Minister has said that it's unrealistic to have this reporting on a shift by shift basis, because staff vary when they start. Do you share the Minister's concerns on that?

[175] **Mr Smith:** I mean, there are challenges, aren't there, but we don't seem to—? It's a methodology that's been used in terms of easing the frustrations at A&E departments, isn't it? You know, 'This is how long you're waiting; this is why'. It's not without its challenges, and I think we could look to work with LHBs to support that, because there is an important job that we all have in terms of dampening down the scaremongering and the anxiety. But, what are the challenges? I'm not familiar with what the challenges are that have been raised, you know. It's pretty straightforward in terms of managing an off-duty—if a dozen, 14 nurses are running a shift in terms of, you know—. As I say, the public are generally very tolerant; if they understand they have to wait a bit longer because we've got somebody that's gone on the sick, or whatever, you know—. I can't see that that is a problem that we shouldn't make efforts to sort, personally, and I think that fairly represents the views that I've heard in terms of the CHCs that have input into this.

[176] **Lynne Neagle:** Okay, lovely. Thank you very much for coming this morning, and thank you for giving us evidence. You'll have a copy of the transcript of the meeting sent to you so that you can check for accuracy. Thank you very much for your time this morning.

[177] **Mr Smith:** Thank you for your time and the invitation; it's much appreciated. Thank you.

[178] **Lynne Neagle:** So, the committee will now break for 10 minutes, to be back here at quarter to. Thank you.

*Gohiriwyd y cyfarfod rhwng 10:33 a 10:46.  
The meeting adjourned between 10:33 and 10:46.*

### **Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 8 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 8**

[179] **Lynne Neagle:** Welcome back, everybody, and can I welcome Kate Chamberlain and Alun Jones to the committee this morning to give evidence? Thank you very much for the paper that you've provided to the committee in advance. Are you happy to go straight into questions?

[180] **Dr Chamberlain:** Yes, we're happy to. Thank you.

[181] **Lynne Neagle:** Gwyn.

[182] **Gwyn R. Price:** Good morning to you both. Could you give your view on whether legislation is the only way to ensure safe nursing standards?

[183] **Dr Chamberlain:** Okay. I think I'd like to open by saying that Healthcare Inspectorate Wales fully supports the objectives of the Bill and, of course, we're aware of the guidance that has been issued by the chief nursing officer, that's being used within the health boards, within wards, in order to assess the staffing that's required—we do look at that in our inspections. But, in spite of the work that is going on, we do continue to find issues relating to staffing levels in the inspections that we undertake.

[184] We explicitly consider staffing alongside issues relating to management and leadership in both our mental health inspections and our dignity and essential care



inspections. During the last year, we've published about 30 reports on those so far, and we found staffing issues probably in about half of them, I would say—that we flagged up as part of those reports. Those sorts of issues relate to shortfalls in numbers; they could relate to difficulties in recruitment and retention; they could also relate to issues around proportions of bank and nursing staff. So, I can see that legislation, actually, in this context, could be quite useful, in terms of helping to focus attention and really provide an impetus behind the implementation of that guidance, behind making sure that there are consistent good levels of safe staffing across all of the areas of healthcare that we're talking about here.

[185] I can also see that legislation could be quite supportive to some of the senior nurses, who are, on a day to day basis, helping to balance the capacity that they've got with the patients that they've got. But I think the thing that I would stress in this context is that it's important to recognise that safe staffing isn't just about numbers. There are a lot of other things that impact upon the ability to deliver safe staffing. So, legislation for this particular aspect, you know, may be useful in some circumstances, but it will not, on its own, provide for safe staffing care. So there are issues to be considered about having the right skills, having the right training, having the right experience and being able to apply the right professional judgment over and above any baseline that may be set in legislation. I think that's probably a long way of saying that it could potentially provide a useful tool in the toolkit, but in and of itself, it would not be, I don't think, sufficient.

[186] **Gwyn R. Price:** Is that your opinion, Mr Jones? Is that your opinion?

[187] **Mr Jones:** I would agree. I would agree with Kate, yes.

[188] **Gwyn R. Price:** Thank you, Chair.

[189] **Lynne Neagle:** Okay, thanks, Gwyn. Any other Members want to come in? Elin.

[190] **Elin Jones:** Yes. The Bill, as it's drafted currently, refers only to statutory staffing ratios in adult in-patient wards in acute hospitals. Now, we have received evidence about, and discussed in this committee, a possible unintended consequence: that a health board would look to meet this statutory requirement in that setting, but at the expense, possibly, of nursing in other contexts that it's responsible for, such as in the community or in community hospitals. I was wondering whether you have a view on whether that could be an unintended consequence. But possibly, more particularly for you: do you think that there should be other health scenarios where the statutory duty could apply, for example, adult in-patient in community hospitals?

[191] **Dr Chamberlain:** I think I'd be wrong to say it couldn't be a possible consequence; that might be one of the coping strategies that would be employed. I don't think it's the only possible unintended consequence. There's also the possibility, for example, that overall capacity might be reduced, in order to make sure that the capacity that remains is appropriately staffed. It could be that, in the short term, if there aren't sufficient numbers in the system, it could result in an increase in bank and agency nursing. So, I think there are a number of areas—a number of potential impacts of this—in terms of unintended consequences. I think 'concern' is too strong a word. I do share the view that this, at the moment, is quite limited in its scope, and I welcome the fact that there is the ability in the legislation to extend into other settings as the evidence becomes available for what should be there. I've already alluded to the fact that we do find issues with regard to other specialties and other types of ward, in particular mental health. I just wonder if it might be worth sharing with the committee some of the examples of things we have found over the past set of inspections, just to give you a feel for the type of things that manifest themselves on a day to day basis. Alun, do you want to explain some of those?

[192] **Mr Jones:** Of course. I mean, we have different examples from different settings, not all of which might come under the legislation, so I think that's interesting in some ways, because you might see the opportunity for an expansion at a later date. We've certainly found examples where ward sisters have been drawn into direct care for patients. We found, for example, a ward sister who's responsible for eight patients on a ward, in order for those patients to be cared for properly. The consequences of that are that that ward sister then can't co-ordinate the staff; she or he can't help with the development of the staff, with the quality of care planning or discharge arrangements. That's something we found in three or four cases, where we could say, you know, the consequences of shortages are the ward sister gets drawn into providing care, and that's good in the short term, perhaps, but over a longer period, there are consequences for training and quality of care, and just generally stretched staff. So, that's an acute care example.

[193] In some of our mental health inspections—we've completed a couple recently—and with one in particular, there were 20 patients on a ward, and two qualified nurses to look after 20 patients. During a particular time when we were there doing our inspection, we found that one of the qualified nurses was doing a ward round to dole out the medicines to the patients, and the other one was on one-to-one observation. Sorry, there were three qualified nurses, actually. One of the others was dealing with a relative, and one was dealing with a patient who needed direct observation. So, essentially, you had 17 patients on the ward who weren't being observed by anyone, because they had other roles to complete. One of the challenges that you have in a mental health setting is the need for flexibility—incidents occur, and some patients need care or they need observation, and that's at quite short notice—and the challenge for the health boards is to bring staff in at quite short notice, you know, within hours. So, in mental health we certainly see—we could give you a couple of examples—those kind of things happening, where staff are drawn to the patients who need that care at that time and, therefore, for others, there are no contingency arrangements, if you like. So, whilst there's a benefit there of having some kind of legislation or guidance, it is a moveable feast. So, they're a couple of our examples.

[194] **Elin Jones:** Okay, thank you. Can I just focus in on one of the unintended consequences you mentioned there? It's not one that we've really focused on to date in this committee's scrutiny, and that's the issue around reducing the capacity on ward, in order to meet the statutory minimum. What that would mean, in practice, is that the ward wouldn't accept any more patients onto it, so there could be a reduction in the service then, as a result of meeting the statutory duty.

[195] **Dr Chamberlain:** I would say that it's definitely possible that it might impact upon flow. In order to maintain safe staffing in one particular area, you may have to constrain what you're able to do on an elective or, you know, optional, basis in other areas. I wouldn't say it's never happened in the past at hospitals, in terms of managing the resources that they've got available, whether that's people resources or other resources. They've had to close ward beds and open ward beds to respond to peaks and troughs. You'd probably have to ask the health boards to what extent that's likely to happen, but I think it's certainly a possibility.

[196] **Mr Jones:** I think that there's a question of balance at a number of levels all the time with this kind of thing, so the health board itself has to make those kinds of decisions about whether reducing capacity is in the best interest of the patients, which thereby reduces access. But, I think, in terms of some of the messages that we have to deliver as an inspectorate, when we write our reports, we have to be mindful that the solution isn't necessarily to close something. In other administrations, in England, for example, the Care Quality Commission has the power to deregister services, but it's something that it doesn't do lightly, because there are consequences for patients. They've got to go somewhere, so there's that balancing act between capacity and quality, I guess.

[197] **Elin Jones:** But, if a health board was particularly stringent on wanting to meet on every shift the statutory minimum ratio, then there would be almost no flexibility for those people taking decisions on accepting onto wards whether they'd do that or not, and patient flow would be severely compromised by that.

[198] **Dr Chamberlain:** But, the counter to that is: at what point is patient care compromised? Yes, you wouldn't want to go below a minimum, but it's quite clear, both within the conversation about this and within the legislation, that the minimum is the minimum and, over and above that, you need to be looking specifically at patient need. You also, over and above that, need to be applying judgment, depending on what the layout of the ward might be, and a variety of other factors and the activities that have to take place. So, there will always have to be an element of professional judgment in this. I think it would be a mistake, at any level, to turn this into a pure numbers game. The type of rigidity that you referred to really could only apply at a very minimum level. Otherwise, you're removing that opportunity for judgment.

[199] **Elin Jones:** No, but it could apply at the minimum level, couldn't it? You know, if a health board is particularly stringent on the minimum staffing ratio, then it takes away the ability of nurses or managers to provide some kind of professional judgment on whether one extra patient could be taken on to that ward, given the nature of that patient's acuity at that time.

[200] **Dr Chamberlain:** And that's a judgment the health board would have to take in its implementation.

[201] **Lynne Neagle:** Lindsay.

[202] **Lindsay Whittle:** Good morning. Listening to your evidence that you think that this Bill will give us difficulties in recruiting sufficient nurses—a bit of a barrier there—how would you advise the mover of this Bill to amend the Bill to remove that barrier? I would be interested in your views on, perhaps, creating more training places for nursing and perhaps improve qualifications for existing nursing staff. Do you think it would encourage former nursing staff to return to their profession, if they thought that life might be a little—I wouldn't say 'easier', but a lot less pressure, then?

