Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Thursday, 12 February 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda

1 Introductions, apologies and substitutions (09.00)

2 Safe Nurse Staffing Levels (Wales) Bill: evidence session 6 (09.00 - 09.50) (Pages 1 - 29)

Professor Dame June Clark
Professor Peter Griffiths
Professor Anne Marie Rafferty

3 Safe Nurse Staffing Levels (Wales) Bill: evidence session 7 (09.50 - 10.40) (Pages 30 - 37)

Peter Meredith Smith, Board of Community Health Councils in Wales

Break (10.40 - 10.50)

4 Safe Nurse Staffing Levels (Wales) Bill: evidence session 8 (10.50 - 11.40) (Pages 38 - 42)

Kate Chamberlain, Healthcare Inspectorate Wales
Alun Jones, Healthcare Inspectorate Wales

5 Safe Nurse Staffing Levels (Wales) Bill: evidence session 9 (11.40 - 12.25) (Pages 43 - 49)

Dawn Bowden, Unison Wales
Tanya Bull, Unison Wales

Lunch (12.25 - 13.30)

6 Safe Nurse Staffing Levels (Wales) Bill: evidence session 10 (13.30 - 14.20) (Pages 50 - 62)

Representing Health board executives

Paul Roberts, Abertawe Bro Morgannwg University Health Board
Anne Phillimore, Aneurin Bevan University Health Board

7 Papers to note (14.20) (Pages 63 - 69)

Safe Nurse Staffing Levels (Wales) Bill: consultation responses

Safe Nurse Staffing Levels (Wales) Bill: correspondence from the Member in Charge, Kirsty Williams AM (Pages 70 - 81)

Legislative Consent Memorandum on the Serious Crime Bill: correspondence from the Minister for Health and Social Services (Pages 82 - 86)

Financial scrutiny: correspondence from the Minister for Health and Social Services (Pages 87 - 92)

8 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting (14.20)

9 Safe Nurse Staffing Levels (Wales) Bill: consideration of evidence received (14.20 - 14.35)

10 Inquiry into new psychoactive substances ("legal highs"): consideration of draft report (14.35 - 15.20) (Pages 93 - 177)

11 Inquiry into the Ambulance Services' performance in Wales: consideration of approach to scrutiny (15.20 - 15.30) (Pages 178 - 179)

12 Inquiry into the GP workforce in Wales: consideration of draft output (15.30 - 16.00)

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Professor Dame June Clark – SNSL(Ind) 05 / Tystiolaeth gan Yr Athro Fonesig June Clark– SNSL(Ind) 05

Consultation on Safe Nurse Staffing Levels (Wales) Bill

Response from: Professor Dame June Clark

General
Is there a need for legislation?
Yes. The defining characteristic of "advice" is that it doesn't have to be taken There is ample evidence both from other fields and in this field that "guidance" or "advice" is not enough to ensure compliance. Examples of other fields where we have seen the effect of legislation as opposed to "guidance" in changing behaviour include seat belts, crash helmets, smoking in public places, use of carrier bags, among others.

In the case of nurse staffing levels, the research which forms the evidence base for this Bill was first published fifteen years ago and has been repeated and validated by other studies many times since. Professional associations such as the Royal College of Nursing have been making recommendations based on this research for many years. Senior nurses responsible for setting staffing levels should have been, and probably were, aware of the research evidence and the professional recommendations; it is likely that it was used in their advice on staffing levels, but the reality is that their advice has been consistently ignored or over-ruled, usually for financial reasons (I have personal experience of this). Before the introduction of general management into the NHS in the late 1980s/1990s the chief nurse had much more power than now: she was an equal member of the management team with the power of veto in management decisions, she held the nursing budget (which was usually the largest budget), and directly managed the whole nursing service. It is often not realised that nowadays although Directors of Nursing carry the title of Director, they do not actually control nursing in their organisations and do not hold the budget for it.: they are accountable to a general manager/chief executive who (along with the Health Board) will weigh the advice of the nurse against the advice of the Director of Finance – the Director of Finance usually wins! The Francis Report, and other similar reports, frequently comment on this "powerlessness" of the nurse in the multi-disciplinary management team. This may be difficult for Nurse Directors to admit ! It was also commented by the BMA representatives at the evidence session on 29th January: when Peter Black asked to what extent nurses were listened to, the BMA representative responded with the remark that while they might be able to raise concerns, they were not listened to; this was expanded by Victoria Wheatley who described how nurses often called upon medical colleagues to support their case.

Even the CNO is vulnerable to this phenomenon. For example, although the "CNO Principles" issued in 2012 in respect of the nurse:patient ratios reflect the research evidence and the professional association guidance, the recommendations on skill-mix are a downgrading of the professional advice – a reduction from 65/35 to 60/40, ie the replacement of qualified nurses by (cheaper) Health Care Assistants, presumably in order to save money. (In fact this belief is erroneous: the research shows that the greater the proportion of registered

nurses in the nursing workforce the better the patient outcomes). It is perhaps significant that in the same year that the "CNO Principles" were issued, the number of commissions for pre-registration nursing education was reduced to 919, compared with 1035 in the previous year and 1,387 in 2003. A reduction in training places in 2012 will lead inevitably to a shortage of newly qualified nurses in 2015 and 2016. The committee might like to explore these decisions with the CNO and the then DG, in particular the extent to which they were driven by affordability rather than assessment of need. I am sure that these decisions were based on affordability rather than any valid estimate of need. Legislation would greatly strengthen the influence of Directors of Nursing on staffing decisions at Health Board level, and perhaps the CNO's position at national level.

The meeting of 29th January included an interaction about a ward in Salford that appeared to conform exactly with the best practice without legislation. This was used as an argument to suggest that legislation was unnecessary. The argument is specious – there are probably individual examples even in Wales where best practice is achieved: the purpose of legislation is to ensure that these standards are met by **all.**

Are the provisions in the Bill the best way of achieving the Bill's overall purpose?
I believe so. None of the alternatives so far suggested are able to achieve the Bill's purposes, because although they have all been available, experience has shown that they have not done so. The provisions in the Bill cover all three of the purposes of the Bill as set out in Clause 1.

Potential barriers to implementing the provisions of the Bill; does the bill take sufficient account of them?
The main barriers to implementation are the availability of nurses and the funding to support them. It is clear that the provisions of the Act could not be implemented overnight. There is some evidence (eg supplied by the RCN) that there are nurses in Wales who have left the NHS because they can no longer tolerate the stress who would be willing to return (this is also reported in California where following implementation of their legislation there is now no shortage of applicants to nursing posts). In Wales the nurses are obviously there, because they are working as agency nurses – what is needed is to convert their employment to normal NHS employment.

The most important and urgent action is to increase the number of education commissions for pre-registration nursing students. There is no shortage of applicants: there are ten applicants for every available place, the problem is the number of places commissioned. As mentioned above, the substantial drop in 2012 and the years since then will be reflected in an acute shortage of newly qualified nurses over the next few years

On funding, the evidence suggests that initial costs are recouped through fewer complications and reduced length of stay. Meanwhile the choice is stark: failure to increase nursing numbers above demonstrably unsafe levels will lead to avoidable deaths.

Unintended consequences
I have used the opportunity of visits to [redacted] California to talk with colleagues there about their experiences. I have also followed reports of their experiences in their media. They indicate that all of the concerns about unintended consequences that have been raised in Wales were also raised before and during the legislation in California – and none of them were realised.
There is no evidence that improving staffing in one area has resulted in depletion in other areas (eg community services). In any case, the distribution of nursing resources within the overall nursing service has always been a responsibility of the relevant nurse manager.

I have never been able to understand why when there is a gap in medical cover (eg a paediatrician goes sick) it would never be considered acceptable to fill the gap with a doctor from another specialty (eg a geriatrician), but it is considered an acceptable solution to move a nurse from one specialty to another in this way.

Provisions in the Bill

Duty on health service bodies to have regard to the importance of ensuring an adequate level of nurse staffing.

This is important because it makes clear the corporate responsibility and accountability of Health Boards to actually listen to, and hopefully act upon, the advice given by their Director of Nursing

To take all reasonable steps to maintain minimum registered nurse to patient ratios, initially in adult inpatient wards in acute hospitals

Duty applies to adult inpatient wards in acute hospitals only

I confirm the advice given in my earlier evidence that the word "minimum" should be replaced by the word "recommended" throughout the Bill. This enables some flexibility for example as knowledge develops, while retaining the advantage of the sustainability ensured by specification in legislation.

The word "initially" is important. I hope that the requirement for safe staffing will in due course be extended to other settings and other disciplines, and I am pleased to see that the Bill includes specific provision for this to happen. I hope that one of the consequences of this legislation will be that, as I personally have been recommending for many years, Wales begins to develop the IT infrastructure which will provide the data that can be used to provide the evidence required for other fields. The information available from the USA (now many states, not just California) and Australia includes recommended ratios which have been developed for other specialties, and there is already UK guidance for children's nursing, midwifery, and A&E departments on which we can build – but this is not yet evidence based. There are several reasons for the initial focus on adult inpatient wards in acute hospitals:

1. This is currently the only part of healthcare on which we have hard and overwhelming evidence;
2. The key outcome which can be demonstrated is mortality which must trump all other areas of patient experience;
3. This area is covers a large (possibly the largest?) area of services and patient experience
4. This area has been made visible by reports such as the Francis report which have caused major public concern
5. Nurses are the most numerous of health workers, provide 80% of direct patient care, on a 24.7/365 basis and have a continuity of patient contact far greater than any other group.

I was shocked to see and hear the evidence presented by the Chartered Society of Physiotherapists. While agreeing with everything they say about the importance of multidisciplinary teamwork, I reject the view that because one cannot provide everything for everybody right now, one should not provide anything for anybody until everything is available. The advice to the CSP should be to start **now** to do the research and collect the data that will provide the evidence base they need.

To take all reasonable steps to maintain minimum registered nurse to healthcare support workers ratios.

While most of the debate has focused on the ratio of nurses to patients, the ratio of nurses to healthcare support workers (skill mix) is equally important. It is assumed that replacing qualified nurses by healthcare support workers is cheaper, but although the evidence base on skill mix is not as robust as for nurse:patient ratios, a review of skill mix studies, McKenna (1995) states that there are now sufficient studies available to show that rich skill mixes of qualified nurses are related to: reduced lengths of patient stay; reduced mortality; reduced costs; reduced complications; increased patient satisfaction; increased patient recovery rates; increased quality of life; and increased patient knowledge/compliance. In recent years in Wales the ratio has been lowered below the professionally recommended ratio of 65/35, specifically by the "CNO Principles" in 2012. The assumption that qualified nurses can be replaced by healthcare support workers is based on the (incorrect) assumption that nursing is simply a collection of tasks which can easily be re-allocated. In fact the key difference is not in the task, but in the qualified nurse's knowledge based decision making and clinical judgement.I am pleased that specific provision on this issue is included in the Bill (Clause 5c)

Requirement to issue guidance
The provision of detailed guidance, based on the evidence and professional advice, is absolutely critical. I am content that the provisions of section 5 cover what is required, subject to the additional points I make below.

Methods to ensure appropriate level of nurse staffing
I am content that provision has been included in Subsection 6. As I suggested in my initial eveidence, I suggest replacing the term "dependency" by the phrase "evidence-based and validated workforce planning tools". Without wishing to undermine the efforts of the CNO to develop a Welsh acuity tool, it should be recognised that this is still not validated and it was reported by Ruth Walker in the meeting of 29th January that in the pilot studies it was found not to be very helpful; the work on developing acuity tools is many countries is vast; there are already several validated tools available and in use in other countries. The most important point is that made by Rory Farrelly the meeting of 29th January when he referred to the importance of "triangulation" ie the combination of the ratios with acuity measurement and professional judgement

Provision to ensure that the minimum ratios are not applied as an upper limit
This is appropriately provided for in section 5e. There was some debate on January 29th about the difficulty of defining "safe care". While it may be difficult to define "safe care", the research clearly defines the level at which the risk for **"unsafe** care" becomes demonstrable and quantifiable.

Process for publication to patients of information
I believe that patients have the right to know whether they are being cared for by a registered nurse or some other person, and it is patronising to assume that they will be unable to interpret the information they are given. Full information should be made available to patients in exactly the same way as the position on the incidence of pressure sores is currently made available in the "1000 lives" project.

Protection for certain activities and roles
These provisions are important

Requirement to consult

It is important that this consultation does not fall into the trap described at the beginning of this paper: in particular the advice of professional nursing must not only be listened to but actually taken.

Monitoring requirements
Requirement for annual report
Requirement to review the operation and effectiveness of the Act
Impact of existing guidance
The failure of compliance with existing guidance that has now been revealed in preparation for this Bill demonstrates the importance of adequate monitoring and review. At the same time it is important that the "paperwork burden" is minimised and is not laid on nurses.

Powers to make subordinate legislation and guidance
A balance between what is on the face of the Bill and what is left to subordinate legislation
I think it is right to minimise the face of the bill and keep it simple, and I believe this has been achieved.

Financial implications
Of course the implementation will need to be costed. The research evidence suggests that initial increases in cost are outweighed by subsequent savings eg on the use of agency nurses, costs of recruiting overseas nurses (estimated at £5000 per nurse recruited), fewer complications etc.

Other comments
I support the key points presented by the RCP:

- The Act must be properly enforced to ensure that it is effective
- Detailed guidance on implementation must be issued to NHS bodies
- Staffing data must be publicly available and easily accessible
- Staffing numbers should be displayed in every ward
- Outcomes must be published in a transparent accountable way to inform future service improvement

June Clark DBE PhD RN FRCN FAAN FLSW
January 2015

Consultation on the Safe Nurse Staffing Levels (Wales) Bill: written submission of evidence to the health and Social care Committee.

Professor Peter Griffiths, RN, BA, PhD
Chair of Health Services Research University of Southampton, England &
National Institute for Health Research Collaboration for Applied Research in Health and Care (Wessex)

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Introduction & overview

I am making this submission in a personal capacity. I draw on over 25 years of experience of working in and alongside the NHS as a clinical nurse, advisor and applied health services researcher.

I have undertaken research related to the impact of the size and configuration of the health care workforce on patient and staff outcomes. From 2006–2011 I was director of the National Nursing Research Unit in England, funded by the Department of Health's Policy Research Programme to undertake research into the nursing workforce. I lead the work on patient outcomes in the international RN4CAST study, exploring associations between the hospital nursing workforce and patient outcomes in 16 countries, in Europe and beyond. I also co-led the English arm of the study. Last year I led the team that undertook evidence reviews for the National Institute for Health and Care Excellence's Safe Staffing Committee as it developed guidance for nurse staffing on hospital wards and in emergency departments.

In addition to the evidence reviews for NICE, I have published extensively on this topic including contributions to recent papers of relevance, such as:

Aiken, L.H., Sermeus, W., Van den Heede, K., Sloane, D.M., Busse, R., McKee, M., Bruyneel, L., Rafferty, A.M., Griffiths, P., et al, 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ 344 (7851), e1717.

Aiken, L.H., Sloane, D.M., Bruyneel, L., Van den Heede, K., Griffiths, P., et. Al. 2014. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet 383 (9931), 1824-1830.

Ball, J.E., Murrells, T., Rafferty, A.M., Morrow, E., Griffiths, P., 2014. 'Care left undone' during nursing shifts: associations with workload and perceived quality of care. BMJ Qual Saf 23 (2), 116-125.

Griffiths, P., Dall'Ora, C., Simon, M., Ball, J., Lindqvist, R., Rafferty, et. al, 2014. Nurses' shift length and overtime working in 12 European countries: the association with perceived quality of care and patient safety. Med Care 52 (11), 975-981.

Griffiths, P., Jones, S., Bottle, A., 2013. Is "failure to rescue" derived from administrative data in England a nurse sensitive patient safety indicator for surgical care? Observational study. Int J Nurs Stud 50 (2), 292-300.

Below I offer some observations and analysis drawing on this expertise and related to research evidence that are relevant to the committee's questions.

Nurse staffing and patient outcomes

It seems clear from extensive evidence that lower levels of nurse staffing in hospitals are associated with poorer patient outcomes.

- There are inconsistencies in the evidence. Not all studies show an association. However, for a number of outcomes, including death, the overall pattern of evidence is clear. There are a number of evidence overviews (including our recent reports to NICE) supporting this.[1–3] I am not aware of any recent substantial reviews that come to a different conclusion.
- Relatively little of the evidence is from the UK, but what there is tends to be broadly consistent with this pattern.
- It does not follow from this evidence that the relationship between nurse staffing and patient outcomes is *causal*. That is, just because hospital death rates are higher in hospitals with fewer nurses, this does not mean that it is a lack of nurses that causes the increase in deaths. There might be other factors at play and indeed, there must be. For example, hospitals with fewer nurses also tend to have fewer doctors. There is also evidence on the importance of *medical* staffing levels for mortality rates. [4 5]
- However, taken in the round, the evidence is consistent with poor nurse staffing *causing* some of the adverse patient outcomes observed in studies.[1–3]

A considered appraisal of the evidence supports a conclusion that low nurse staffing is one cause of the variation in death rates, and other adverse outcomes between hospitals.

Local determination

It does not necessarily follow that mandatory staffing levels are an effective approach to addressing the problem. In principle, the argument that staffing levels are best determined locally is appealing. However, the evidence available suggests that local determination is not sufficient to assure safety.

- The consequence of variation in staffing levels seen between hospitals does not clearly indicate the correct level of staffing on particular wards.

- However, our review for NICE found little evidence about the use of any formal systems for local determination of staffing levels.[1] Crucially we do not know whether patient outcomes / experiences are improved when such systems are used.
- In our RN4CAST study we found that most of the English Trusts we surveyed claimed to be reviewing nurse staffing regularly and a majority used formal tools to determine staffing levels.[6]
- Despite this, we still found that variation in staffing levels was substantial, with many Trusts routinely operating at staffing levels far below that recommended by international guidance or required by legislation, including the level of 1 registered nurse to 8 patients which was identified by NICE as a threshold.[7]
- Crucially, it also appears that this variation in staffing is still associated with variations in mortality.[6 8] The Mid-Staffordshire enquiry and the more recent Keogh review also highlight staffing deficiencies.

It is hard to conclude that 'local determination' alone (with or without the use of tools) is sufficient to assure safe staffing levels.

Mandatory staffing

By contrast, there is some evidence that points to improved outcomes for patients and nurses associated with various mandatory safe nurse staffing policies.

- Evidence from studies of mandatory staffing policies in the US and Australia, while not conclusive, do suggest that hospitals that meet the mandatory ratios have better outcomes than those that do not. There is some evidence of improvement over time and little evidence of adverse consequences. [9–15]
- Benefits attributed to the policies include improved patient outcomes and improved staff outcomes, including hospital's abilities to recruit and retain staff.[16]
- I am not aware of an unbiased comprehensive high quality review of this evidence. It is of note that NICE explicitly excluded consideration of such policies from their evidence review for guidance "safe staffing for nursing in adult inpatient wards in acute hospitals".

It appears that mandatory minimum staffing policies, which allow staffing to flex above specified minimums, can be beneficial to patient care.

Identifying the minimums

Recommended minimum staffing levels can operate (broadly) in one of two forms. A ratio of patients per nurse or an average number of number of nursing hours per day that are to be available to patients on wards of a given type.

- Typically, mandatory ratios from other countries are in the range of 4-6 patients per nurse in general wards. Ratios recommended for care of older people wards are sometimes lower, although the rationale for this is far from clear.[17]
- NICE identified ratios exceeding 8 patients to 1 nurse as a threshold associated with increased risk of harm and advised additional steps to assure safety once if this threshold was exceeded.[18] The emphasis is on assuring safety if the 8:1 threshold is exceeded, implying 8:1 is safe.
- This figure (8:1) is appears to originate from that identified by the Safe Staffing Alliance (SSA). It is worth noting therefore the basis of the Alliance's campaign.
- The SSA position is that a ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety. This is the level at which care is definitely considered to be unsafe, putting patients at risk. The emphasis here is on demonstrating and determining a safe staffing level at a ratio of 8:1 or below.
- The figure of 8:1 does not directly emerge from any research evidence as a clear 'cut point'. However, for most UK studies where specific patient to nurse ratios can be identified, ratios above 8:1 are clearly in the higher risk group. However, insofar as there is evidence of a threshold, it may occur at a lower ratio than this. For example in our study on missed nursing care, rates of missed care were only significantly reduced for wards with the highest staffing levels, where nurses cared for about 6 patients or fewer (see figure 1 below).[19]

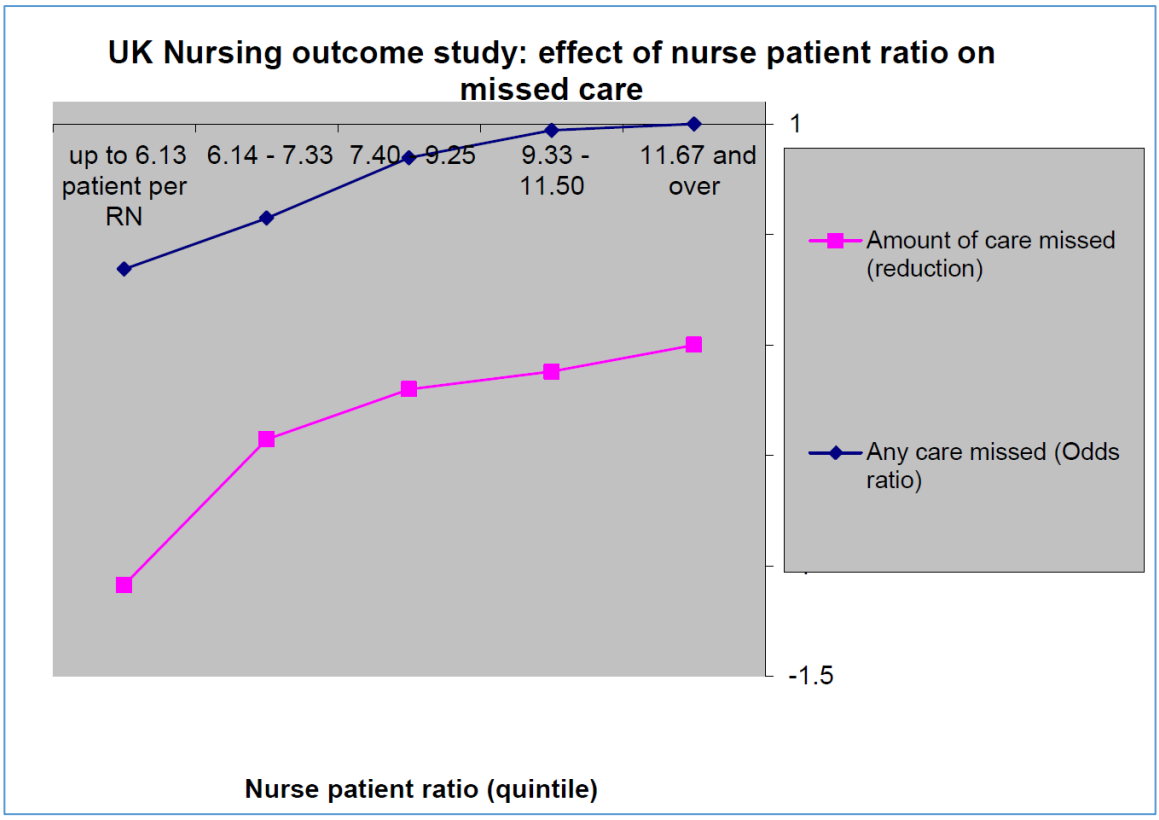

Figure 1: Data from 'Care left undone' during nursing shifts: associations with workload and perceived quality of care

- In all UK studies of nurse staffing patient outcomes, risk increases between the best-staffed hospitals compared to the next best-staffed group of hospitals. Risk is increased before staffing reaches levels that would be considered 'low' if benchmarked against the average (see addendum to the evidence review for the NICE safe staffing guidance[1]).