[203] **Dr Chamberlain:** I'm not sure that the Bill itself would create a barrier to recruiting, but I think, in implementing and responding to the Bill, health boards might encounter difficulties in recruiting and bringing the staff in that they need. They may do. Probably, from where I sit—I'm not as familiar with the marketplace for nurses as some of the other people that you have giving evidence at this committee—I would have thought, and this is purely a personal view, that given that nursing staff primarily go into their job because they are keen to care and provide a high standard of care for the patients that they are looking after, that the more time they have to do that and the more satisfied they are with their ability to do that, the more attractive, then, it becomes as a working place in order to attract nurses, who may have left, back into working in that sort of environment. But, to be honest, that's pure speculation on my part.

[204] **Mr Jones:** I think the only thing I'd say is that I think the Bill provides an opportunity for there to be a statement about what is acceptable. That has to be helpful in the first instance, but there are a number of things that have to follow that, and workforce planning is one of them. So, it's looking beyond the Bill. Having made that statement, it's about thinking through how that can then work. So, there will be initial consequences, I'm sure, in terms of cost and, perhaps, supply of nurses, but they are things that perhaps there will be a momentum to solve because of the Bill. Perhaps that will help.

11:00

[205] **Lindsay Whittle:** Thanks for that. With the permission of the Chair, it's a moving beast, isn't it? The health of the nation is changing all the time, and more advanced technology in health means that we're learning all the time, which is very good, but we heard from previous witnesses that, with three-year budgets, that doesn't help a nurse who's perhaps planning a 30 or 40-year career. So, how could we address that?

[206] **Dr Chamberlain:** Can you just explain the point a little bit more?

[207] **Lindsay Whittle:** The point I'm saying is that, if budgets are critical to this, which is what it seems, then how can we encourage the health boards to plan their budgets, have a proper workforce plan in the future to ensure that each nurse who comes in—. There may be some nurses who are content with just doing that particular job, but others may want to go on to learn greater skills, so should the budget follow the individual?

[208] **Dr Chamberlain:** I think if we're going to build flexibility into a system that enables staff almost to move with the need, then there needs to be the budget in the system to support ongoing training of staff once they're in post. I think, in almost any business or any industry, it's not necessarily desirable for somebody to be doing the same thing all the time, in exactly the same way, almost forever. But, in order for staff to feel able to develop with the care that's being provided, to be able to respond to the changing needs of the patients that are coming in, they need to be properly developed themselves; they need to have the right sort of training, and they need to be encouraged to think of their career in the health service as something that will help them to develop and move on between different settings and different types of care. Again, that's one welcome provision within the Bill as it's drafted: the idea of protected time to make sure that staff do have time to undertake the training that's necessary, both for the care they're providing now and for the care that they will need to provide.

[209] **Lindsay Whittle:** So, that's the positive message from this Bill.

[210] **Dr Chamberlain:** That's a welcome inclusion.

[211] **Lindsay Whittle:** Thank you.

[212] **Lynne Neagle:** John.

[213] **John Griffiths:** In terms of unintended consequences, we've just discussed other health settings that might be impacted on in terms of the requirement to meet minimum ratios, and what that might mean elsewhere. In terms of the wards themselves, and the support that's available from health staff other than nurses, whether it's physiotherapists or those doing the tasks that are essential to the team effort below the nursing level, as it were, do you have any concerns that this legislation might adversely impact on those other roles, and that could in fact make the job of the nurses more difficult, in as much as they may end up doing tasks that are currently performed by those others?

[214] **Dr Chamberlain:** I'll ask Alun to come in in a moment, because I'm not sure that we've seen, even in being stretched now, that there's necessarily evidence that nurses are being used to cover for other professionals in terms of the input. But, obviously there are areas in which there's not necessarily the input that might be required. I'm thinking more, probably, about mental health settings at the moment, in terms of some of the input of occupational therapies, activities, those sorts of things, where we're already seeing that there isn't as much of that as might be desirable in those sorts of settings. I don't have a great deal of my own evidence to draw on in terms of what's happening in ward settings at the moment.

Alun?

[215] **Mr Jones:** Occupational therapists was the one that occurred to me, just from a few recent pieces of work we've done, both in mental health and rehabilitation-type wards. I'm saying this sort of anecdotally rather than in a scientific way, but it's clear in our last few inspections that we've seen a shortage of occupational therapists. I don't think that's a role that nurses can substitute for, if there are more nurses—if that's your question. So, I think there's a broad range of issues across the health sector, not just with nurses. I'm not sure whether that really answers your question.

[216] **John Griffiths:** I think one of the issues is that there are those who provide essential support on the wards for the nurses—not just the allied health professionals, but the support staff, the auxiliaries—and if budgets were affected in terms of meeting better nurse staffing ratios and they had to find savings elsewhere, I think there's a worry that those other staff who do all these essential tasks might find that their numbers are reduced, and the nurses might then have to perform those tasks and that would make life more difficult for them, obviously, and would mean that they didn't have enough time perhaps to devote to the nursing tasks that are so essential. But, those aren't concerns that you've registered in terms of this proposed legislation?

[217] **Mr Jones:** I don't think so. I mean, within nursing, there's the example I gave earlier on, which is about the ward sisters and the role that they play. We've seen examples during our inspections where ward sisters are shared across two wards, on different floors of a hospital, and that makes it difficult for them to spread their time, their expertise and the leadership, if you like, across those two wards. So, whether there would be consequences for whether health boards would think in those terms, and whether they'd do something with the lead nurses—I'm not sure whether that might be a consequence.

[218] **Dr Chamberlain:** If I may sort of come back on the context of this, really, it almost takes us back to where we started, which is that this is only one aspect of the toolkit for making sure that there is safe and effective care on a ward, and it shouldn't be seen in isolation from the need to look at the package of input that is going into the care of a patient, and that will remain the responsibility of the health board. It will be something where, with an effective ward sister, they will be looking at the input that is going into their ward, the care that is being received by their patients—not just by nurses; they will have a view on what is coming in from elsewhere and what the balance of activity is. They will also have the opportunity to escalate that if they think that their qualified staff are being drawn into activities that do not effectively use the qualifications that they have.

[219] So, provided there are the protections in place to enable concerns where that happens—. Because, as Alun said, a ward sister doing a registered nurse caseload-type role is almost what you're referring to, one level up. So, it's entirely possible; it may happen. It's important there are the processes in place within health boards for that to be made known and for that to be escalated, so that the health board's in a position then to respond to the pressures that are causing that. I mean, I don't think anybody thinks that the introduction of the legislation would mean that everything would be perfect all of the time, and it quite clearly recognises that, actually, this is about taking reasonable steps to address problems where they are occurring. Part of that is being able to identify them, and that's why the escalation is so important.

[220] **Lynne Neagle:** In terms of your written evidence, you raised some concerns about the scope of the Bill, and you said that it might be more appropriate to talk about settings in which NHS care is provided, which would cover things like nursing homes—care that was commissioned elsewhere. Could you expand on that evidence?

[221] **Dr Chamberlain:** I've talked already about the fact that I think, you know, I can understand why it's limited to the settings that it is at the moment in terms of adult in-patient care, but welcome the flexibility that, as evidence emerges and as opportunities emerge, it could be broadened to other settings within NHS or NHS settings. Because I'm sort of quite keen that we think about equivalence of standards, equivalence of expectations across boundaries—so across sectoral boundaries and across provider boundaries—I wouldn't want to think that the legislation in some way limited the opportunity to progress that when the time was right and the evidence was right. And that's why I think the wording here is quite important.

[222] **Lynne Neagle:** Okay, thank you. We have have also had evidence that it's unrealistic for information on the numbers of staff and the skill mix to be published for patients on a shift-by-shift basis. Have you got any comments on that view?

[223] **Dr Chamberlain:** Again, I'll give a personal view and then I'll invite Alun to give his as well. If I'm thinking about it from the perspective of the patient, which I try to, I'm not sure to what extent, as a patient, I would really understand what I was being told if I was given the skill mix, because that's not what's uppermost in my mind. I'm not there as a patient to manage the ward or to make sure it's being managed properly; what I care about is the care that I get. But I think there is something about communicating clearly to patients who is present on a ward and what roles they play on the ward—so, to clearly communicate to them how the ward is staffed, who it's staffed by, what their names are and something about what their roles are. And, again, that is something that would be useful on a shift-by-shift basis. Again, in an inspection that I was out on myself, there was feedback coming from some of the patients about significant differences in approach—or not significant, but differences in approach between, say, weekend staff and day staff. So, to be able to understand clearly who's there, what they're there for, who you can approach, who you can raise matters with, you know, to me, I think, would be more reassuring to me as a patient than simply knowing what the ratios are and that sort of information. It's about why you'd want to receive it. I don't know if you want to add to that, Alun.

[224] **Mr Jones:** I think the thing I'd add is that it's right to expect hospitals and health boards to account to the public on what they're doing on a number of levels. So, the principle of them publishing information on staffing levels and ratios, I think, is a positive one. I think it helps to generate a culture where they are being open and honest about those numbers and there can be a discussion about it. So, I think that, in itself, is helpful, but if it does become a burden on the staff to produce that information—if there's not an easy way of doing that—then I can understand why there might be some reservations about doing it, but I'm not sure I understand the sort of technical challenges of that. It seems like a reasonable request. The hospitals should be collecting that information anyway. It is information that exists, so I think I'd be in favour of that, unless it's a burden and takes staff away from front-line care duties.

[225] **Lynne Neagle:** Okay. Thank you. The legislation proposes a list of issues that would be used to measure outcomes for patients, such as numbers of falls and hospital-acquired infections. Have you got any comments on the appropriateness of the list that's been suggested and whether you think that will be actually effective in measuring outcomes?

[226] **Dr Chamberlain:** I think it's a useful list of indicators of things that should be tracked. They're certainly things that we also look at ourselves, in part, in terms of the intelligence that we use to help focus our inspections. They are important metrics of the quality of care that's being provided. Whether you could necessarily track a causal effect between the Bill and the outcome of those indicators—. In a way, it sort of harks back to my previous role where, once you start looking at numbers, numbers are purely a signpost to where you need to go to ask questions. They don't give you any answers. Alun?

[227] **Mr Jones:** I think it's a helpful list. I agree with what Kate has said in terms of causality, but I guess the indicator that jumps out to us in terms of our recent experience of inspections is the figures around training. So, I think it's really important to keep an eye on training, because I think it's easier to make that link between being stretched for staff and not being able to release staff for training. So, I think that's a really important indicator. I think that is on your list, and I would endorse that as one of the principal measures.