The correct minimum staffing level cannot be derived solely from the scientific evidence base. Professional and indeed social judgement must be exercised. The international evidence points towards levels of staffing that are much higher than currently found in many hospitals the UK.

It is at least conceivable that while a policy that specifies a minimum level of (say) 6 patients to 1 nurse may have a positive effect, a policy that specifies a different level may have a different effect.

The 'correct' mandatory staffing level remains unclear. However, the widely recognised figure of 8 patients to 1 nurse should not be regarded as a safe level. Ratios from other countries general identify safe staffing minimums for general wards as between 4 & 6 patients per RN, depending on the setting.

Other considerations

While attention is focussed on mandating a staffing level, with the Safe Staffing Alliance campaign focussing on daytime staffing, consideration needs to be given to other factors.

- There is substantial evidence that night-time staffing in some units is extremely low.[20] There is a danger that focussing on daytime staffing could exacerbate this.
- One strategy for increasing the efficiency of the nursing workforce is a move from a three shift per day system to a 2 shift system. The potential advantages are efficiencies from reduced handovers and overlaps between shifts.[21]
- The 2 shift system also means that 'night time' staffing levels, typically much lower, can be operated for a longer period of the day.
- While it may indeed be that in many wards the requirements for nursing care are lower at night, a reduction in staff in this evening period is not necessarily warranted.
- There is growing evidence that these so called '12 hour shifts' are associated with poorer patient outcomes irrespective of the nurse to patient ratios.[22–24] This could be in part because of reductions in the total amount of nursing care that is available or because of other factors.

While closely equivalent, mandating the average daily nursing hours per patient over 24 hours rather than the patient to nurse ratio at a given time, may be more appropriate than a mandatory ratio to be applied at particular times of day. This Nursing Hours Per Patient Day approach is taken in Western Australia.

The Nursing Hours Per Patient Day method gives some additional flexibility around how patient care is organised across the day but reduces perverse incentives to alter shift patterns and night-time staffing levels for reasons unrelated to patient need.

Conclusion

While the evidence is broadly in favour of mandatory minimum staffing levels, it is by no means conclusive and a careful, properly resourced evaluation of any such policy seems essential.

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Health and Social Care Committee: Written Evidence on Safe Staffing Bill, Anne Marie Rafferty CBE

I am making my comments in my capacity as Professor of Nursing Policy, King's College, London and researcher in the area of workforce, specifically, nurse staffing and patient outcomes, not as a member of an organisation or stakeholder.

General

Is there a need for legislation to make provision for safe nurse staffing levels?

Safe staffing legislation could provide a helpful vehicle to set and ensure adherence to 'best practice' staffing guidelines in the absence of responsiveness within the system to changes in demand such as acuity and dependency and alignment with capacity. There is significant evidence of variation in workload management and workforce planning practices and methodologies across England (see attached papers) including historical methods with consequent negative impacts on nurses and patients where these fall short. The chronic understaffing of wards had serious impacts on the welfare of patients and nurses and poses a major threat to the sustainability of the NHS. History suggests that nurse staffing patterns are sensitive to the economic cycle of 'boom and bust' and that variations are unrelated to demand or patient need though this is not the only driver of staffing as the draft Bill indicates. Setting staffing levels on a safe, secure and scientific footing would bring benefits to patients, carers, the multidisciplinary team and the system as well as nurses making it attractive to enter and remain in as a career. Safe staffing should, however, be seen as part of a wider Human Resources strategy with clear accountability for staffing at Board level and not an isolated event or end in itself.

Are the provisions in the Bill the best way of achieving the Bills overall purpose?

England has implemented 'safe staffing guidance' but stopped short of setting ratios. The provisions made in the proposed Bill have much in common with those proposed and currently being implemented in England but Wales would be unique in going a step further by enacting legislation. It is too soon to appreciate the impact of implementing safe staffing guidance in acute wards in England but setting out provision in legislation would provide a strong signal that the Welsh Assembly was serious about supporting safe staffing. It would also provide an opportunity to compare the impacts of different approaches to safe nurse staffing across devolved administrations, especially England, which has implemented guidance on the issue by comparing the differential implementation as a natural experiment.

What, if any, are the potential barriers to implementing the provisions of the Bill?

The Bill takes account of the potential costs but savings that can be off set against those costs, including the costs of operationalising implementation. Costs are not simply economic but have to

be considered in terms of the costs of not acting and the calculus of human suffering associated with poor staffing, which is well documented in The Report of the Francis Inquiry referred to in the background Memorandum. Barriers beyond the economic to implementation could be recruitment in 'difficult to recruit to areas' both in geographical and sub-speciality terms. Recent experience of implementing safe staffing guidance suggests that staff may be redeployed from better to less well staffed areas and this may not prove popular with staff but could form part of an evaluation and options appraisal framework underpinning the review outline in the Bill.

Are there any unintended consequences in the Bill?

These seem to be well covered in the Bill

Provisions in the Bill

The duty on health services bodies and holding Boards accountable for staffing decisions is essential for safeguarding standards and providing stewardship of resource. Specifically, the public reporting of data is and risk management surrounding decisions are central to ensuring public accountability for safe staffing. The wording on the other two provisions has changed from minimum to safe staffing and I concur with the provisions as outlined. It is prudent to adopt an incremental approach to implementation since different environments and specialities may have needs and demands.

The requirement for the Welsh government to issue guidance setting out methods and other items outlined in the draft Bill are positive in supporting the enactment of the Bill. The requirement to review the operation of the Act is to be welcomed.

Impact of existing guidance

It is too early to tell but liaising closely with experience in England would be crucial to guiding implementation of provisions made.

Powers to make subordinate legislation and guidance

These elements seem well covered at present.

Financial implications

I have no further evidence to add beyond that outlined in the Explanatory Memorandum.

Other comments

Only that safe staffing needs to go hand in hand with good human resource practice and be capable of responding to changes in patient acuity and dependency not seen as a 'magic bullet' or isolated event. Everything depends on how it is implemented at local level. The opportunity for implementing safe staffing as a complex intervention through a randomised controlled trial, for example, could also be considered.

Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study

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Summary

Background **Austerity measures and health-system redesign to minimise hospital expenditures risk adversely affecting patient outcomes. The RN4CAST study was designed to inform decision making about nursing, one of the largest components of hospital operating expenses. We aimed to assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data were associated with variation in hospital mortality after common surgical procedures.**

Methods **For this observational study, we obtained discharge data for 422 730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries. Administrative data were coded with a standard protocol (variants of the ninth or tenth versions of the International Classification of Diseases) to estimate 30 day in-hospital mortality by use of risk adjustment measures including age, sex, admission type, 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission. Surveys of 26 516 nurses practising in study hospitals were used to measure nurse staffing and nurse education. We used generalised estimating equations to assess the effects of nursing factors on the likelihood of surgical patients dying within 30 days of admission, before and after adjusting for other hospital and patient characteristics.**

Findings **An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% (odds ratio 1·068, 95% CI 1·031–1·106), and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7% (0·929, 0·886–0·973). These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients.**

Interpretation **Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.**

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Introduction

Constraint of health expenditure growth is an important policy objective in Europe despite concerns about adverse outcomes for quality and safety of health care.[1,2] Hospitals are a target for spending reductions. Health-system reforms have shifted resources to provide more care in community settings while shortening hospital length of stay and reducing inpatient beds, resulting in increased care intensity for inpatients. The possible combination of fewer trained staff in hospitals and intensive patient interventions raises concerns about whether quality of care might worsen. Findings of the European Surgical Outcomes Study[3] across 28 countries recently showed higher than expected hospital surgical mortality and substantial between country variation in hospital outcomes.

Nursing is a so-called soft target because savings can be made quickly by reduction of nurse staffing whereas savings through improved efficiency are difficult to achieve. The consequences of trying to do more with less are shown in England's Francis Report,[4] which discusses how nurses were criticised for failing to prevent poor care after nurse staffing was reduced to meet financial targets. Similarly, results of the Keogh review[5] of 14 hospital trusts in England showed that inadequate nurse staffing was an important factor in persistently high mortality rates. Austerity measures in Ireland and Spain have been described as adversely affecting hospital staffing too.[6,7]

Research that could potentially guide policies and practices on safe hospital nurse staffing in Europe has been scarce. Jarman and colleagues[8] reported an

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association between large proportions of auxiliary nurses (which implies a low overall mix of nursing skill) and high mortality in hospitals in England. Rafferty and colleagues[9] noted that low hospital mortality in England after common surgeries was associated with nurses each caring for few patients. Research in Belgium[10] found hospital mortality after cardiac surgery was significantly lower in hospitals with lower patient to nurse staffing ratios and in hospitals with a higher proportion of nurses with bachelor's education than in hospitals with higher staffing ratios and fewer nurses with bachelor's education. Likewise, data from a Swiss study[11] suggested significantly increased surgical mortality associated with inadequate nurse staffing and poor nurse work environments.

This nascent but growing scientific literature about nursing outcomes in Europe is complemented by research from North America showing that improved hospital nurse staffing is associated with low mortality.[12] Additionally, growing evidence exists that bachelor's education for nurses is associated with low hospital mortality.[13–17]

Research into nursing has had little policy traction in Europe compared with the USA where almost half the 50 states have implemented or are considering hospital nurse staffing legislation.[18,19] On the basis of findings showing improved outcomes for patients, the Institute of Medicine recommended that 80% of nurses in the USA have a bachelor's degree by 2020,[20] and hospitals have responded with preferential hiring of bachelor's nurses. European decision makers might be unclear about the applicability of research done in individual countries in Europe or North America to Europe more generally. Specifically, scientific evidence is needed to inform the continuing European Union policy debate about harmonisation of professional qualifications for nurses.[21]

RN4CAST, funded by the European Commission, was designed to provide scientific evidence for decision makers in Europe about how to get the best value for nursing workforce investments, and to guide workforce planning to produce a nurse workforce for the future that would meet population health needs.[22] Investigators of the study of 488 hospitals in 12 European countries noted substantial variation between countries with regards to patient to nurse workloads and the percentage of nurses qualified at the bachelor's level.[23] These variations in nursing resources are important predictors of patients' satisfaction with their care and in nurses' assessments of quality and safety of care.[24]

We aimed to assess whether differences in patient-to-nurse workloads and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data are associated with variation in hospital mortality after common surgical procedures. The nine countries are representative of variation in Europe with respect to organisation, financing, and resources given to health services. The study's findings provide previously unavailable evidence to guide important decisions about improvement of hospital care in Europe in the context of scarce resources and health-system reforms.

Methods

Study setting

Data for this observational study were from administrative sources on hospital patients and characteristics of hospitals, and surveys of 26 516 bedside care professional nurses done in 2009–10 in 300 hospitals in nine European countries (Belgium, England, Finland, Ireland, the Netherlands, Norway, Spain, Sweden, and Switzerland). Similar patient discharge data consistent with the patient mortality protocol were not available for three RN4CAST countries (Germany, Poland, and Greece). The study included most adult acute care hospitals in Sweden, Norway, and Ireland, and geographically representative samples of hospitals in the other countries.[22]

The European study protocol received ethical approval by the lead university, Catholic University of Leuven, Belgium. Each grantee organisation in the nine participating countries received ethical approval at the institutional level to do nurse surveys and analyse administrative data for patient outcomes. We also obtained country level approvals to acquire and analyse patient outcomes data.

Outcomes

We obtained patient mortality data for postoperative patients discharged from study hospitals in the year most proximate to the nurse survey for which data were available, which ranged between countries from 2007 to 2009. Our analyses included patients aged 50 years or older with a hospital stay of at least 2 days who underwent common general, orthopaedic, or vascular surgery, and for whom complete data were available for comorbidities present on admission, surgery type, discharge status, and other variables used for risk adjustment. We used the procedures published by Silber and colleagues[25] to define common surgeries and comorbidities (appendix). We selected common surgeries for study because almost all acute hospitals undertake them, risk adjustment procedures for surgical patients have been well validated, and risk-related comorbidities can be more accurately distinguished for surgical patients than for medical patients because they are present at admission by contrast with complications arising in the hospital. We coded data in all countries with a standard protocol by use of variants of the ninth or tenth version of the International Classification of Diseases.[26] Researchers are not able to validate coding in administrative hospital discharge files. Countries can have validation protocols for administrative data but this information is not available. Findings of studies in Europe show that routinely collected administrative data predict risk of hospital death with discrimination similar to that obtained from clinical databases.[27] We restricted

See Online for appendix

hospitals to those with 100 or more targeted patients. The primary outcome measure was whether patients died in the hospital within 30 days of admission. Risk adjustment variables included patient age, sex, admission type (emergency or elective), 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission, which are included in the Charlson index.[28]

Nurse staffing and education measures were derived from responses to surveys of nurses in each hospital with the RN4CAST nurse survey instrument.[22] The term nurse refers to fully qualified professional nurses. In all countries except Sweden, hospitals were sampled in different regions, after which a variable number of adult medical and surgical wards were randomly sampled in each hospital, depending on hospital size (between two and six wards in each hospital in every country except England, where all wards were sampled, up to a maximum of ten). All nurses providing direct patient care in these wards were surveyed. In Sweden, all hospitals and all medical and surgical wards were included by sampling all medical surgical nurses nationally.

In the RN4CAST study, nurse staffing for each hospital was calculated from survey data by dividing the number of patients by the number of nurses that each nurse reported were present on their ward on their last shift, and then averaging ratios across all nurse respondents in each hospital. Low ratios suggested more favourable staffing. Collection of data for hospital nurse staffing directly from nurses avoided differences in administrative reporting methods across countries and ensured that only nurses in inpatient care roles are counted. We measured nurse education by calculating the percentage of all nurses in each hospital that reported that the highest academic qualification they had earned was a bachelor's degree or higher.

Statistical analyses

We estimated associations between nurse staffing and nurses' education and 30 day inpatient mortality for patients before and after adjusting for additional hospital characteristics and risk-adjusting for differences in patient characteristics. Hospital characteristics included country, bed size, teaching status, and technology; we defined high technology hospitals as those that undertook open heart surgery or organ transplantation. We included the hospital nurse work environment, measured by the Practice Environment Scale of the Nursing Work Index, as a control variable like in previous studies of nursing and mortality.[15] Patient characteristics included age, sex, admission type, type of surgery (with 43 dummy variables for the specific surgery types), and presence of 17 comorbidities (appendix). Because individual patient outcomes were modelled with a combination of hospital and patient characteristics, we estimated the effects of different characteristics with population average models using a generalised estimating approach and random intercept models using hierarchical linear modelling. Both approaches took into account patients being nested within hospitals, and in both types of models we included dummy variables to allow for unmeasured differences across countries. Because the results were almost identical, and the estimated effects of nursing characteristics were the same in terms of their size and importance, we show only the generalised estimating results. We tested for the effects on mortality of an interaction between nurse staffing and education, which was not significant and is not included in the results. All statistical analyses were done with SAS (version 9.2).

Role of the funding source

The sponsors of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results

We obtained mortality data for 422 730 patients; the number of hospitals and surgical discharges varied across countries (table 1). The percentage of surgical patients who died in the hospital within 30 days of admission was 1·3% across the nine countries combined, and was lowest in Sweden and highest in the Netherlands (table 1).

Response rates for surveys of nurses ranged from less than 40% (2990 of 7741) in England, to nearly 84% (2804 of 3340) in Spain, and averaged 62% (29 251 of 47 160) across the nine countries. Differences in both nurse staffing and nurse education were large both between

	Number of hospitals	Mean discharges per hospital (range)	Deaths/discharges (%)
Belgium	59	1493 (413–4794)	1017/88 078 (1·2%)
England	30	2603 (868–6583)	1084/78 045 (1·4%)
Finland	25	1516 (175–3683)	303/27 867 (1·1%)
Ireland	27	738 (103–1997)	292/19 822 (1·5%)
Netherlands	22	1419 (181–2994)	466/31 216 (1·5%)
Norway	28	1468 (432–4430)	518/35 195 (1·5%)
Spain	16	1382 (186–3034)	283/21 520 (1·3%)
Sweden	62	1304 (295–4654)	828/80 800 (1·0%)
Switzerland	31	1308 (158–3812)	590/40 187 (1·5%)
Total	300	1308 (103–6583)	5381/422 730 (1·3%)

Only hospitals with more than 100 surgical patient discharges were included in the analyses. Data shown are for discharged patients for whom information about 30 day mortality, age, sex, type of surgery, and comorbidities were complete. Data were missing for those characteristics for less than 4% of all patients.

Table 1: **Hospitals sampled in nine European countries with patient discharge data, numbers of surgical patients discharged, and numbers of patient deaths (RN4CAST data)**

countries and between hospitals within each country (table 2). In Spain and Norway, all nurses had bachelor's degrees. The mean age of the patient sample was 68 years (SD=10); table 3 shows other patient characteristics. Of 439 800 patients studied more than 50% had orthopaedic surgeries, whereas roughly four in ten underwent general surgeries, and slightly less than one in 10 underwent vascular surgeries. The most common comorbidities were diabetes without complications, chronic pulmonary disease, metastatic carcinoma, and cancer.

	Nurse staffing (patients to nurse)		Nurse education (% of nurses with bachelor's degrees)	
	Mean (SD)	Range	Mean (SD)	Range
Belgium	10·8 (2·0)	7·5–15·9	55% (15)	26–86%
England	8·8 (1·5)	5·5–11·5	28% (9)	10–49%
Finland	7·6 (1·4)	5·3–10·6	50% (10)	36–71%
Ireland	6·9 (1·0)	5·4–8·9	58% (12)	35–81%
Netherlands	7·0 (0·8)	5·1–8·1	31% (12)	16–68%
Norway	5·2 (0·8)	3·4–6·7	100% (0)	100–100%
Spain	12·7 (2·0)	9·5–17·9	100% (0)	100–100%
Sweden	7·6 (1·1)	5·4–9·8	54% (12)	27–76%
Switzerland	7·8 (1·3)	4·6–9·8	10% (10)	0–39%
Total	8·3 (2·4)	3·4–17·9	52% (27)	0–100%

Means, SDs, and ranges are estimated from hospital data—eg, the 59 hospitals in Belgium have a mean patient-to-nurse ratio of 10·8, and the patient-to-nurse ratio ranges across those 59 hospitals from 7·5 to 15·9. Similarly, the 31 hospitals in Switzerland have, on average, 10% bachelor's nurses, and the percent of bachelor's nurses ranges across those 31 hospitals from 0% to 39%.

Table 2: **Nurse staffing and education in nine European countries**

	Number (%)
Men	189 815 (45%)
Emergency admissions	141 584 (34%)
Inpatient deaths within 30 days of admission	5381 (1·3%)
Surgical categories	
General surgery	162 974 (39%)
Orthopaedic surgery	220 301 (52%)
Vascular surgery	39 455 (9%)
Comorbidities	
Cancer	15 297 (4%)
Cerebrovascular disease	7400 (2%)
Congestive heart failure	10 274 (2%)
Chronic pulmonary disease	28 373 (7%)
Dementia	5744 (1%)
Diabetes with complications	6478 (2%)
Diabetes without complications	35 450 (8%)
AIDS/HIV	50 (0%)
Metastatic carcinoma	17 911 (4%)
Myocardial infarction	12 002 (3%)
Mild liver disease	5953 (1%)
Moderate or severe liver disease	1354 (0%)
Paraplegia and hemiplegia	2043 (1%)
Peptic ulcer disease	2323 (1%)
Peripheral vascular disease	12 452 (3%)
Renal disease	10 085 (2%)
Connective tissue disease or rheumatic disease	6962 (2%)

Table 3: **Characteristics of surgical patients (n=422 730) in the study hospitals**

Table 4 shows results of modelling the effects of the two nursing factors (staffing and education) on mortality after adjustment for differences across countries in mortality (in the partly adjusted model) and for differences in the full set of potentially confounding factors (in the fully adjusted model). After we considered severity of illness of the patients and characteristics of the hospitals (teaching status and technology) in the adjusted model, both nurse staffing and nurse education were significantly associated with mortality (table 4). The odds ratios (ORs) suggest that each increase of one patient per nurse is associated with a 7% increase in the likelihood of a surgical patient dying within 30 days of admission, whereas each 10% increase in the percent of bachelor's degree nurses in a hospital is associated with a 7% decrease in this likelihood. These associations suggest that patients in hospitals in which 60% of the nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of the nurses had bachelor's degrees and nurses cared for an average of eight patients. We worked out this 30% reduction (reduction in mortality by a factor of 0·70) by applying (and multiplying) the reciprocal of the OR associated with nurse staffing across two intervals (from eight to six patients per nurse) and the OR associated with nurse education across three intervals (from 60% to 30%)—ie, $1/1{\cdot}068 \times 1/1{\cdot}068 \times 0{\cdot}929 \times 0{\cdot}929 \times 0{\cdot}929 = 0{\cdot}703$.

Discussion

Our findings shows that an increase in nurses' workload increases the likelihood of inpatient hospital deaths, and an increase in nurses with a bachelor's degree is associated with a decrease in inpatient hospital deaths (panel). Findings of the RN4CAST study showed more

	Partly adjusted models		Fully adjusted model	
	OR (95% CI)	p value	OR (95% CI)	p value
Staffing	1·005 (0·965–1·046)	0·816	1·068 (1·031–1·106)	0·0002
Education	1·000 (0·959–1·044)	0·990	0·929 (0·886–0·973)	0·002

The partly adjusted models estimate the effects of nurse staffing and nurse education separately while controlling for unmeasured differences across countries. The fully adjusted model estimates the effects of nurse staffing and nurse education simultaneously, controlling for unmeasured differences across countries and for the hospital characteristics (bed size, teaching status, technology, and work environment), and patient characteristics (age, sex, admission type, type of surgery, and comorbidities present on admission). OR=odds ratio.

Table 4: **Partly and fully adjusted odds ratios showing the effects of nurse staffing and nurse education on 30 day inpatient mortality**

variation in hospital mortality after common surgical procedures in European hospitals than is generally understood. Variation in hospital mortality is associated with differences in nurse staffing levels and educational qualifications. Hospitals in which nurses cared for fewer patients each and a higher proportion had bachelor's degrees had significantly lower mortality than hospitals in which nurses cared for more patients and fewer had bachelor's degrees. These findings are similar to those of studies of surgical patients in US and Canadian hospitals in which similar measures and protocols were used.[14,15]

Our finding that each 10% increase in the proportion of nurses with a bachelor's degree in hospitals is associated with a 7% decrease in mortality is highly relevant to the recent decision by the European Parliament (Oct 9, 2013) to endorse two educational tracks for nurses—one vocational and one higher education.[21] In view of the RN4CAST findings, the goal of standardised qualifications of professionals as expressed in the Bologna process[29] is a long way off from being achieved. Our findings support the recent EU decision to recognise professional nursing education within institutions of higher education starting after 12 years of general education. However, our results challenge the decision to continue to endorse vocational nursing education after only 10 years of general education because this training might hamper access to higher education for nurses in some countries—eg, Germany where no nurses in the 49 hospitals studied in RN4CAST had a bachelor's degree.[23]

The RN4CAST finding that improved hospital nurse staffing is associated with decreased risk of mortality might be inconvenient in the present difficult financial context and amid health-system reforms to shift resources to community-based settings. Nevertheless, this study is the largest and most rigorous investigation of nursing and hospital outcomes in Europe up to now, and has robust results. Our findings reinforce those of smaller studies in Europe,[8–11] and a large body of international published work.[12,14] Our data suggest a safe level of hospital nurse staffing might help to reduce surgical mortality, as called for by the European Surgical Outcomes Study.[3]

Beyond improvements in care, investments in nursing could make good business sense. In the USA, each US$1 spent on improvements to nurse staffing was estimated to return a minimum of $0·75 economic benefit to the investing hospital, not counting intangible benefits.[30] Furthermore, a move from less qualified licensed vocational nurse hours to qualified professional nurse hours is estimated to save lives and money.[31] Improved nurse staffing in US hospitals is associated with significantly reduced readmission rates, which is compelling in view of financial penalties in 2013 to 2225 hospitals for excessive readmissions.[32] Although hospital finance and payment policies differ between the USA and Europe, the underlying goal of better value for investments is the same.[33]