[228] **Lynne Neagle:** Okay. In terms of the evidence we've had that we can achieve the outcomes of this Bill without the need for legislation, have you got any comments on how well health boards are currently complying with the guidance that's been issued on staffing levels?

[229] **Mr Jones:** I think it's clear that health boards would want to comply with the staffing levels. There's no doubt in my mind that they try very hard to do that.

[230] **Lynne Neagle:** But are they complying and to what extent?

[231] **Mr Jones:** In terms of whether they are complying, well, on a number of our inspections, we have raised staffing issues, as we've said. In some cases they're not complying with the minimum chief nursing officer ratios of nurses to patients or nurses to healthcare support workers. So, we've seen examples where those standards aren't met. We've also raised concerns where those ratios have been met, but we don't feel that the ward is safe because of the environment, because of the acuity of the patients and the patient needs.

[232] So, I can see examples both sides of compliant and not-compliant, where the end result is actually the same. It's that the ward isn't being operated safely. So, I think it is helpful for us to go to look to see the exact layout, the situation in the ward and to look at the local situation. You know, I feel you'd need to go and have a look—either that or the health boards themselves need to really scrutinise their wards and make sure that they're thinking about that on a daily basis, on a shift-by-shift basis, and that it's safe regardless of what the guidance is. I think that's a local decision.

11:15

[233] **Lynne Neagle:** Peter Black.

[234] **Peter Black:** Are you able to speculate on the reasons why they're not meeting those guidelines?

[235] **Mr Jones:** It think it's difficult to answer that on behalf of the whole of Wales, but, certainly, we have seen examples where there are vacancies, so the wards are stretched, because they have too many vacancies. That can present itself in not enough staff on the ward for a shift, or it can mean that bank and agency staff are drawn in and that doesn't always lead to the same level of quality of care. We've seen examples where there were three qualified nurses on a ward on a shift, two of them were bank or agency, and they may not have been inducted, they may not have worked on that ward before, so they don't understand where things are, what the environment is, or, perhaps, the nature of the patients and their needs, so, I'm not sure if that answers your question, really, but it's clear to me that there are staffing shortfalls in some instances, because of vacancies.

[236] **Peter Black:** So, if those guidelines were statutory, is it likely that that would be overcome?

[237] **Mr Jones:** I think that could depend on how deep the pockets are of the health boards and how big their bank is and their access to agency staff in the first instance. They might

need to draw upon those in order to meet those levels. We've talked already about workforce planning as a whole in the longer term, and there would need to be a lot of scrutiny on workforce planning in order to meet those levels in the longer term.

[238] **Peter Black:** So, in a sense, once those become statutory, it would take time to reach those levels and they might have to draw on agency and bank nurses in the meantime to get there. That's what you're saying.

[239] **Mr Jones:** I think that's certainly possible in some of the cases we've seen where we've inspected and we've found that nursing levels have been propped up with bank and agency on some shifts.

[240] **Peter Black:** Some of the evidence we've had is that, if there are statutory levels, nurses will come back into the profession on a permanent basis, rather than going through the agency or bank, and that might help address some of those vacancies. I'm not sure you have the expertise to comment on that, but—

[241] **Dr Chamberlain:** I'm not sure we do, but, I mean, I think there is, even then, likely to be a bit of a time lag, because they will want to see and hear from their previous and former colleagues that this is actually playing through into improved conditions on the ground.

[242] Also, from talking to the clinical director within HIW, there are other issues that impact upon an organisation's ability to fill all its vacancies. You know, service reconfigurations—there's a lot of that going on at the moment—may create uncertainty, which can introduce more delays into recruitment processes. So, there's something about—it sort of plays into what Alun was saying about workforce planning; there's something about being clear about how you get from state A to state B and you don't compromise standards on the way.

[243] There's also something about sort of surges and pressures and demand and the natural inclination of the system, particularly during winter pressures, for example, to deal with the patients that present and to want to be able to deal with those. Hence, sometimes, it may be difficult, in short notice, to call in the volume of staff that you need to be able to meet the demands that you've got in front of you. Again, that's why I think it's important to be monitoring, quite clearly, when standards aren't met, so that pressure points and hotspots can be identified and patterns can be identified.

[244] **Lynne Neagle:** Just one final question from me, then: if legislation isn't the answer, what would you recommend as a way of improving the staffing levels? You said in your written evidence that you think the acuity tool could be encouraged further. Could you expand on that and say if there's anything else you think could be done?

[245] **Dr Chamberlain:** I think I'd almost reframe the question, which is, regardless of whether legislation is the answer or not, there are other things that need to be done. So, clearly, the guidance is there in terms of the principles, the minimum ratios and the development of the acuity tools in order to improve the establishment setting and improve the effectiveness of workforce planning to make sure that the staff that are recruited, that are required, are trained and are meeting the projected demands. I think all of that needs to be supported all the way through the line, and effective monitoring to make sure—coming back to my response to Peter Black—that the hotspots are identified and are responded to systematically. I think, if all of that works through and is properly monitored and performance managed—if transparency is there in the system—and all of that is pushed and worked through effectively, there may not need to be legislation. But that doesn't mean that legislation would not, potentially, give it a momentum and a drive.



[246] **Lynne Neagle:** Okay. Thank you very much.

[247] **John Griffiths:** Can I just ask, Chair, just in general, in terms of HIW's role, would this Bill help HIW fulfil its role and, if so, to what extent?

[248] **Dr Chamberlain:** When we go out and we do our inspections, we draw on whatever standards and best practice are in place to use as the benchmark, but, ultimately, when we go out and inspect the care that's being provided on the ward, we're not ticking whether they are complying with a particular ratio, we are looking to see what care is being provided and what factors are impacting upon their ability to deliver care. So, in a way, it helps, because it gives a basic underpinning to the standards that we are applying. It certainly isn't a hindrance, but it's not a necessity, if you like.

[249] **Lynne Neagle:** Okay, thank you. Well, can I thank both of you for coming in this morning and for your oral and written evidence? I'm sure Members will have found it very useful. As you'll know, you'll get a copy of the transcript of the proceedings to check for accuracy in due course. So, thank you very much for your time.

11:22

### **Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 9 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 9**

[250] **Lynne Neagle:** Can I welcome Dawn Bowden and Tanya Bull from Unison this morning to the committee? Can I thank you for your written evidence, which Members have received? Would you like to make some opening remarks, or do you want to go straight into questions?

[251] **Ms Bowden:** I think the opening remarks that I probably want to table at this point are: Unison's position has been very clear for some considerable time, that we support and we are in favour of legislating for minimum staffing levels around nursing staff in particular, but, if the Welsh Government can come forward with a system of ensuring those safety standards across nursing and other grades of staff, which I will come on to in response to some questions later on, if you want me to, then I think we're quite happy to have further discussions about that. So, we're not totally wedded to the concept of legislation if other methodology can actually deliver what the legislation's intention is to deliver. So, I think that would be the only opening remark I'd make at this stage.

[252] **Lynne Neagle:** Okay, lovely. Thank you. I'll open it up now to questions from Members. I'll take Gwyn first. You don't have to declare an interest as a Unison member, I am advised, but you can if you want to.

[253] **Gwyn R Price:** No, it's all right—I'll stop my dues. *[Laughter.]* Good morning to you both, anyway.

[254] **Ms Bowden:** Morning.

[255] **Gwyn R. Price:** You've just answered, really, a part of the question—whether legislation is the only way to ensure safe nurse staffing levels on adult in-patient wards, because you may not know, or you do, that, in England and Northern Ireland, they have achieved this without legislation.

[256] **Ms Bowden:** Indeed, and I think that comes back to the point I was just making. So, just to kind of build on that, I guess, we have seen the chief nursing officer's recommendations that came out in 2012 on qualified and non-qualified nurse ratios, and, to a

greater or lesser extent, these are being complied with. In those areas where they're not being complied with, and we have information from those health boards where this 60:40 ratio is not being met, I think the issue for us would be what do we do to ensure that those health boards do comply if there isn't legislation, because, at the moment, there certainly seem to be issues with Betsi Cadwaladr, with Cardiff and the Vale, and with Hywel Dda, where they're not actually meeting that 60:40 recommendation. So, that was just something that came out then in terms of the ratio between qualified and non-qualified nursing staff, and it's not being universally met. There may be a whole host of reasons why that is not being universally met, but clearly from our perspective there doesn't appear to be any way of ensuring that those guidelines, those recommendations, are enforced. So, that, I can see, is the benefit of legislation: that once you legislate for something, then there isn't really a way around it.

[257] However, if you do legislate, then you can potentially move into areas of, as I think is referred to in the paper—and certainly the Minister for Health and Social Services has referred to—potential unintended consequences. And my concern around that would be if, in this Bill, we only have proposals for statutory minimum nurse staffing levels in a particular area—adult acute wards—my concern would be that if we legislate for that, but don't legislate for everything else, then we could see staff being pulled off of other areas to ensure that the legal statutory minimum is employed in those areas where the law applies, and it doesn't in other areas, and so other areas start to suffer. So, I think that's one of the potential unintended consequences of not legislating—of legislating, sorry. So, if that answers your question—.

[258] **Gwyn R. Price:** So, if the Welsh Government put proposals forward that you thought could achieve it without legislation, you'd be willing to talk on that.

[259] **Ms Bowden:** I think we would certainly be happy to have those discussions, yes.

[260] **Gwyn R. Price:** Thank you, Chair.

[261] **Lynne Neagle:** Thank you. Darren Millar.

[262] **Darren Millar:** I just wanted to explore that in a little bit more detail. So, what mechanisms are being used elsewhere that we aren't using in Wales in order to improve that?

[263] **Ms Bowden:** There are acuity tools and planning tools that are being used elsewhere that are available in Wales. I think the planning tools and the acuity tools that are being used here are more akin to the Scottish model, as I understand it. But there are basic tools that are being used there that we could learn from and that we could use as well. I don't know the specific detail because I'm only au fait with the Welsh practice, but I know that, clearly, as there isn't legislation in England and they are meeting these minimum requirements in areas where we're not, then they could only be doing that through the use of projected acuity tools and projected planning tools.

[264] **Darren Millar:** And in terms of discussions with colleagues elsewhere, what sort of sanctions are being used elsewhere where the guidance isn't being met? Are you aware of any?

[265] **Ms Bowden:** In Wales?

[266] **Darren Millar:** Well, over the border in England—

[267] **Ms Bowden:** I can't really comment on England; I mean, I don't—

[268] **Darren Millar:** Okay. What sort of sanctions do you feel would be appropriate to use

in Wales? Perhaps that would help us.