Panel: Research in context

Systematic review

We searched PubMed for original research articles published in English between Jan 1, 1985, and Aug 10, 2013, with the search terms (separately and in combination): "nursing", "staffing", "administrative data", "outcomes", "mortality", "European Union", and "cross-national" and "international." We also did a manual search based on bibliographies of papers we found. Studies linking nursing and clinical patient outcomes were restricted in Europe to one country studies[8–11] and to research in North America.[12–17] In Europe, cross-national studies assessing how hospital nursing affects patient outcomes are restricted to assessment of outcomes based on patient or nurse report rather than objective clinical outcomes.[24]

Interpretation

We report the first study to use detailed information about nursing workforce such as staffing and education level to investigate how these factors affect patient mortality across countries in Europe. We relied on unique data from direct-care nurses collected with a common method across many hospitals in different countries. We used a standardised approach across countries to measure and adjust the risk of mortality on the basis of administrative records. Findings of our analysis of 300 hospitals in nine countries show that an increase in nurses' workloads by one patient increases the likelihood of inpatient hospital mortality by 7%, and a 10% increase in bachelor's degree nurses is associated with a decrease in odds on mortality by 7%. These findings emphasise the risk to patients that could emerge in response to nurse staffing cuts and suggest that an increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

Our study has several limitations. We assessed one outcome, mortality, and only in patients undergoing common general surgeries. Our measure of education relied on each country's definition of bachelor's education for nurses, which differs by country. Our global measure of nurse staffing shows nurse workloads across all shifts, and might be skewed in some hospitals if nurses working at night (when patient-to-nurse ratios are higher than in the day) responded to our survey at different rates than nurses on day shifts. The models we used to measure associations allowed us to control for unmeasured differences in mortality across countries and for measured differences across patients and hospitals, but unmeasured confounding factors at the individual, hospital, and community level could have affected our results. We cannot link the care of individual patients to individual nurses. Additionally, mortality outcomes for patients were taken from the year that most closely matched the nurse survey year, but because of lags in patient data availability, the two data sources were not always perfectly aligned. Finally, our data are cross-sectional and provide restricted information about causality.

Additional research in Europe is needed to establish whether our multicountry findings can be replicated for high mortality surgeries and for medical patients; and whether in Europe, like in the USA, nursing is related to a range of adverse outcomes that contribute to high costs. Longitudinal studies of panels of hospitals would be especially valuable to help to establish causal associations between changes in nursing resources and outcomes for patients. Comparative effectiveness research is needed to identify what workforce investments return the greatest value, and under what circumstances. Research beyond simple mortality outcomes would be welcome to help to establish standards of care by which performance of health-care organisations could be more fully assessed. In a context of widespread health-system redesign and reforms, increased funding for studies of health workforce investments could result in high-value health care.

In summary, educational qualifications of nurses and patient-to-nurse staffing ratios seem to have a role in the outcomes of hospital patients in Europe. Previous findings from RN4CAST show that patients are more likely to express satisfaction with hospital care when nurses care for fewer patients each.[24] To add to these findings, our data suggest that evidence-based investments in nursing are associated with reduction in hospital deaths.

Contributors

LHA, WS, LB, MM, PG, RB, and MTM-C did the literature search. LHA, WS, DMS, KVdH, AMR, PG, MM, RB, AS, and CT designed the study. WS, LHA, KVdH, RB, PG, MD, JK, MK, MTM-C, AMR, RS, AS, CT, and TVA collected data. LHA, DMS, LB, MM, WS, and TVA analysed data. All of the authors contributed to data interpretation, writing, and revision of the report.

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Conflicts of interest

We declare that we have no conflicts of interest.

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Nurse staffing and education in Europe: if not now, when?

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By financing the RN4CAST project,[1] the European Union (EU) showed its concern about patient safety: the project's aim was to measure the value of nursing care. Such measurement has long been recognised as challenging. Drawing on discharge data from nine of the 12 RN4CAST countries for more than 420 000 patients aged 50 years or older, Linda Aiken and colleagues[2] in *The Lancet* show that an increased workload of one patient per nurse was associated with an increase in the odds of surgical inpatient mortality, within 30 days of admission, by 7% (odds ratio 1·068, 95% CI 1·031–1·106). Patients in hospitals in which 60% of the nurses had a bachelor's degree, who looked after an average of six patients, had a mortality rate almost 30% lower than patients in hospitals where only 30% of the nurses had a bachelor's degree and cared for an average of eight patients. The investigators included hospitals from two countries of the European Free Trade Association (Switzerland and Norway) and seven of the 28 countries in the EU. The EU is a vast area linked by bilateral agreements in which the prevailing objective of a European market has recently introduced a social dimension to address inequalities (eg, workers' rights and safe working conditions);[3] patients can circulate freely to get the best care, and nurses can travel for optimum occupational working conditions.[4,5]

To search for associations between mortality and nurse staffing and educational level, the investigators developed a European study with an ecological design. The analytical methods applied were consistent with the state of knowledge in the specialty, and researchers introduced the necessary control variables to account for differences in the environment in which patients and nurses were surveyed. The investigators recognise the limitations of the study and possible effects on their results. However, the findings are consistent with those already documented in the USA[6] and Europe,[7,8] and contribute to a body of knowledge that should provide information for health-care policies of several countries.

The study is the first pan-European public report to monitor how many patients were managed by nurses during their last work-shift. This method is more accurate than the nurse–population ratio, which often includes midwives too,[9] and is more informative than other measures (eg, number of full-time equivalent nurses), which provide information about how many nurses are in employment, but not how many work in the clinic. The data suggest important variability within and between countries, possibly because no homogeneous standards exist, even in countries with a public health service where patients should receive a standard level of nursing care and nurses should work in similar conditions. The study includes information about how decisions with respect to university nursing education were indicative of the composition of daily nursing staff and their patients, which raises an important question about variability despite the tenure in Europe, since 1999, of the Bologna Process. This declaration includes more than 47 EU, European Free Trade Association, and other countries (ie, European higher education area), and aims to harmonise university education.[10]

Results of the study by Aiken and colleagues[2] show that the skills of the staff acquired at university create the conditions for safe staffing. The investigators report a 7% reduction in patient mortality for every 10% increase in the number of nurses with bachelor's degrees. The continuing presence of graduate nurses in the staff (ie, at least one per shift), able to guarantee surveillance and clinical judgment, creates a protective environment for surgical patients.

The data refer to the years 2007–10, so the researchers did not document the situation immediately before the EU economic crisis or the effects of austerity

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measures introduced in several countries.[11] If the study was replicated, the results might be different; in many countries, austerity measures have caused a reduction in the number of nurses at patients' bedsides.[12] The nurses remaining at the bedside have large workloads, with negative results on patients, and as a result the public image of nurses is worsening in several countries.[13]

Recession has highlighted the cost of graduate education for nurses; therefore, health-care organisations could be attracted by vocationally trained nurses, in the belief that costs might be lower and the nurses more effective. Paradoxically, and notwithstanding the support for research (including from the EU's Seventh Framework Programme), in November, 2013,[5] the EU decided to approve two pathways for nursing education: a vocational school or training after 10 years of general education; and a higher education or university pathway after 12 years of education, which is a change from the previous directive that envisioned at least 12 years of general education before nursing education.

The study by Aiken and colleagues[2] provides evidence in favour of appropriate nurse–patient ratios and also provides support for graduate education for nurses. Whether these findings are used to inform health-care policy or how they are implemented in practice will be interesting to see. We fear that the evidence here will not be tried and found wanting, but will rather be deemed too expensive to act upon.

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We declare that we have no competing interests.

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Caring nurses hit by a quality storm

Low investment and excessive workloads, not uncaring attitudes, are damaging the image of NHS trusts, argue the authors of groundbreaking research into Europe's nurse workforce

Nurses are getting a bad press in England for being 'uncaring' at a time when nursing in the United States is benefiting from favourable public perceptions, supportive policy initiatives and the largest and most talented pool of applicants to nursing schools in history.

Interestingly, both countries had nursing commissions that released reports in 2010 heralding the future of nursing; the responses could not have been more different.

The US Institute of Medicine's report called for nurses' scope of practice to be broader, for nurses to lead innovative care models, for at least 80 per cent of the nurse workforce to have bachelor's degrees, and the number with doctoral degrees to be doubled by 2020. Media coverage was positive and initiatives to implement recommendations came swiftly.

In contrast, much of the media response to the Prime Minister's Commission on the Future of Nursing and Midwifery accused nurses of having uncaring attitudes and scoffed at recommendations for them to receive bachelor's education.

The annual Gallup public opinion poll in the US shows nurses leading all other occupations when it comes to trust. What is different about nurses in England? They are the public face of the NHS, as exemplified by the tribute in the opening ceremony of the London Olympics. As such, they may be revered in good times and blamed when the NHS disappoints.

The context of caring

Instead of blaming nurses and expecting care to improve, it may be more productive to consider complaints about nurses as early warning signs that the quality of health care is being eroded, and then consider how to avert the 'quality storm'.

As a result of an EU-funded study of the nurse workforce in 12 European countries, RN4CAST, we know much about the challenges faced by nurses working in NHS hospitals in England. We are also able to compare nurses' reports on conditions of practice in NHS hospitals with nurses' experiences in 11 other European countries and the US (Aiken *et al* 2012). RN4CAST's findings about 488 European hospitals through the eyes of 33,659 nurses, including 2,918 nurses practising in 46 NHS hospitals in England, are revealing and informative.

In Box 1 (see page 24) we show England's rank compared with the best-ranking

SUMMARY

Research by the authors, some of it unpublished, indicates that nurses in England are not 'uncaring'. On the contrary, they score highly on measures of caring. Negative perceptions of nurses in England can be explained by their excessive workload and inadequate skill mix. Put simply, nurses in England do not have the time to show how much they care.

Authors Linda Aiken, Anne Marie Rafferty, Walter Sermeus. For details see page 25

European country, based on five hospital nurse workforce dimensions: job-related burnout; staffing and resource adequacy; skill mix; proportion of nurses with a bachelor's degree; and work environment quality.

Countries were ranked based on averages across all hospitals in each country. While we use nurses as informants about their hospitals, our ranking is related to resources and nurse workforce outcomes at the hospital level because policies to address quality concerns will likely be directed to hospitals rather than to nurses. This approach also takes into account that some hospitals are better than others on these dimensions, but public perceptions of hospital care are likely to be a result of the experiences of patients and their families.

Nurse burnout, measured with a well-validated instrument, revealed that, on average, 44 per cent of bedside care nurses in the representative sample of NHS hospitals studied scored in the 'high burnout' range. Indeed, only one other country has hospitals with a higher percentage of 'burned out' nurses than England.

England ranks unfavourably compared to many other countries in Europe on dimensions that suggest why nurses in NHS hospitals may suffer from high burnout. Nurses in each study hospital in the 12 countries rated the overall adequacy of staffing and resources. Only four of the 12 countries ranked worse than England on nurses' assessments of staffing adequacy. Nurses also rated their hospitals on the quality of their work environments, and England again ranked near the bottom.

COMPLAINTS ABOUT 'UNCARING' NURSES CAN BE EXPLAINED BY THE UNDER-RESOURCING OF SERVICES

On another measure of staffing, known as nursing skill mix, which is the proportion of all hospital care staff who are professional nurses, England scored worse than all but two other countries. A significant proportion of caregivers in NHS hospitals are not professional nurses, although the public may not be aware of this.

A growing research literature shows that hospitals with a higher proportion of nurses qualified at bachelor's degree level have lower risk-adjusted mortality and fewer adverse patient outcomes (Aiken *et al* 2014). However, hospitals in England averaged only 28 per cent of bedside care nurses with a bachelor's degree, compared with 45 per cent across Europe. Only four countries had lower proportions than England. All hospital nurses in Norway and Spain held at least a bachelor's degree.

Despite high rates of burnout in England and resources that are less generous than elsewhere in Europe, we found no evidence that the attitudes of nurses in England towards their ▶

PETE ELLIS

Box 1: England's rank among 12 European countries

	England's rank	Best-ranking country
Nurse burnout	11	Netherlands
Staffing and resource adequacy	7	Switzerland
Skill mix (% of registered nurses)	10	Germany
Nurses with bachelor's degree	8	Norway and Spain
Work environment quality	10	Norway

Source: unpublished results from RN4CAST. The countries included are Belgium, England, Finland, Germany, Greece, Ireland, Netherlands, Norway, Poland, Spain, Sweden and Switzerland.

Note: Rankings are based on hospital averages for each characteristic (for example, the percentage of nurses with high burnout, and the percentage reporting adequate staffing and resources, was calculated for each hospital, and then the average across all hospitals in each country was calculated). On the four favourable characteristics, countries were ranked from high (rank 1) to low; on nurse burnout, countries were ranked from low (rank 1) to high.

▶ patients are negative and no support for media reports that nurses are uncaring. We asked nurses in each country how frequently they felt that they 'don't really care what happens to some patients'. Nurses in England nurses ranked best on this dimension, with 89 per cent responding 'never'.

Some media stories suggest that recent requirements for nurses in England to obtain a bachelor's degree are responsible for less caring behaviour. We explored our data to see whether nurses in England with a bachelor's education had more negative perceptions of patients than other nurses. The answer was no; they showed high regard for patients regardless of their educational qualifications.

Rationing of comfort

We did find a possible explanation for why some patients might perceive nurses in England to be uncaring – and it relates to workload.

Box 2 examines the types of care nurses say they cannot complete because of their heavy workloads. Norway was selected as a comparison country because of its well-resourced healthcare system, and because most of its hospitals were ranked by nurses as having good work environments.

A significant share of nurses in hospitals in both countries report that not all of their patients have all of their care needs met because of nurses' demanding workloads. But, overall, nurses in England are significantly more likely than nurses in Norway to report omitted care.

These findings suggest that nurses may be implicitly rationing some kinds of care because of their high workloads. Critical needs such as pain control and medication and treatment administration are less likely to be omitted than educating patients and families about self-care after discharge and spending time talking with patients and families about their concerns (Ball *et al* 2013).

Two-thirds of nurses in hospitals in England report that they do not have time to comfort and talk with patients. This is consistent with higher nurse workloads in NHS hospitals, fewer professional nurses among care staff at the bedside, and poorer nurse work environments than is the case in Norway and many other European countries.

Box 3 provides additional insight into unmet care needs, particularly the comforting functions of nurses that may be important to patients' positive perceptions of care. Nurses who assess their work environments as poor are twice as likely as those who assess them as excellent to report a lack of time to comfort and communicate with patients.

Our findings suggest that increasing nurse resources and improving work environments in NHS hospitals are more likely than blaming nurses for uncaring attitudes to result in patient-centred care (Aiken *et al* 2012).

Box 2: tasks for which nurses (%) say they lack time

	England	Norway
Pain management	7	4
Treatments and procedures	11	7
Prepare patients for discharge	20	14
Skin care	21	30
Administer medications on time	22	15
Oral hygiene	28	30
Adequately document nursing care	33	21
Patient surveillance	34	25
Educate patients and family	52	24
Comfort and/or talk with patients	66	38

Source: unpublished data from RN4CAST provided by authors.

The difficult economic context in Europe and elsewhere is contributing to the gathering 'quality storm'. Cost containment, especially as applied to hospitals, results in higher intensity of services delivered in less time and more rapid patient throughput from admission to discharge. These changes require more nurses, not fewer, to prevent deterioration in care quality and safety that can harm patients and lead to higher costs if expensive complications such as infections result (Cimiotti *et al* 2012).

Increasing the intensity of services and patient throughput in inpatient care, while maintaining quality and safety, is not possible if nursing resources are reduced, as documented in the Francis report on failures of care at Mid Staffordshire NHS Foundation Trust. Also, having too few nurses can cost more if complications increase.

Early warning signs

We make a case here for thinking more broadly about the meaning of negative perceptions of nursing care in the NHS and elsewhere.

Policy solutions rely on an accurate diagnosis of problems. Getting nurse resource levels and hospital culture correct are crucial. We found no evidence that public concerns about a lack of caring by nurses in England is associated with less professionalism, commitment or hard work.

On the contrary, the high rate of burnout in England suggests that nurses are trying their best under difficult circumstances. It is likely that complaints about 'uncaring' nurses can be explained by the fact that nursing services are comparatively under-resourced in hospitals in England.

Investments in evidence-based strategies to improve nurse work environments, as exemplified in the Magnet Recognition Program (McHugh *et al* 2013); applying evidence to achieve safe nurse staffing and nursing skill mix; and moving to a bachelor's qualified nurse workforce (Aiken *et al* 2014), hold promise for stabilising quality and safety gains and staving off the gathering quality storm in health care in England.

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Journal Club #NursingJC

Join our First Friday Twitter discussion about issues raised in this article. Friday May 2 from 12.30-1.30 using #NursingJC

In the US, close to 10 per cent of hospitals have qualified for Magnet status by demonstrating excellence in nursing care, a distinction that is recognised by national quality benchmarking organisations as the mark of a high-performing healthcare organisation. There is no equivalent form of recognition of nursing excellence in England or elsewhere in Europe.

Hospitals in the US are preferentially hiring bedside care nurses with bachelor's degrees, a market indicator of their higher value to their employing organisations.

The Institute of Medicine of the US National Academy of Sciences has elected nurse members, creating a forum for high-level interprofessional discourse on healthcare challenges, an organisational model that again does not have an equivalent in Europe.

Nurses' concerns about quality of care, patients' reports of negative care experiences, and press reports about uncaring nurses are harbingers of declining quality and safety, and should be considered warning signs that austerity measures may be risking harm to patients **NS**

Box 3: care linked to environment

Nurse rating of work environment	% of nurses lacking time to comfort and/or talk with patients
Poor	83
Fair	72
Good	56
Excellent	41

Source: unpublished data from RN4CAST provided by authors

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22 January 2015

Ms Sian Giddins
Deputy Clerk
Health & Social Service Committee
National Assembly for Wales
Cardiff Bay
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Dear Ms Giddins

HSSC Inquiry – Safe Nurse Staffing Levels (Wales) Bill

As requested, herewith is the evidence of the Board of Community Health Councils in Wales in relation to the above inquiry.

I look forward to attending the meeting of the Health and Social Care Committee that is scheduled for 12th February in order to speak to this submission and take questions from Assembly Members. I would be happy to hear from you should you need to speak with me before then.

Yours sincerely,

PMS

Peter Meredith-Smith
Director
Board of Community Health Councils in Wales

Ffôn/Tel: [redacted] / [redacted]

Board of Community Health Councils in Wales

Health & Social Care Committee Submission: Safe Nurse Staffing Levels (Wales) Bill	
SUBJECT:	Safe Nurse Staffing Levels (Wales) Bill
STATUS:	Board of CHC Submission to H&SCC Committee (Final Draft)
CONTACT:	Peter Meredith-Smith, Director of the Board of CHCS in Wales
DATE:	22nd January 2015

INTRODUCTION

This submission to the Health and Social Care Committee of the National Assembly for Wales, relating to the Safe Nurse Staffing Levels (Wales) Bill, is submitted by the Board of Community Health Councils in Wales in advance of their attendance at a meeting of the committee scheduled for 12th February 2015.

Supported by the Board of Community Health Councils (CHCs), the 8 CHCs across Wales represent the interests of and act as the independent voice for the citizens of Wales regarding their NHS services. They fulfil these functions by: (a) continuously engaging with the populations they represent and the health service providers serving those populations, (b) systematically monitoring and scrutinising local health services, through service inspections and visits, (c) supporting the public to engage in consultations about major NHS service changes that have an impact on them and (d) enabling users of the NHS in Wales to raise concerns about the services they receive, primarily by providing an Independent Advocacy Service.

The views represented in this submission are informed by feedback from individual CHCs across Wales relating to this issue of interest to the Health and Social service Committee, and from data and information derived from the Board of CHCs' information systems (pertaining the monitoring of the core functions of the CHCs across Wales).

GENERAL COMMENTARY

The CHCs support the proposal to introduce this legislation. There is a general feeling amongst those who have contributed to this response that without the force of law, against the present background of severe financial restraint within NHS Wales, the well-publicised staffing pressures across our health services will continue. It is likely that this will have a consequent negative impact on the safety, efficacy and quality of patient care.

Feedback from CHC members who are involved in service visiting and scrutiny programmes frequently indicate a health service landscape across Wales that is characterised by a system that is under extreme strain. It is apparent to our members that nursing staffing shortfalls are often contributory factors to this unacceptable situation.

Having clarity about agreed safe staffing levels in clinical areas across the NHS in Wales would assist our members and staff to more effectively fulfil their health service scrutiny role.

We believe that the making of this legislation would be a key step towards strengthening public confidence in the safety of their NHS services.

The three most helpful sources of information available to the Board of CHCs to inform its views on the nursing staffing situation across the NHS in Wales are data and information derived from the CHCs':

- Continuous Engagement Work
- Service Monitoring and Scrutiny programmes
- Independent Advocacy Service

On the basis of what we learn from our continuous engagement and service monitoring and scrutiny work, it is possible to offer in general terms an overview of what the users of NHS services that we engage with "want" from their NHS. In summary, we are frequently told that they want:

- Services that keep them safe
- Reasonable quality of care
- Care delivery that assures that they are treated with respect
- Their privacy and dignity to be assured whilst in hospital
- Good engagement with clinical staff (being kept informed about their care)
- To be assured that services are safely staffed

Quite clearly, appropriate and safe levels and skill mix of nursing staffing are necessary if these expectations are to be met.

We are also able on the basis of our engagement work to provide a summary of how, in general terms, patients describe their experiences of the NHS. Typical perspectives offered being:

- Despite evident pressures, services are generally adequate
- When things go wrong nursing staffing problems are often significant
- When things go wrong it is not generally the "fault" of individual nurses
- Problems are usually a consequence of the situation that nurses are in
- Lack of nursing workforce stability leads to a lack of continuity of care

Specific themes directly related to nursing staffing that often feature in feedback from our members or the patients and relatives that we engage with include:

- Suggestions that nurses are often not readily available to provide assistance "at the time that they are needed"
- Nursing staff are constantly "rushed with too much to do"
- Nurses seem to be on duty for very long periods and often seem to be very tired at the end of what appear to be very long shifts
- Health Care Support Workers are often more visible that Registered Nurses

The Board of CHCs in Wales' *Concerns and Complaints Database* is another source of information relevant to this debate. Although the explicit issues of "nursing shortages" or "inadequate nursing staffing levels" do not feature in the data available to us, other information derived from the database may provide a "proxy indication" of staffing deficiencies across the NHS in Wales.

A recent review of information derived from the database indicated that, of the concerns or complaints logged on the system, 14% related to nursing in secondary care. Most of those complaints, in general terms, related either to failures or shortcomings in the "Clinical Practice" (61% of complaints reviewed) or "Poor Engagement or Communication" between clinical staff and patients (19% of complaints reviewed).

Drilling down into these overarching areas highlighted five specific areas of concern or complaint raised by those who contact us. They being:

- Failures in the Fundamentals of Care
- Failures in Treatment Delivery
- Negative Staff Attitudes
- Lack of Information
- Compromised Privacy & Dignity

Again, these are areas of service shortcoming or failure that can directly relate to staffing pressures (be they inadequate staffing numbers or skill mix problems).

The CHCs that have contributed to this response have also provided specific examples of serious issues that they have or are dealing with, that have inadequate nursing staffing as one of the root causes of significant clinical or service failings. For reasons of patient confidentiality, it would not be appropriate to detail these herein.

SPECIFIC QUESTIONS POSED BY THE HEALTH AND SOCIAL SERVICES COMMITTEE

Are the provisions in the Bill the best way of achieving the Bill's overall purpose?

The CHCs who offered a view agreed that the provisions in the Bill are generally the best way of achieving the Bill's overall purpose.

What, if any, are the potential barriers to implementing the provisions of the Bill? Does the Bill take sufficient account of them?