[269] **Ms Bowden:** That's a good question. The obvious sanction in every—. Whenever there's a piece of legislation introduced, if there's a sanction it usually tends to be a financial sanction. I'm not sure that a financial sanction is going to be particularly helpful in the difficult financial circumstances that we're in at the moment, and are likely to be in for the foreseeable future. So, I do think that's an area that needs some serious consideration. We may have to look at Welsh Government taking a more direct hand in those health boards where they are not, for whatever reason, doing what needs to be done. Ultimately, you know, the Welsh Government, the health Minister, can't micromanage health boards, but I do think that the Welsh Government has a direct responsibility to ensure that the law it introduces—if it does so—is complied with, so maybe there would need to be more direct intervention from Welsh Government.

[270] **Darren Millar:** And what about trying to secure some sanctions to enforce its existing guidance? Do you think there ought to be—

[271] **Ms Bowden:** Yes. In that sense, there should be no difference. Where we have current guidance that's been issued for very good reason and it's not being complied with without good reason, then I see no reason for not having direct intervention from Government.

[272] **Darren Millar:** But you don't feel that financial sanctions are perhaps the right way to go.

[273] **Ms Bowden:** No, personally, I don't, because I've seen at first hand what the impact of difficult financial circumstances on health boards is, and on our members. So, you know, it's this kind of thing, isn't it: punitive financial measures seem to be targeted at some groups and not at others, and I'm not sure that punitive financial measures in this set of circumstances, where we're trying to provide healthcare, would be the best way forward.

[274] **Darren Millar:** Okay, thank you.

[275] **Lynne Neagle:** Peter Black.

11:30

[276] **Peter Black:** Thank you, Chair. I think, just to be clear, that the evidence we heard earlier on was that although England had better staffing ratios, they're not meeting the safe guidelines that we would like to see here. Of course, the experience is variable across England. I think also, it's worth pointing out, the Bill doesn't actually suggest there should be financial penalties, but there are other ways of intervening in health boards to try to put these right.

[277] **Ms Bowden:** Absolutely.

[278] **Peter Black:** In terms of the way this would be implemented, you've expressed a concern that it might pull staff off other wards to do this, because we're concentrating on the acute wards. Can you elaborate on that—where those staff might come from, and would they have the necessary skills to go onto the acute wards?

[279] **Ms Bowden:** If we are talking about—. There is a whole range of specialisms across any particular health board. We have nurses who are general nurses, who are trained in a wide range of specialisms and non-specialisms, so there is the opportunity to move people about. It happens now—it does happen now—and it's actually one of the things that we have objected

to, where nurses are moved from one area to plug gaps in other areas, because although they are generally qualified nurses, they're quite often trained in a specialism and it's not always totally appropriate to move them out of one area into another. So, that really is what my concern is: that that could happen on a more frequent basis than it does now, if all we are trying to do is to meet legal minimum standards, as opposed to having a safe system across the piece.

[280] **Peter Black:** Isn't the likelihood that, as experienced elsewhere where these minimum standards have come in, that should lead to greater recruitment of nurses, and nurses coming back into the profession, because they have a more stable employment situation in which they can work?

[281] **Ms Bowden:** I think that is one of the potential benefits, absolutely. If we are going to move towards minimum ratios, then we clearly are going to have to have more nurses than we currently have. I know that already this year, actually, there are going to be an extra 230 nurse training places in Wales, so we're kind of moving in that direction. But nevertheless one of the things that we see on a regular basis, we see the workforce information that's provided by NHS Wales employers, and we see the amount of money that's spent in the NHS on agency staff. I mean, agency costs were something in the region of 2% of the entire NHS budget in the last year. That's one of the things that we've been talking to the NHS employers and to Welsh Government about, in terms of how we can reduce that.

[282] Now, in the move towards minimum numbers, I think in the short term, we might see that increase, because you can't train extra nurses overnight—that takes a period of time. We clearly have gaps at the moment where we're not able to recruit in some specialist areas. So, it isn't a piece of legislation, I would suggest, that we can bring in on day one and implement on day two. There's going to be a process that would need to take place whereby we have enough people in the system to be able to fill those positions.

[283] **Peter Black:** Do you think the legislation, therefore, takes the right approach in leaving a lot of this to guidance from Welsh Government Ministers who have to take account of moveable situations like that?

[284] **Ms Bowden:** Yeah, in general terms we're supportive of the general thrust of this legislation. I think that the main concern that we have got in terms of this legislation, and I know we're not alone in saying this, is that it is really only dealing with one very small area of NHS service delivery. We think that there is a very strong case for minimum standards across every clinical area, particularly in community nursing. You know, we're moving—the direction of the NHS at the moment is trying to move people out of hospitals into the community. All of the evidence shows that when people are treated in the community, in their own homes, the recovery time is shorter, it frees up beds for other acute admissions, and so on and so forth. So, the obvious move is towards getting people out into the community, and yet, we are not, in this Bill, looking at what is a priority area for Government: getting people treated closer to home. We're not giving the community the same kind of measure, if you like, in terms of minimum staffing as we are in acute wards. So, that's the downside of this Bill, if you like. The general thrust, I think, is absolutely in the right direction. It just doesn't go far enough.

[285] **Peter Black:** It's a bit more difficult to actually ascertain numbers in terms of community than in a ward.

[286] **Ms Bowden:** Absolutely. And I think we've said that in our evidence. Gathering that kind of information and that kind of evidence is very easy on a ward. It's not so easy in the community, but because it's not easy it doesn't mean we shouldn't do it.

[287] **Peter Black:** But maybe if we get this right, we could then move on to do that later. Okay.

[288] **Lynne Neagle:** Thank you. John Griffiths.

[289] **John Griffiths:** Yes, thanks, Chair. In terms of the unintended consequences and some of the concerns that you've mentioned already, Dawn, support staff are very important in terms of the team that delivers these health services. I know some are concerned that, in getting better nurse ratios, there might be, because of budgetary pressures and other factors, a tendency perhaps to reduce the support staff, which might, in fact, result in nurses doing tasks that they currently do not generally perform, so it could be detrimental for the support staff, the nurses and the overall delivery of services. Is that a danger that you recognise?

[290] **Ms Bowden:** It's a danger and a concern, absolutely, Chair. I think, again, it's one of the areas that we touched on in our evidence. We are aware of circumstances where, both in the nursing and in the support staff areas, jobs have been either downgraded or have been taken off the establishment altogether to bolster the recruitment of qualified nurses. Now, all that that does, it seems to us, is that if you cut the number of support staff to enable you to fund additional qualified nursing staff, you end up taking nursing staff off of those nursing duties, because those support duties still need to be done. So, every time you cut a ward clerk post or a medical secretary post or a medical records post, or whatever, you will find that it will end up with nursing—either registered or non-registered nursing staff—having to pick that work up, because it still has to be done. So, the support mechanism for qualified staff, the service could not operate without them. That is a clear and present danger. It happens now, and there is the potential for that to increase if we're going down this road, potentially.

[291] **John Griffiths:** Okay.

[292] **Lynne Neagle:** Thanks, John. Elin.

[293] **Elin Jones:** Yes. I wanted to ask you about—. Sorry, I've got a cough so I'm sucking a sweet here, as well; I'm sorry about that, I forgot about it. The Bill is, on the whole, quite silent about what actions would be taken against a health board for failing to comply with the statutory duty. It talks about an annual report and then the health board needing to provide a detailed plan to prevent recurrence. It's not particularly strong on that. Do you have any views as to whether the legislation should be stronger or clearer on how health boards should be made to comply?

[294] **Ms Bowden:** Yeah. Two things. One is the reporting period of two years. I think we commented on that in our evidence. I think we certainly feel, initially, in the initial stages after the introduction of legislation, we think that leaving it for two years is probably too long. I know it talks about, in the first year, a report being more frequent than that, but I think we would be looking at more frequent monitoring and reporting than something every two years. So, that would be the first thing.

[295] And, then, to come back to Darren Millar's point about what we would then do to enforce, I think that's a discussion that needs to be had. The legislation doesn't cover that. I don't think anybody's given any real thought to that yet. There do need to be incentives and sanctions. So, you have to take a carrot-and-stick approach, I guess. But, I come back to what I said in answer to Darren Millar's question: that I wouldn't see financial sanctions as being the answer. We've got to find some way, but I don't know what they might be. That's an area for further discussion, but, certainly, unless you apply some kind of sanction, whatever that might be, then it kind of makes legislation slightly meaningless if you don't do anything, doesn't it?

[296] **Lynne Neagle:** Thank you. Can I ask, Dawn, whether you think there's sufficient evidence that outcomes for patients would be improved by having a statutory safe staffing level?

[297] **Ms Bowden:** Well, there's certainly plenty of evidence out there that shows that if you have a lower nurse-to-patient ratio, you get better outcomes. I think, again, we refer to it in our evidence. The evidence that is out there, you know—we're talking about the various reports that have been done in the past—shows that, once you get to a nurse-to-staff ratio above 1:6 or 1:8, then you actually start to see harm being done to the patient in the delivery of care. Once you get between 1:4 and 1:6, then you start to see better outcomes, and the better outcomes, clearly, are getting people out of hospital. You know, one of the biggest problems that we've got at the moment is the pressure on the emergency services, and quite often, the pressure on the emergency services is that there are no beds available when people come in, and that's partly to do with that we can't get them out. Now, is that to do with inadequate staffing levels? It may well be. Certainly, the evidence appears to support the fact that if you reduce the patient to qualified nurse staffing ratio, then outcomes improve, and, as I say, that seems to be well documented.

[298] **Lynne Neagle:** In terms of the list that appears in the Bill of indicators that can be used to measure outcomes, such as infections, are you satisfied that that's the right approach?

[299] **Ms Bowden:** Absolutely. I think all of those areas would, you know—. If those are not the consequential outcomes of minimum staffing levels, then we clearly would need to revisit what is going wrong, but as I say, the evidence that is available to us at the moment does appear to indicate that all of those areas seem to improve when you have lower staff-patient ratios.

[300] **Lynne Neagle:** In your written evidence, you have expressed concern that there might be some problems because of increased bureaucracy leading to staff being taken away from caring roles. Could you expand on that?

[301] **Ms Bowden:** Really, what we're talking about, coming back to the point that John Griffiths raised, I guess, is that in some of the areas, if we are looking at reducing other groups of staff, support staff and so on that do a lot of the clerical work, the support work that goes behind qualified nursing, then we end up getting qualified nursing staff bogged down with bureaucracy. I think we were also talking about it in the context of reporting mechanisms and reporting outcomes. Now, clearly, that has to be done. We have to be able to measure whether the care that's being provided is meeting the desired outcomes, and there, inevitably, is going to be some bureaucracy around that. I think all we were saying is that that has to be minimised and streamlined in such a way that we don't find qualified nursing staff sat down for hours on end, filling in endless forms and dealing with endless bureaucracy, to be able to show that this legislation is working.

[302] **Lynne Neagle:** Okay, thank you very much. Are there any further questions from Members? No? Okay, well can I thank you both for coming, for your written and your oral evidence and for your time with us this morning? Thank you very much.

[303] **Ms Bowden:** Thank you.

[304] **Lynne Neagle:** Oh, and just to say that you will have a transcript of the proceedings to check for accuracy in due course. Thank you.

11:43

**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**

[305] **Lynne Neagle:** Okay, well, we are running slightly ahead of time, so I propose that, if Members are content, we take item 12 on the agenda as the next item of business. So, can I propose, in accordance with Standing Order 17.42(vi), that the committee resolves to meet in private for item 12 and returns to public session at 13:30?

*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.*

[306] **Lynne Neagle:** Are all Members content? Okay, lovely, thank you.

*Derbyniwyd y cynnig.  
Motion agreed.*

*Gohiriwyd y cyfarfod rhwng 11:44 ac 13:31.  
The meeting adjourned between 11:44 and 13:31.*

**Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 10**  
**Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 10**

[307] **Lynne Neagle:** Can I welcome everybody back to today's Health and Social Care Committee meeting? I welcome our witnesses this afternoon: Paul Roberts, from Abertawe Bro Morgannwg University Local Health Board, and Anne Phillimore, from Aneurin Bevan Local Health Board. Both witnesses here today are representing health board executives. As you know, we have taken some evidence previously from nurse directors. Can I thank the witnesses for the paper that they provided in advance? If you're happy, we'll go straight into questions from Members—or did you want to say something?

[308] **Mr Roberts:** Would it be possible, Chair, just to make some brief remarks?

[309] **Lynne Neagle:** Yes, by all means.

[310] **Mr Roberts:** I suppose it's, really, just to summarise the key points that were in the evidence we gave. I suppose the thing I wanted to get across very strongly is that the NHS in Wales—all its constituent organisations—supports very strongly safe staffing levels within hospitals and healthcare as a whole. We believe in that. That is one of our objectives, and the fact that's the objective of the Bill is something we welcome.

[311] Also, there's no debate on the evidence. You know, the evidence is pretty broadly known—it is international as well as local—that nurse staffing levels have an impact on improving quality, as do skill mixes on wards as well. We've seen the evidence that has been set out by a number of the people, as witnesses. I guess the thing we're interested in having the discussion about is the most effective ways of achieving those objectives, and I suppose we have some concerns about whether legislation is the most effective way to address them.

Why just nursing? Healthcare is a multidisciplinary process. Why just acute services?

[312] **Lynne Neagle:** Okay, we'll go into all those issues now.

[313] **Mr Roberts:** Okay, but I thought it was just important to lay some of that out just before we got started, Chair.

[314] **Lynne Neagle:** Lovely, thank you. I should've welcomed Ann Jones and Mike Hedges to the meeting, as well, because they're substituting this afternoon. So, thank you for those remarks, and we'll open it up now to questions, and I've got Gwyn Price first.

[315] **Gwyn R. Price:** Thank you, Chair. Good afternoon, both. What are the main barriers that LHBs face in complying with the existing all-Wales nurse staffing principles guidance?

[316] **Mr Roberts:** I'm happy to kick off and then hand over to Anne, if you like. The biggest barrier by far is recruitment. All health boards, over the last couple of years since the 2012 chief nursing officer guidelines came into place, have got programmes of compliance, but the major issue for us is being able to recruit into those posts. You know, we can go into more detail into some of those statistics, but I know my director of nursing, who gave evidence previously, talked about the vacancies within our health board. We are constantly trying to recruit. Therefore, there are issues about the commissioned training numbers, which Anne, my colleague, can say more about. We're pleased to see that it's increasing, but there is a shortage of registered nurses within Wales and across the UK, and, frankly, also in a lot of other developed countries internationally, too. So, that's the biggest barrier.

[317] **Lynne Neagle:** Okay, thank you.

[318] **Ms Phillimore:** To pick up on that: absolutely. Also, the commission of nurses has a minimum time frame, really, of four years, from when they put the commissions in to when a nurse comes out the other end, and it could be longer. Four years ago, we commissioned, essentially, to maintain and increase services, but subsequently, obviously, Francis has happened in England, so the English position has changed quite dramatically, and the nursing shortages in England are, arguably, considerably—or at least as challenging, if not greater than in Wales. One of the variables that's changed in Wales though is that we've had a very steady and very low number of people who are leaving the NHS. That has actually risen over the last year to 18 months, and I believe most health boards are trying to actively find out why that is and do something about stopping it. So, we're in a bit of a perfect storm: we are employing all of those people whom we commissioned four years ago. I think, without exception, we're employing all the people going through university. We are looking abroad and we're bringing people in, but we're in an extremely competitive market on this at the moment. I've just come from a workshop, and people from the Nuffield Trust, King's Fund and from Harvard were there, and what they're actually saying is they're not aware of anywhere globally that is not likely to be facing a shortage of qualified nurses over the foreseeable future. So, the market is our big challenge.

[319] **Gwyn R. Price:** Do you think increasing the staff ratio would bring back people, perhaps, who have left their profession because of the pressure they felt they were in?

[320] **Ms Phillimore:** We would certainly hope that. I mean, we believe that having safe staffing levels is very important for patients, but equally as important for staff. We believe it gives good team working—multidisciplinary team working—and we believe and the evidence shows that good team working equally impacts on good patient care. The evidence is there: Michael West's work about good team working is there. So, yes, if we can provide a good working environment for nurses, then we believe that goes into a positive spiral and not a negative spiral, but it's getting ourselves into that position.



[321] **Mr Roberts:** I would also want to emphasise, as I have before, that that isn't about nurse staffing levels alone; the key to those better outcomes and, therefore, the workplace being better for nurses, is good multidisciplinary team working, where all the staff groups have adequate staffing, and that they're set up and managed in the right way in in-patient environments. But, no doubt, if they are, that would help particularly with return to practise, and I think you've had evidence on return to practise before.

[322] **Lynne Neagle:** Thank you. Darren Millar.

[323] **Darren Millar:** I just wanted to follow up on Gwyn's question first, if I can, about these challenges. You say that these same challenges, Anne Phillimore, are happening in England as well as they are in Wales. Why is it then that they're so much better in terms of their staffing ratios in England than Wales? Doesn't that demonstrate that the staffing and recruitment challenges are more acute here?

[324] **Mr Roberts:** I would suggest it's a slightly more complicated picture than that. The piece of work that was done by the Nuffield the other week for the BBC set out, once again, one of the issues about bed numbers in Wales per head of population compared with that in England. We have a great deal more in-patient beds per head of population in Wales, so, in a sense, you're looking at a very different deployment of nurses in Wales than you're seeing in England. I think it's a very variable picture in England, too. If you go to London, you'll see nurse turnover rates of approaching 20% and, you know, sometimes greater. If you go into some of the provincial parts of England, it's more as it is in Wales, which is relatively low. I know—in fact, I was at a meeting in London just last week, talking to chief executive colleagues there, and many of them are recruiting in very large numbers from abroad in order to try and meet the ratios that are expected of them.

[325] **Darren Millar:** But the point I'm making is, when you look and compare the nation as a whole, and, indeed, Scotland as a whole, with Wales as a whole on nurse staffing ratios in our hospitals, they appear to be doing a better job of implementing the guidance of their Governments than you do, as health board executives implementing the guidance in your hospitals—and in spite of facing precisely the same recruitment challenges.

[326] **Mr Roberts:** I'm not convinced about that, though. I think that if you look at acute environments, I think nurse staffing in Wales compares pretty well. I think the problem, with some of the statistics, is you're looking across all sorts of different places of care where nurses nurse. In a sense, that's at the heart of the problem, isn't it? Very blanket and rigid guidance on nurse staffing levels don't necessarily translate from one setting of care to a different setting of care—

[327] **Darren Millar:** No, I appreciate that, because—

[328] **Lynne Neagle:** [*Inaudible.*]—finish.

[329] **Darren Millar:** I'm sorry, Chair, I'm just trying to get to the nub of this. The guidance in England is about acute hospital settings; the guidance from the chief nursing officer here is about acute hospital settings. So, there is no difference in terms of the guidance. So, why is it that you're failing to meet the guidance? You say its recruitment. But why are they able, for whatever reason, to recruit? You're suggesting that, because we've got a higher number of in-patient beds, the recruitment problems are perhaps more difficult for us in Wales as a result. But what's the evidence that you've got less of a community base, as it were, to push into—

[330] **Lynne Neagle:** Before you answer that, can I just say that we have asked for

information from the Department of Health in England to actually see in a concrete way the extent to which they are meeting the guidance, because the evidence we've had is contrary?

[331] **Darren Millar:** Okay. Well, I'll talk about Scotland then. Why is it that Scotland seems to be doing so much better? There seems to be an aversion to talking about England.

[332] **Mr Roberts:** I don't have an aversion to talking about any of them, but I'm not an expert on what they're doing in England or doing in Scotland. I know from conversations with colleagues, because we have meetings with colleagues across the boundary, that nurse staffing and nurse recruitment are a major, major challenge for colleagues. In fact, the meeting I was at happened to be with colleagues in England, not Scotland, but they were telling me what a great challenge nurse recruitment is for them at the moment, and, as I say, part of their answer to that was very large-scale recruitment abroad, around the world.

[333] **Ms Phillimore:** Certainly, my sharing with colleagues in some areas of Scotland, not all areas of Scotland—likewise I'm not an expert on Scotland—. Aberdeenshire in particular, Grampian, have exactly the same issues around nurse staffing and are grappling with the same problems. And, indeed, I believe some of their executives have been held to account for that. So, I don't think it's a homogenous picture. I think that in areas like Edinburgh I am sure that they recruit quite well because they attract a lot of people there, and that's probably the same within Wales. There are some areas where we would find it easier to recruit than others because we not only have our own populations but we have inflow populations. So, it is variable, but I'm not an expert on that.