The CHCs have offered the following suggestions:

- Inadequate numbers of staff "in the system" to support an acceptable nursing staffing model
- Inadequate numbers of student nurses "in training" to support future nursing staffing needs
- Poor workforce planning throughout the NHS in Wales
- Inadequate financial resources to support an adequate nurse staffing model
- An approach to workforce planning (and workforce management) in Wales that prioritises financial planning over a needs-based workforce

Are there any unintended consequences arising from the Bill?

Because the proposed law would only require safe staffing on adult inpatient wards in acute hospitals, against the background of resource pressures referred to above, there is a risk that HNS managers would denude staffing levels in other clinical areas to ensure that adult in-patient wards are compliant with the law. This would lead to potentially unsafe staffing levels in clinical areas that are not subject to the legislation.

There is a risk that establishing "safe staffing levels" could set a "ceiling on staffing numbers" that could fetter appropriate workforce development – i.e. minimum "safe" staffing levels do not always ensure the best quality care (which may require higher numbers of staff than minimum numbers).

Provisions in the Bill

The duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided.

- The CHCs fully support this provision.

- There must be a standardised methodology for approaching this across all Health Boards. Workforce planning needs to be strengthened from the bedside to the Board (and across Wales).

- The LHB Chief Executive should be clearly identified in the legislation as the accountable officer regarding this provision.

- Safe staffing is not easy to quantify and monitor using current systems and approaches employed in Wales; such systems need urgent development.

- Safe staffing should be included as a key "quantifiable" LHB Health Board performance measure, open to scrutiny in public Board meetings.

- The Francis Report was very specific on the need for enhanced "Ward to Board" ownership and communication of front-line care and performance. Such clear measures could help in addressing this Board-level communication and scrutiny.

The duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios which will apply initially in adult patient wards in acute hospitals.

- CHCs agree with this but "reasonable steps" need to be defined to avoid ambiguity.
  .
- The sanctions for failure in this duty need to be clear.

The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

- Safe staffing should be a legal requirement in all clinical environments, not just adult inpatient wards (this should include community and primary care environments too).

The requirement for the Welsh Government to issue guidance in respect of the duty set out in Section 10A(1)(b) inserted by section 2 (1) of the Bill which:

- **Sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing (including methods set out in Section 10A (6) inserted by Section 2(1) of the Bill)?**

  The CHCs very strongly endorse the requirement for guidance to be provided as stated. Welsh Ministers should keep such guidance under continuous review.

- **Includes provision to ensure that the minimum ratios are not applied as an upper limit?**

  The CHCs fully support this and regard such an approach as essential (see relevant comments above).

- **Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?**

  Such transparency is crucial. It will engender public confidence. Some CHCs have suggested that the *Annual Quality Assurance Statement* could provide a vehicle for informing the public regarding this in general terms .

  It is also crucial that patients and their relatives are made aware of the numbers of staff that should be on duty against those that are actually on duty "in real time" at ward level (and other clinical area level). The CHCs would be happy to explore how they might support LHBs to keep the public informed reading safe staffing levels.

- **Includes protections for certain activities and particular roles when staffing levels are being determined?**

  These protections are absolutely essential and are fully supported by the CHCs. The activities listed in the Bill must be considered and properly accounted for in workforce planning methodologies.

The requirement for Welsh Ministers to consult before issuing guidance?

This is supported by the CHCs.

The requirement for each health service body to public an annual report?

This is supported by CHCs. Such transparency is essential if public confidence is to be maintained.

The requirement for Welsh Ministers to review the operation and effectiveness of the Act?

Supported. CHCs would like firm assurance that Welsh Ministers will review the operation and effectiveness of the Bill. If legislation is agreed, CHCs would expect that regular close monitoring of implementation takes place with regular performance reports provided, with a formal evaluation being undertaken. There should be active involvement from professional and academic bodies to support the development and monitoring of any measures.

View on the effectiveness and impact of existing guidance?

Current guidance has not sufficiently improved staffing levels; hence the need for legislation. We would expect agreed nurse/patient ratios to be met

consistently, although there may be an argument for sensible tolerances to be built into any workforce planning and management systems. Where agreed nursing staffing ratios are not met, we would expect to see urgent recovery plans developed and implemented, and for Welsh Government to take action if problems persist.

Balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

No specific comments.

Financial implications of the Bill.

Quite clearly, if nursing staffing establishment have been under-resourced to date, there may be additional cost implications as a consequence of this legislation. However, this could be significantly offset by a concomitant reduction in spend on nursing bank and agency staff and overtime. Additionally, we might expect reduced sickness levels amongst nurses as staffing levels improve (so mitigating the extra costs that might be associated with the introduction of this legislation). Finally, we are aware that international evidence indicates a positive impact on treatment and care outcomes when nursing staffing levels are optimum. It has been argued that this too contributes to cost reduction across the "whole system" of healthcare.

Other Issues

No additional comments.

- ENDS-

Agenda Item 4

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Healthcare Inspectorate Wales – SNSL(Org) 21 / Tystiolaeth gan Arolygiaeth Gofal Iechyd Cymru – SNSL(Org) 21

Response to consultation on the Safe Nurse Staffing Levels (Wales) Bill

About Healthcare Inspectorate Wales:

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

Our response:

General

- ***Is there a need for legislation to make provision about safe nurse staffing levels?***

  Healthcare Inspectorate Wales (HIW) strongly supports the objectives of the Bill to:

  - Enable the provision of safe nursing care to patients at all times;
  - Improve working conditions for nursing and other staff;
  - Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

  Most of our findings relating to staffing come from our dignity and essential care inspections and our mental health inspections. During the current year

we have published 30 dignity and essential care inspections. We have identified issues relating to staffing in half of these.

The issues identified have tended to relate to shortfalls in staffing numbers, difficulties encountered with recruitment and retention and a high degree of reliance on bank and agency staff. In three instances we sought immediate assurance from the Health Boards that the issues were being addressed.

Guidance on the principles underpinning safe nursing were issued to Health Boards in Wales by the Chief Nursing Officer in April 2012 and acuity tools for adult acute hospital wards were introduced in April 2014. Progress is being made, but we continue to find that implementation is inconsistent: not all ward areas have set their own local safe minimum staffing levels and wards are not regularly using an acuity tool to reflect and match staffing numbers to patient needs.

It is possible that legislation in this area may help to provide the focus and momentum necessary to embed this guidance fully in daily practice.

We are pleased to see that the proposals recognise that it is important to look beyond simple ratios. Safe staffing is dependent upon more than numbers: it must also reflect the need of the patients, the environment in which care is being provided, the skills and experience of the staff members and the proportion of care provided by bank and agency staff who may have limited experience in the area. We therefore support the intention to ensure that minimum staff ratios are seen as a baseline and not as a target.

- ***Are the provisions in the Bill the best way of achieving the Bill's overall purpose (set out in Section 1 of the Bill)?***

- ***What, if any, are the potential barriers to implementing the provisions of the Bill? Does the Bill take sufficient account of them?***

The availability of Registered Nurses and the ability to recruit is likely to be a barrier. The Bill will need to be supported by effective workforce planning and provision of education to ensure that there are sufficient trained and experienced nurses available to meet the identified needs.

It is right to recognise that determining appropriate staffing levels is not straightforward and cannot be done by applying a simple formula. However, the need to balance professional judgement, and the constantly changing nature of demand, will make it difficult to be specific in the guidance. This in turn will make it challenging to communicate clearly to patients how the staffing in place meets the guidance. It will also make it more challenging to hold health bodies to account for delivery against the legislation.

The current financial environment facing Health Boards is likely to present challenges for them in meeting safe staffing levels at all times

- ***Are there any unintended consequences arising from the Bill?***

  It is possible that, at least in the short term, attempts to maintain staffing numbers would significantly increase the proportion of bank and agency. This may impact on continuity and quality of care.

  There is a possibility that Health Boards may move resource from areas without statutory guidance in order to meet the requirements of the guidance in acute adult wards. For example, we have already identified staffing problems in NHS Mental Health inspections and have highlighted these in all reports on these inspections published so far this year.

Provisions in the Bill

The Committee is interested in your views on the individual provisions in the Bill and whether they deliver their stated purposes. For example, do you have a view on:

- ***the duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided?***

  There is a lack of clarity over the intended scope of this provision. It would be helpful to establish whether the provision is intended to encompass care commissioned from providers in other administrations such as England or commissioned from/ provided in independent care settings.

- ***the duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios which will apply initially in adult inpatient wards in acute hospitals?***

- ***the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?***

  We have also found staffing challenges evident in mental health wards and in community hospitals which would not be covered by the initial guidance. We therefore welcome the provision to enable guidance to be provided in these and other settings.

  However, given our comments about scope in relation to provision 1(a) we would question whether the reference to “settings within the NHS” is too restrictive and whether this might more appropriately be “settings in which NHS care is provided”.

- ***the requirement for the Welsh Government to issue guidance in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:***

  - ***Sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing***

- ***Includes provision to ensure that the minimum ratios are not applied as an upper limit***

- ***Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty***

  We support the need for openness and transparency in communicating to patients.

- ***Includes protections for certain activities and particular roles when staffing levels are being determined.***

  We have conducted three inspections where the Ward Sister has had to undertake a direct care role due to staffing difficulties and had therefore found difficulty in undertaking their role in providing leadership, co-ordination of care and support to other staff. This can result in poor communication, lack of attention to care planning and documentation and also weak discharge planning. We therefore welcome inclusion of protection for the supernumerary status of persons providing supervisory clinical expertise and leadership functions.

  We also welcome the recognition of the need to make time available for training. A number of our inspections have highlighted incomplete mandatory training. We have also highlighted instances where staff have not been able to be released for training or have completed training in their own time.

- ***the monitoring requirements set out in the Bill***

- ***the requirement for each health service body to publish an annual report***

  We welcome the recognition within the Bill that each of the above requirements could be incorporated within existing monitoring and reporting processes. It is important that the requirements of the Bill do not impose additional and excessive bureaucratic overheads on health bodies.

Impact of existing guidance

- ***Do you have a view on the effectiveness and impact of the existing guidance?***

  The existing guidance applies only to general medical and surgical wards. It is a useful baseline, but is not sufficient on its own and needs to be applied alongside acuity tools and professional judgement. Currently the acuity tool is mandated twice a year. Although it could be used more frequently we do not see this often during our inspections and its use could be encouraged further.

Powers to make subordinate legislation and guidance

- ***Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?***

  The balance proposed appears to provide sufficient flexibility for the substantive guidance to be readily amended in light of new research and understanding and in responses to changes in the delivery of care.

Financial implications

- ***Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?***

  HIW is not in a position to comment on the financial implications of the Bill.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Unison Cymru Wales – SNSL(Org) 06 / Tystiolaeth gan Unison Cymru Wales – SNSL(Org) 06

Safe Nursing Staffing Levels Bill
UNISON Cymru Wales written evidence (January 2015)

Introduction

UNISON is the UK's largest healthcare union with over 400,000 members working in the NHS. In Wales, UNISON represents 35,000 members providing NHS services. Our health members are nurses, student nurses, midwives, health visitors, healthcare assistants, paramedics, community care workers, cleaners, porters, catering staff, medical secretaries, clerical and administration staff and scientific and technical staff.

Unless there is a mandatory minimum, quality patient care will suffer. Over 90% of respondents in UNISON's 2013 staffing levels survey said they support mandatory minimum staffing levels, but it has to be acknowledged that quality is more important than quantity; staff numbers are only part of the problem. We believe that compassionate care would not only benefit the patient but also the working lives of our members.

General

Q: Is there a need for legislation to make provision about safe nurse staffing levels?

UNISON believes that there should be a legally enforceable minimum nurse to patient ratio. We support and recognise the role which workforce planning tools have to play in helping organisations identify the right levels, but the use of these must be mandatory and, in the absence of this, the default position should be a legal minimum.

UNISON Cymru Wales has extensively sought the opinions of our members about the Bill, as we believe ongoing consultation with staff on the ground is crucial. Our Welsh members are overwhelmingly in favour of mandatory minimum nurse staffing ratios as they believe that this is the only way to provide a better quality of service for patients, increase staff morale and increase satisfaction in the workplace. For example, some of our members have

described scenarios where they have had to oversee 26 patients in acute areas at one time. This is not only clinically for patients, but also a dangerous working environment for staff.