[334] **Mr Roberts:** I would also suggest that the NICE guidelines, which apply to England, as we know, on nurse staffing are really relatively new. I mean, they were only published in the summer of last year, and I think it's really too early to say what impact they've had on nurse staffing in England. I think you can find crude measures, but if one reads those guidelines there are lots of the complexities that you need to look at to see whether the guidelines about safe staffing are being implemented well in England too. I suspect it's early days there and, you know, there's a lot of progress they need to make too, and I think we're in the same boat. I don't think we're very far apart on that.

[335] **Darren Millar:** I mean, I don't think anybody is arguing that everything is perfect either in England, Scotland or any other part of the country. I'm just trying to get to understand why we seem to be so much further behind with these ratios in Wales than elsewhere. Can I ask you another question? This is about how the Welsh Government interacts with health boards to hold them to account for the delivery against the chief nursing officer's guidance. What discussions take place? How regularly do you have to report back, for example?

[336] **Mr Roberts:** Again, I'll do it from my perspective. My colleague, as a workforce director, may have other experiences from this. You've already heard evidence from a couple of the directors of nursing, and I've read it but I can't quite remember what they said. But one of the things is that we've been asked to do a twice-yearly review of nurse staffing levels by Welsh Government, which we report up to the chief nursing officer. That first started last summer, so that's a new process that's in place, and that's something that directors of nursing are individually responsible for. As organisations, we're held to account both for the inputs—so, staffing levels—when we have our twice-yearly meetings with Welsh Government to hold us very formally to account as executive teams, what we call the JET meetings, and frequently nurse staffing levels, turnover, recruitment, a lot of the indicators, are discussed at those meetings, but I think, more importantly, a lot of the sorts of outcome data for patients, some of which are in section 3 of the Bill, are discussed in those meetings too. So, if we're wanting to improve on infection rates or pressure ulcers or some of the other areas, we understand the impact that nurse staffing has on that, and that will often come up in our

questioning.

[337] **Darren Millar:** And are there ever any discussions about Welsh Government intervention if these things don't improve? I mean, what sort of sanctions does the Welsh Government suggest might be imposed if you don't fulfil the guidance?

13:45

[338] **Mr Roberts:** As you know, we have a performance framework that gives escalation levels within it, and those would apply to any area of performance, including nurse staffing levels. Welsh Government have to make a judgment about, you know, how much failure to implement over a reasonable period of time is down to the management and leadership of the board and how much it is to do with the market. As we were talking about earlier, they have to make a judgment about that, as they do about a whole range of other things. But I think that framework gives a clear way of holding us to account for a whole range of things, but nurse staffing and safe nurse staffing would be one of them.

[339] **Lynne Neagle:** Anne, did you have anything to add?

[340] **Ms Phillimore:** Just to say that we submit the return. Clearly, the chief nursing officer doesn't just look at it and say, 'That's interesting.' We have to account for any areas where we are not meeting the levels and give a full understanding of what we're doing, how we are doing it, et cetera. At health board level, we have quite a substantial infrastructure to track our own vacancies, to look at how we are achieving against those nurse staffing levels. We also triangulate that information with other types of information, such as patient incidents, patient complaints, staff morale, just to try and understand the impact, if you like, of what's happening in any particular ward over a period of time in terms of staffing levels.

[341] **Lynne Neagle:** So, when you say you have to account for it, is that accounting in a written report or does—?

[342] **Ms Phillimore:** Yes.

[343] **Lynne Neagle:** So, are there ever instances where the CNO would come back to you and say, 'Well, hold on a sec, ward D1 West, or whatever, is a problem—what's going on with this?'

[344] **Ms Phillimore:** She would come back via my nurse director colleague, but I feel quite confident she would come back and raise any issues that she had.

[345] **Lynne Neagle:** Okay. Peter.

[346] **Peter Black:** I think you agreed with Gwyn Price that having safe staffing levels would enable nurses to come back into the profession and encourage them to do so, but you also set out quite graphically some of the issues you've got in recruiting nurses. So, despite the fact there are clear guidelines laid down by the Welsh Government saying you should have nursing levels at this particular level, you're not achieving that, and, despite the fact that those nurses can see that that is the objective, they are still not coming back in numbers. Do you think that, maybe, doing the same thing is always going to get the same results, and maybe we need something different to actually sort of jar those nurses who may come into the profession into actually taking action?

[347] **Ms Phillimore:** I personally would agree that doing the same thing—. You know, if you do the same thing you've always done, you'll always get the same results. So, we are looking at a range of different ways in which we can actively encourage people back into the

workplace. Also, we need to be mindful of other ways of attracting people into the profession. We do have an all-graduate profession, obviously, in Wales, which does mean that everybody is a graduate, but that's not necessarily been the case in England. So, we have a very fixed pool, if that makes sense.

[348] So, we're looking at a range of things. I'm not convinced, and I've had no evidence from anybody who we've spoken to, or any feedback from staff, that legislation would be the thing that would make the difference. We made an investment—part of which was funded by Welsh Government, but we made an additional investment—in terms of nursing levels in our health board and I'm sure others have, and that actually gave a very positive message to nurses.

[349] **Peter Black:** There is evidence out there that says that, where you have legislation, like they have in California and Australia, it does make a difference, and you do get people coming back into the profession.

[350] **Ms Phillimore:** It may do. I'm just saying that I personally haven't had that feedback.

[351] **Mr Roberts:** I guess our plea about that is that Members obviously just carefully consider that. I suppose one of my answers to your question is that one of the things, I think, that can encourage people back into an environment that is easier and more fulfilling to work in is other members of the team. For instance, our director of nursing is very keen, where we can't recruit nurses, for us to make sure that we're recruiting administrative staff to support the ward manager or the ward sister and to recruit ward hostesses to help with meals and things like that—none of whom are registered nurses. Arguably they're healthcare support workers if you widen the definition of healthcare support worker, I suppose.

[352] I suppose my concern about having a big legislative sledgehammer around this is that it tempts you only to go for the registered or the healthcare support worker route. I think encouraging people back in means that you need to have well-managed and much more controlled environments, and I think that's often around other members of the team, as well as registered nurses. So, if you can't get registered nurses, it's sometimes better to use the money you would've used to appoint registered nurses or healthcare support workers to recruit things like administrative or hostess type support.

[353] **Peter Black:** I understand that that'll take pressure off the registered nurses and enable them to do more, but the nurses I've spoken to in Bridgend hospital and elsewhere still say that they're rushed off their feet, they're struggling to find time to even take breaks, and, often, they're reliant on agency nurses to get the mix right in wards.

[354] **Mr Roberts:** I don't doubt that. They're telling us that too and they're correct. In the places—and we have done this in Bridgend and I know you've visited—where we have given good admin support and good things like hostess and domestic support, that has taken some of the pressure off them. I'm not trying to say it's the whole answer, I just think it's part of it.

[355] **Ms Phillimore:** I was going to say that the other key variable, or one of the other key variables, is actually the quality of the leadership and management on those wards. So, we totally agree with the supernumerary basis of the ward managers, but, interestingly, you can look at a range of different wards that are staffed at similar levels and have very different outcomes in terms of how the staff on those wards are. So, there are a number of variables in it and that's another very important one.

[356] **Peter Black:** I wouldn't disagree with that. [*Inaudible.*]—putting management into the hospital has made a huge difference in terms of how that hospital is managed. Just coming

back to this issue about teams, I think the case that has been made to me, and, to an extent, to the committee, is that nurses, effectively, have 24-hour, seven-days-a-week contact with patients. And where you have safe levels that are commensurate with the needs of the patients on the ward—I'm trying to keep this in language I understand, never mind anybody else, but commensurate with the needs of patients on the ward—that enables those nurses to interact better with other disciplines to make appropriate referrals, to make sure that patients are discharged on time, and to, effectively, contribute much better to that multi-disciplinary team. If you agree with that, do you not think, therefore, that having these safe nursing levels will actually enhance your teams and, therefore, there is a case for saying that you should maybe make a start by making those nurse levels a statutory responsibility?

[357] **Mr Roberts:** If I may, I completely agree with the underlying argument. You know, those safe nursing levels, it is 24-hour care. I think, for many areas of in-patient care, the nurses have the biggest influence on the experience of patients and the quality of care. I have no argument about that and the evidence is pretty clear about that too. But, I mean, just let me give you a sort of hypothetical example of why I think there are some dangers in this. It is often the toughest operational environments where we can't recruit. If we—very quickly, because the legal framework was in place—had to go out and recruit registered nurses, because we had to, for legal reasons, hit those numbers in quite a sort of crude way, I would argue that we could damage the staffing in some of those areas, because those nurses would be applying for jobs perhaps in other parts of the health board, or even in other health boards, and, actually, some of the areas where I think those arguments apply most would be affected by that.

[358] I think this needs a scalpel, not a sledgehammer. I think we have to have very careful staffing strategies to try and deal with those sorts of issues that help us retain and recruit nurses with proper support from other members of the multi-disciplinary team in those particularly tough areas—things like medical wards; they're the toughest areas to work, as I'm sure people know.

[359] **Peter Black:** I can understand the implementation is a concern and I think the Bill actually relies on guidance to do that and ministerial discretion. So, there is scope in the Bill for the Minister to bring this in in discussion and consultation with health boards as part of that. So, you know, if that implementation was done in a careful and considered way, would that help?

[360] **Mr Roberts:** Can I try and answer that in a slightly different way? I mentioned earlier that the NICE guidelines that came in for England—and we know where they came from; essentially, they came out of the Mid Staffs, but a number of the reports that happened there, and, you know, being in the health board where we had 'Trusted to Care', you would argue that the same arguments would apply—I think that they set out a very good evidence-based approach, from organisational level down to, you know, day-to-day, hour-to-hour operational control, a really good evidence-based way of dealing with nurse staffing.

[361] I have the same criticism about them, that they're only focusing on acute nursing, but I think, you know, I would be quite happy if Welsh Government were to introduce, over the right period of time, some mandating around that.

[362] **Lynne Neagle:** Anne, have you got anything to add?

[363] **Ms Phillimore:** No. I think I would absolutely support that.

[364] **Lynne Neagle:** Okay, thank you. I've got John then Lindsay.

[365] **John Griffiths:** Yes, I was going to ask a question about the role of nursing directors,

Chair, but, before I do, I wonder if I could just ask Anne to elaborate a little on the current situation with staffing in our hospitals? I think you said, Anne, that over the last year there has been considerable difficulty in terms of retention. Are we talking about just nurses there, or is that wider than that?

[366] **Ms Phillimore:** I would say it's specifically around nurses. I wouldn't say it's 'considerable difficulty'. Our retention levels are still very good compared to England. However, the point, really, was that, when we commissioned for nurses four or five years ago, we relied on retention rates that had been pretty stable in Wales for a number of years. To have an alteration of those at around 2% has had an impact on our supply chain. So, that's really the point I was making. So, one of the things we're focusing on is not only bringing in nurses, but, actually: how do we retain and bring back our very experienced nurses who we would like, who offer good care at the moment, and we know that they offer good care at the moment? So, it's a rounded picture, but quite small changes in some of the assumptions around workforce planning can actually have an impact three or four years down the line.

[367] **John Griffiths:** So, is that situation unique to nurses or is it wider in terms of other roles within the NHS?

[368] **Ms Phillimore:** It's probably more generalised. I mean, we're seeing it, for example, in a slightly different arena in GP retention, where we are losing people. So, it's a number of areas. Doctors and nurses are the areas where it causes us greatest difficulty, because they are the ones who have the longest lead-in times to bring more into the system. So, if our healthcare support worker turnover goes up, although it's still a concern to us, we're in a much better position to respond quite quickly—to do some stuff, bring people in and get them trained up to do that. So, that flexibility about being able to treat the workforce as a whole, predicated on the idea that we believe that—that the workforce has to work properly as a whole to give the best quality outcomes for patients—is quite important to us.

[369] **John Griffiths:** Okay, in terms of the role of nursing directors, we heard that the ability of nursing directors to get their voices heard and to get action on their concerns around nursing staff levels and other issues within a health board is, perhaps, more limited than it should be and that at executive board meetings, for example, they're relatively powerless, compared to other players in that arena. Obviously, that's something that's very relevant and germane to these particular issues that we're dealing with and that the Bill would deal with. What would you say with regard to those concerns?

[370] **Mr Roberts:** I would absolutely contradict them. I just think that that's not correct. I'd heard you'd heard evidence, so I'm glad I've got the opportunity to say something different. I mean, you've actually met my director of nursing at a previous hearing. He's a confident professional voice both for the profession, but for standards of care for patients. He has a huge voice within my own executive team. He's listened to and respected, and he has the same on the board as well. I can't think of any good examples of where we've, you know, sort of drowned him out for financial considerations or other targets, and, if you were to go and have a look at the minutes of our board meetings, you would see that a vast amount of our time is spent on talking about patient care quality and experience and what contributes to making those a success, rather than on some of what you might call the business side of things. So, my experience is exactly the opposite of that. I think, providing you've got a high-quality director of nursing, and I believe we have, then their voice is a strong one.

[371] **Lynne Neagle:** Thanks. Okay, I've got Lindsay. Can I just make a plea now to Members—we've got quite a bit of ground to cover—to be brief, please, and brief answers as well?

[372] **Lindsay Whittle:** I'll be brief. Mr Roberts, you mentioned that your colleagues have

‘massive recruitment drives’, I think were the words you used, abroad. Are Welsh health authorities having massive recruitment drives abroad? And we’ve heard from the directors of nursing that there are 700 to 800 vacancies. Do you know if they are budgeted vacancies, please?

14:00

[373] **Mr Roberts:** Anne may want to pick up some of the recruitment issues. We have certainly done recruitment abroad and we’re certainly intending to do more recruitment abroad as well. Some of the scale I heard about from my English colleagues, where one hospital chief exec I was talking to had recruited about 250 nurses abroad in the space of five or six months, which, incidentally, I think brings with it quite a few problems. We haven’t recruited at that scale, but we think international recruitment is part of the answer to the question.

[374] In terms of your other issue about vacancies, I know that the director of nursing said this to you, but I will repeat it: we don’t hold vacancies in nursing for financial reasons. Our budgeted numbers of nurses in our health board—and I suspect there’d be a similar pattern in others—over the last three years has gone up by 6.4%. Our nursing numbers in post have stayed roughly stable, and that is because of the recruitment difficulties that we have. So, in answer to your colleague on your right, we have to do some different things to try and address that issue in my view.

[375] **Lindsay Whittle:** Could you tell us which countries you’ve been to?

[376] **Mr Roberts:** We’ve certainly been to Spain and, I think, to one or two other European countries as well, and we’re exploring at the moment the Philippines, which is an area that a number of the English trusts are recruiting from as well. Ireland is another of the countries that we’ve been to.

[377] **Lindsay Whittle:** What about the healthier nations, like Canada, Germany, Cuba?

[378] **Mr Roberts:** What I’m not familiar with is the recruitment issues in those particular areas. We have colleagues who are quite expert in that and will know the places where there are nurses who are interested in working in the UK, and we tend to target those. It’s not my area of expertise. Anne may be able to help with that.

[379] **Ms Phillimore:** A few years ago, there were a lot of overseas recruitment drives, both within Wales and within England, and a lot of those were focused particularly on Spain and the Philippines. Then there was a drop-off of those, and actually the Philippine workforce turned quite largely to the States. The States have substantially bigger problems with nurse recruitment than we do at the moment, so we’re up against quite a challenge. So, in terms of the Philippines, it is a possibility, but it is less of a ready market for us than it would have been several years ago.

[380] In terms of the European Union, obviously, one of the things we have to assure ourselves about—it’s a free market, but we do have to make sure that the language barriers are something we look at. Some of the nursing models in some of those areas are not like for like. Bringing in a Spanish nurse is not necessarily the same as one of our registered nurses. So, again, these aren’t necessarily simple solutions, and they have to be looked at in a wider strategy for bringing in nurses to do the things we need them to do at the standards that we want them to do it at, because clearly there’s no point just bringing in a nurse for the sake of being a nurse; if we’ve set standards in this country that we believe are the correct standards—. I’m not suggesting that they’re not up to their country’s standard, but it’s just that the job itself may be a slightly different job in some.

[381] In terms of Germany, I believe that they are probably in, not necessarily a similar position to us, but they're not a net exporter of nursing, although they are a net exporter of doctors.

[382] **Lynne Neagle:** Thank you. Okay. Mike Hedges.

[383] **Mike Hedges:** Very briefly, Mr Roberts, a lot of nurses from the Philippines are in your board; there are a lot of them working in Morrision Hospital and a lot of them living in Morrision. But aren't you in a much more competitive market for nurses than you used to be? I mean, nursing homes and a whole range of other people are now recruiting nurses; is that not a problem? Shouldn't you be asking for more to be trained in the universities? I know of people who met the minimum requirements to undertake a nursing degree but who were rejected by Swansea University this year. Although they met the minimum requirements, they didn't meet that university's requirements. Shouldn't the pressure be put on those? If you've got a shortage, the only way to get over a shortage is to train more people in this skill.

[384] The last question is: isn't another one of the problems that, in the 1980s, a number of people who qualified as nurses then didn't get jobs, and it was a bit off-putting for people later on?

[385] **Lynne Neagle:** Can you be really brief; we are getting caught up in nurse recruitment issues, and we need to focus on the legislation? So, very brief answers, please.

[386] **Mr Roberts:** You're correct that I think it is a much more difficult market. You're correct also that we need to increase the training numbers. There was an announcement that I'm sure you saw yesterday about an increase for the coming year, which we welcome. I met, as part of a group of NHS chief executives, last week with the deans of the schools of health from around the UK to discuss exactly that issue with them. They know they have to widen access into their courses. They are also lobbying us to try and help with them lobbying for greater numbers too. So, there's a lot of dialogue about that issue going on.

[387] **Lynne Neagle:** Okay, thank you. Have you got anything to add? No? Okay. Ann, on the financial implications.

[388] **Ann Jones:** If I could just turn to the financial implications of the Bill and just ask you: in your evidence, you say that the cost and complexity of this Bill may mean that there are more cost-effective and more rapid means of achieving the same outcomes. Could you tell me what you think those would be?

[389] **Mr Roberts:** Yes, I mean, there clearly are cost implications. I believe, though, that ensuring safe staffing numbers is a cost-effective thing to do, so I want to be really clear about that, because it reduces complication rates. We spend too much on agency at the moment, so, if we can find a sustainable position around nursing, I've got no doubt that's a more cost-effective solution. So, I want to be clear about that.

[390] I think I've touched on one or two of the areas, actually, and that's about looking more creatively at the multidisciplinary team. If you look at what we're doing at the moment in trying to make sure that we safely staff our hospitals in medical terms, we're not only looking at doctors and we're not only looking necessarily at the traditional skill mix amongst doctors, either. We've got to extend those same arrangements into nursing too, and some of those arrangements are more cost-effective, not least because, in this current market, it's possible to recruit to them.

[391] **Ann Jones:** Okay. So, in the context of your evidence around costs, what additional



data do you think will be needed to be collected by the LHBs to meet the requirements of this Bill?

[392] **Mr Roberts:** I'm always nervous when additional data are talked about, because we collect sacksful of them now. I'm not sure there are additional data, in a sense; what I do think is that if this legislation were put into force or it was done by a different means through something like the NICE guidelines becoming mandatory, as opposed to statutory, I would suggest we need to do some very, very careful planning and monitor very carefully, particularly for some of the unintended consequences of implementing these sorts of arrangements, and some of those could be financial—for instance, higher use of agency staffing rather than lower use, which is what we would all want.

[393] **Ann Jones:** Okay. Proposed in the Bill is additional nursing staff, but that would be cost neutral. Do you agree with that?

[394] **Mr Roberts:** I think it's really difficult to answer that question, because I think it goes back to the roots of my concerns. My job and the job of my director of nursing and my board as a whole is to make sure that we've got safe staffing levels right across the board. I think there may be an argument for that on the acute side, but we're in the middle of a programme of changing the focus of our services from acute arenas into primary care and community services, and I've got to make sure and the board's got to make sure they're safe there, and I think there are financial consequences of that.

[395] So, I just think it's a very complex equation. It's difficult to give a black-and-white answer to the question.

[396] **Ann Jones:** So, 'cost neutral' as outlined in the explanatory memorandum then is not as simple as it's made out to be?

[397] **Mr Roberts:** It's clearly not cost neutral compared with where boards have started, because boards have started in a position where they're not meeting these requirements, so there is a cost of implementation of the chief nursing officer's guidelines, which most of us have made a lot of progress on, but we're not, you know, there yet. And, clearly, there's a cost involved in doing that. I personally believe that's a cost that is worth incurring.

[398] **Ann Jones:** Okay. And just finally, Chair, if I may, just on the agency nurses, there was a report just—I don't know what date it is—last week, that said that spending by the spending by the Welsh NHS on agency nurses has increased by 80% in a single year, from £12.8m in 2013 to £23m in 2014. Do you see the added increases to agency nursing as being a barrier to this, or—

[399] **Mr Roberts:** I think potentially. I mean, there's a range of factors for that increase in spend. Some of it, certainly in terms of my health board, is that, perhaps not surprisingly, we've taken a huge amount of trouble to try and make sure that we, you know, operationally, day in, day out, ensure that we've got the safe levels of nursing we need, but sometimes that's achieved through getting agency staff in place, which, as we know, is not the ideal arrangement either in cost or quality terms.

[400] If we very quickly, in a statutory manner, upped the responsibilities of wards for achieving those, then it could result in more expenditure on agency, certainly in the short term. That would worry me.

[401] **Ann Jones:** Okay, thank you.

[402] **Lynne Neagle:** Peter, on this.

[403] **Peter Black:** Just to come back on the cost neutrality, I mean, the outcome is more nurses in full-time employment and you use fewer agency nurses.

[404] **Mr Roberts:** Correct.

[405] **Peter Black:** So, that presumably would get you a cost neutrality.

[406] **Mr Roberts:** I suspect it would. I mean, you know, I think one would have to cost it more carefully, but, as I say, I don't think the financial argument is the key argument about safe levels on acute wards. So, that would be my personal view.

[407] **Ms Phillimore:** It's really going back to—. And I think you've heard this probably before, but, from a pilot that we did, which we called 'the perfect ward', in Aneurin Bevan, we were trying, essentially, actually to prove that cost neutrality. We didn't, but then we didn't prove it was as—but neither was it as costly as putting x number of extra nurses in. So, partly because it is complex and some of the costs fall out in quite different areas of the system—. So, if you avoid five or six incidents, there's different types of saving there, both in terms of, you know, the experience of individuals, but also the cost of the system. That isn't necessarily easy to capture, so there may be cost neutrality. There certainly isn't a like-for-like cost increase, but it's how you track those through quite complex systems.

[408] **Peter Black:** I suppose, if you're discharging patients early, you have community care costs as well.

[409] **Ms Phillimore:** Yes. So, it's just a very complex system to track costs through.

[410] **Lynne Neagle:** In your written evidence, you raise concerns about the Bill focusing just on adult acute settings. Can I ask then what you think the Bill should say? Would you make any recommendation as to the Bill being wider than that?

[411] **Mr Roberts:** I suppose you've heard me question the need for statutory as opposed to mandatory and using regulatory powers—

[412] **Lynne Neagle:** But say we're going for legislation, what do you think it should say?

[413] **Mr Roberts:** —so I'm making that clear. Well, I suppose that health boards have a duty under all sorts of regulatory methods for making sure they've got safe staffing levels for all groups of staff. My concern about acute nursing is that I think the NHS, and, if I can be so bold, sometimes politicians, are criticised for focusing a lot on acute services and I think the message this potentially sends is this is another piece of legislation about acute services. Primary care is a major issue for us, as my colleague has already addressed. So, I certainly think that health boards should have a duty around safe staffing levels across the board, but, to put that into a Bill when we face the challenges that we do, I'm not convinced that that would be the right answer to the problem.

[414] **Ms Phillimore:** I think there's something about—. What we wouldn't want to create is a two-tier nursing system, where, you know, nurses are protected in an acute environment, but not protected in a community environment, particularly as we want to actively encourage more of our nursing to take place in a community environment. So, I think we just need to be really careful about—. I have to look after a whole system; I have a preference for a whole-system approach.

[415] **Mr Roberts:** Perhaps I could just also just give a small example: in recent months, we've had quite a lot of HIW inspections and spot checks that the Minister's put in place. The

biggest areas where they've raised concerns about staffing levels has been on mental health wards for older people and not on our acute wards, where, generally speaking, they've been reasonably satisfied with staffing levels. So, for me, I might argue the priority for investment and recruitment might be in some of our mental health areas. This might push me from, you know, being able to have that as my priority potentially and I worry about that.

[416] **Lynne Neagle:** Okay, thank you. Mike, then John.

[417] **Mike Hedges:** Two very brief questions: what concerns me about this, and I don't know whether it concerns you, is the danger of moving nurses out of community into hospitals. The other thing that concerns me is far too often the term is 'for health, see hospitals' and primary care and community care seems to be forgotten. Do you share these concerns that really we need to get more done in primary care and more community nurses rather than concentrating only at the hospital end, because, if we don't do that, we'll just have more people coming in at the hospital end?

[418] **Mr Roberts:** I completely recognise that that's not what is intended by this Bill, because the intentions and the objectives of the Bill are very good, but I think that could be an unintended consequence. I think it certainly could be a message that is received by the wider NHS that this is yet another concentration of resources, focus and attention on acute services, as against primary and community services.

[419] **John Griffiths:** Could I just ask a question about timescales? We've touched on the financial issues and, obviously, it would take some time to get staffing up to the level that would be required if this legislation went ahead. Could you give us an idea of what you think a reasonable timescale would be, because, obviously, there is a question in terms of a commencement date for the legislation?

14:15

[420] **Lynne Neagle:** Shall we go to Anne first?

[421] **Ms Phillimore:** Yes. I mean, depending on when the timetables were, it would be, essentially, the graduation date of the current commissioning round, which would be roughly, I would say, between three and four years, probably, depending on the timings of various things. So, the three to four years would enable us to make sure—. Having said that, obviously, we've just had an increase in commissioning, so that will start to get more supply in three or four years hence.

[422] **Lynne Neagle:** Paul?

[423] **Mr Roberts:** I agree with that.

[424] **Lynne Neagle:** The same. Okay, lovely, thank you. Can I just ask, Paul, about—. You've used the term 'mandatory', and we've had that in previous sessions where people have talked about mandatory guidance as opposed to statutory, which is legislation. Can you just clarify what you see as mandatory guidance because the CNO's got guidance but do you see that as mandatory or just guidance?

[425] **Mr Roberts:** I do. I mean, we account, as health boards, to Welsh Government, and, if Welsh Government tell us something is mandatory, then it is. That is what I would see as mandatory.

[426] **Lynne Neagle:** Anne?

[427] **Ms Phillimore:** Absolutely. As far as we're concerned, those are the standards that we should be meeting now.

[428] **Mr Roberts:** For instance, quite a lot of NICE guidance is mandatory for Welsh health boards, and that's not a bad thing at all. Of course, because the piece of work on nurse staffing was only done for England, it isn't in this case, but, with many other examples of NICE guidance, it is mandatory for us.

[429] **Lynne Neagle:** We've had evidence from people like the physiotherapists that they're concerned that the sort of multidisciplinary approach in wards might be jeopardised by this legislation. As people who are responsible for budgets, do you think there's a danger of health boards choosing to reprioritise resources towards nurse and nursing assistant staffing and then maybe other professions losing out?

[430] **Mr Roberts:** I don't think boards would deliberately set about doing that, but I think, when there is a statutory duty on you, and you know you're at risk of breaching a statutory duty, then you tend, inevitably, to put more emphasis on achieving that statutory duty. So, I think it could be an unintended consequence, and we certainly accept our duty is to make sure the staffing levels are right for all of the multidisciplinary team, but I think you can see that a real statutory focus on one area can have the impact of having a detrimental effect on other areas. I think that's just life, really—it's part of how systems work.

[431] **Lynne Neagle:** Anything to add, Anne?

[432] **Ms Phillimore:** No.

[433] **Lynne Neagle:** No. Okay. Darren, you wanted to come back in?

[434] **Darren Millar:** It was more around recruitment issues. I think they've been explored in some detail. Perhaps I could just ask this one question. I mean, do you think that, perhaps, on the recruitment side of things, if there were more of a Wales-wide approach to recruitment rather than individual health boards trying to recruit, that may assist in alleviating some of the challenges?

[435] **Ms Phillimore:** I think we would give anything a go, really. What I would say about nursing is that it tends, at basic nursing level, to be quite a local recruitment catchment. So, probably, we're more in danger of taking from one another. We are in the slightly advantageous position in Aneurin Bevan of being able to poach from England, so at least we're not—. But, when you go to the more senior nursing positions, then it becomes slightly more of a wider market, because obviously the salaries are higher and people are more likely to move. So, there are advantages to an all-Wales position, and I think we, certainly as a group of workforce directors, seek to do on a Wales-wide basis anything that we think will advantage Wales, really, in terms of being employable—

[436] **Darren Millar:** But, certainly, if you're trying to bring people in from overseas, that would—

[437] **Ms Phillimore:** Oh, certainly in terms of overseas we have those discussions—

[438] **Mr Roberts:** And I do think there is something about trying to maximise the Welsh NHS as a place to work, you know, reputation-wise, using some of our existing staff to promote it and doing that on a Wales-wide basis. I tend to agree with Anne—I think the bulk of our recruitment of nurses is always going to be local, but I think there is something about just upping our game in terms of the way we work together in terms of the sort of ethos and reputational nature of the NHS in Wales.

[439] **Ms Phillimore:** Certainly, if we're going abroad, there's a definite advantage to going with a Welsh sort of hat on, if you like, because we won't be known, you know, mostly. So, you know, we want to give our advantage.

[440] **Mr Roberts:** Yes. Indeed.

[441] **Lynne Neagle:** Okay. If there are no other questions, can I thank the witnesses for coming this afternoon and giving evidence, and, again, for your written paper? You will have a transcript of the meeting to check for accuracy in due course. Thank you very much for your time.

14:20

### **Papurau i'w Nodi Papers to Note**

[442] **Lynne Neagle:** We've got several papers to note to look at. Can I ask Members to note the minutes from the meeting of 29 January; correspondence from the Royal College of Nursing regarding the committee's inquiry into GP workforce in Wales, which is paper to note 1; the written evidence consultation responses received as part of the committee's consideration of the Safe Nurse Staffing Levels (Wales) Bill; correspondence from the Member in charge, Kirsty Williams, regarding the said Bill; correspondence from the Minister for Health and Social Services regarding the legislative consent memorandum on the Serious Crime Bill, which is paper to note 3, and, obviously, that was discussed, but this was the way of getting it into the papers; and, finally, correspondence from the Minister for Health and Social Services regarding health finances and reform, paper to note 4? Is everybody happy to note those? Okay.

14:21

### **Cynnig o dan Reol Sefydlog 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod Motion under Standing Order 17.42(vi) to Resolve to Exclude the Public from the Remainder of the Meeting**

*Cynnig:*

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

*Cynigiwyd y cynnig.  
Motion moved.*

*Motion:*

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

[443] **Lynne Neagle:** Can I propose under Standing Order 17.42(vi) to exclude the public from the remainder of the meeting? Is everybody content? Thank you.

*Derbyniwyd y cynnig.  
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 14:21.  
The public part of the meeting ended at 14:21.*