Our UNISON survey in 2013 found that an alarming 45% of nurses were caring for eight or more patients on their shifts which highlights the need for a safe staffing levels bill. Validated workforce planning is effective in producing safe staffing levels as it is predictive, rather than retrospective and takes into account the fluctuations among the Local Health Boards. It is known that hospitals are the busiest at the weekends and on Mondays, when they are dealing with the backlog of pressures from the weekend's admittances. A workforce planning tool would take into account these issues and therefore could weigh staffing levels differently at the weekend to during the week. On the other hand a legislated ratio is static and does not take these factors into account. UNISON welcomes the reference to validated workforce planning tools in the Bill under Clause (6), but argues that further work needs to be undertaken to decide whether they can be used further.

Q: Are the provisions in the Bill the best way of achieving the Bill's overall purpose (set out in Section 1 of the Bill)?

As highlighted in our original consultation response UNISON believe that, as the proposed application of safe staffing levels doesn't apply to all staff in every health care setting, it detracts from the overall impact and purpose. From our perspective, this is a signification omission and we are disappointed that the Bill does not develop the point further. Extending application to all healthcare staff would allow our dedicated and hardworking members, in all pay bands and in all clinical areas, the time to provide the high level of care they desire, in a safe environment that engenders compassion.

We welcome that the Bill does make reference to healthcare support workers but this definition needs to be tightened up in several regards. The application of ratios of health care workers, other than nurses, should be applied to safe staffing levels in adult care in acute hospitals and beyond. Our members have described situations in which nursing staff are drawn away from clinical duties to undertake basic cleaning duties. Similarly, if inadequate numbers of clerical staff in medical records or wards are employed, nurses end up being diverted from their clinical tasks to clerical duties.

Q: What, if any, are the potential barriers to implementing the provisions of the Bill? Does the Bill take sufficient account of them?

The chief barrier to successful implementation of the Bill and consequential improvements in the Welsh health care system would be the adoption of unrealistic nurse staffing ratios.

UNISON advocates a 1:4 nurse to patient ratio as we believe this will provide the best quality patient care at all times. Studies have shown that there are better clinical outcomes with a ratio of 1:6 or lower and that harm starts to occur when nurses are caring for 8 patients or more, although, clearly, "one size does not fit all". Therefore, each ward/clinical

area must be assessed for its particular appropriate staffing levels both in the day and at night.

Moreover, by only applying a safe staffing ratio to nurses the Bill does not adequately consider the pressure on nurses' duties that are the consequence of inadequate numbers of other healthcare workers, e.g. domestic and clerical staff as previously stated.

The Safe Staffing Alliance, of which UNISON is a member, recommends that nurses must at all times be supported by a sufficient number of healthcare assistants. Yet, the Bills' priorities remain solely focussed on the employment of qualified nurses, often at the expense of Healthcare Assistants. Whilst UNISON welcomed the additional £10 million given by Welsh Government to Health Boards for the employment of additional nursing staff, we have seen examples of Health Boards in Wales downgrading Healthcare Assistants' posts to pay for additional qualified nurses. This is not acceptable and means that qualified nurses are not getting the appropriate level of support to enable them to undertake their duties effectively.

Q: Are there any unintended consequences arising from the Bill?

On no account should the Bill lead to a 'plug gap' situation where staff are robbed from one unit and moved into the inpatient adult acute sector.

The majority of our members believe that there should be a requirement in the legislation for "protected time", for staff training and development built into nurse staffing ratios. Currently there are too many incidences when staff are pulled off mandatory training days to cover sickness on the ward, leaving those staff without the training they need. It should not be an unintended consequence that the Bill increases such situations.

Q: The duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided?

UNISON agrees with Clause 2.5 (b) 'allow for the exercise of professional judgement' as NHS employees are often in the best position to know when systems in the Service are working efficiently and therefore when an appropriate level of nurse staffing is provided.

Education is a crucial force in the protection of both the patient and the worker. Aiken et al. 2004 found that a 10% increase in employment of degree-level educated nurses led to a 7% reduction of an inpatient dying. Increased staffing levels would also alleviate the pressures on practice placement settings, which would make it easier for nurses to dedicate time to support students. This would also benefit the health community at large.

Q: The duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios, which will apply initially in adult inpatient wards in acute hospitals?

It is important that there is a duty on health service bodies in Wales to take all steps to maintain these recommended nurse to patient ratios.

Q: The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

We understand that the duty will first apply to adult inpatient wards in acute hospitals because this is where the main body of evidence lies, however UNISON believes that agreed ratios should not only be restricted to adult care in acute hospitals. UNISON believes that in order for patients to receive the highest possible quality of care, the agreed ratios should be applied and extended to all clinical areas, including Community settings. Applying the duty only to acute hospitals will not sufficiently meet the standards required across the NHS. We understand that in order to extend the ratio there needs to be robust data collection methods and results in place. For this to occur, data collection in other healthcare setting should commence as soon as possible in order to identify reasonable staffing levels.

3 Ibid- the requirement for the Welsh Government to issue guidance 4 in respect of the duty set out in section 10A (1) (b) inserted by section 2(1) of the Bill which: sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing (including methods set out in section 10A(6) inserted by section 2(1) of the Bill)?

We welcome the use of validated workforce planning tools and the exercise of professional judgment within the planning process as methods. However, we believe there should be further consultation and agreement with all interested stakeholders, including employee representative organisations on the tools and methods to be used in establishing staff ratios.

Includes provision to ensure that the minimum ratios are not applied as an upper limit?

UNISON believes that the Bill highlights the importance that minimum ratios are not applied as an upper limit in Clause (5) of the guidance and Clause 6 (b). Safe staffing levels should represent a high quality of staffing levels, and agreed ratios should reflect requirements and circumstances in each hospital. Hospitals should be monitored to ensure that the agreed ratios are not regarded as upper limits, instead ensuring that the applied ratios mean they can deliver a high quality level of care. It is important that NHS organisations regard the agreed ratios as an absolute minimum, and broadly view these minimum ratios as “a level of care below which standards do not fall”.

Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?

The Francis Report was clear about the positive role that information sharing can play. We believe that transparency of staffing levels is an important driver of patient confidence, and patient awareness of roles. Detailing responsibilities and numbers of staff on duty will aid this process.

UNISON agree that information on the numbers and roles of nursing staff on duty should be published in areas accessible to patients and their families, but it is essential that the recording, monitoring and reporting process is streamlined. This view has been echoed in both the Francis Report and the Berwick Review which both found that there needs to be a systematic and responsive approach to determining nurse staffing levels. There are too many examples where nurses, and other health care workers have been caught up in bureaucratic systems which force them to take time away from the patient. NHS staff are already over-worked so any process for reporting data must not increase this burden. The streamlining of the process will not only improve administration for nurses and ward clerks and other staff, but will ensure the clarity required for an accurate system of monitoring.

Publication of such figures is meaningless unless the standards are clearly set and allow for the fluctuations of patient acuity and dependency.

Includes protections for certain activities and particular roles when staffing levels are being determined:

- the requirement for Welsh Ministers to consult before issuing Guidance?

UNISON strongly welcomes the requirement for Welsh Ministers to consult before issuing Guidance.

- the monitoring requirements set out in the Bill?

We suggest that the monitoring requirements set out in the Bill are extended to first include collecting data on whether a nurse's break was taken at an appropriate time, for example if a healthcare worker is working a long day and doesn't receive a break until 8 hours into their shift. Secondly, we believe that indicator 3.1 (h) should be expanded to include staff wellbeing alongside nursing overtime and sickness levels. Thirdly, an additional monitoring requirement that should be included is 'care undone'. In UNISON's report 'Running on Empty: NHS Staff Stretched to the limit', 55% of our members said that due resource constraints care was left undone, even though many of them had not taken their breaks and had worked overtime.

- the requirement for each health service body to publish an annual report?

We welcome the requirement for each health service body to publish an annual report and that it can be published as part of a wider report.

- the requirement for Welsh Ministers to review the operation and effectiveness of the Act as set out in section 3?

UNISON would suggest that for the first year, internal reviews in operation and effectiveness of the Act should be taken on alternative months to confirm that the staffing levels are appropriate. This would increase after the first year of the organisation. In conjunction, we agree that a first whole system review must be carried out as soon as practicable after the end of the one year period beginning with the date when the Act comes into force. We do not agree that subsequent reviews should be carried out at intervals of no more than 2 years. This has the potential to leave long periods of where harm could have occurred, this is especially true for the second review. The monitoring of the Act should be built in to the annual review to ensure that there is continuity across the processes.

We also believe that success of the Bill would be demonstrable improvements in the measures of healthcare as set out in 3(5), including for example, the measures should also include a monitoring of reductions in length of stay in hospital.

Q: Do you have a view on the effectiveness and impact of the existing guidance?

UNISON supported both the 2012 All Wales Nurse Staffing Principle Guidance and the 2014 NICE guidelines on 'Safe staffing for nursing in adult inpatient wards in acute hospitals'. The All Wales Nurse Staffing Principle Guidance was based on acuity rather than solely patient numbers and many of the Local Health Boards defined a range of safe staffing nurse's levels rather than a single defined figure. The 2012 guidance issued to the Health Boards in Wales recommended that the number of patients per registered nurse should not exceed 7 by day, which although is a move in the right direction, is still too high to provide a safe level of care. The guidance also lacked effective implementation as it was not a statutory requirement. The 2014 NICE guidelines are more similar to the proposed Bill and share similar issues such as 'plugging the gap' and the lack of reference to 'care undone' (where a number of staff reported that care was left undone).

Q: Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

The ability to extend the bill to additional healthcare settings that is currently subordinate legislation is welcomed and should not be disregarded.

<u>Financial implications</u>

Q: Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

Costs are always a concern and how the upfront costs impact the Welsh Public Health service is extremely important. However, findings by Bray et al. 2004 suggest that there is no evidence of overall cost increases, as the increase in funding for more nurses balances out with reduced costs associated with the length of stay of a patient and fewer infections. We would like a commitment from the Government that upfront costs will not be cut to the disadvantage of the Welsh Healthcare worker.

Q: Do you have any other comments you wish to make about the Bill or specific sections within it?

This Bill, if enacted properly, should lead to a marked improvement in the standards of healthcare in Wales. The 2009 Boorman Review into NHS Health and Wellbeing established solid links between understaffing, stress, job satisfaction and patient care.

While safe staffing levels are a positive move we believe that this should be applied to the whole health care system. To be a truly first class health care system the Welsh Government need to improve staffing ratios for all healthcare workers.

UNISON welcome further consultation throughout this process and look forward to speaking to the Committee in due course.

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG CYMRU

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)

Briefing for:	National Assembly for Wales, Health and Social Care Committee.
Purpose:	The Welsh NHS Confederation response to the Inquiry into the general principles of the Safe Nurse Staffing Levels (Wales) Bill
Contact:	Nesta Lloyd – Jones, Policy and Public Affairs Officer, Welsh NHS Confederation [redacted] Tel: [redacted]
Date created:	08 January 2015.

Evidence from The Welah NHS Confederation – SNSL(Org) 03 / Tystiolaeth gan Conffederasiwn GIG Cymru – SNSL(Org) 03

Introduction.

1. The Welsh NHS Confederation, on behalf of its members, wholeheartedly welcomes the opportunity to respond to the inquiry into the general principles of the Safe Nurse Staffing Levels (Wales) Bill.

2. By representing the seven Health Boards and three NHS Trusts in Wales, the Welsh NHS Confederation brings together the full range of organisations that make up the modern NHS in Wales. Our aim is to reflect the different perspectives as well as the common views of the organisations we represent.

3. The Welsh NHS Confederation supports our members to improve health and well-being by working with them to deliver high standards of care for patients and best value for taxpayers' money. We act as a driving force for positive change through strong representation and our policy, influencing and engagement work. Members' involvement underpins all our various activities and we are pleased to have all Local Health Boards and NHS Trusts in Wales as our members.

4. The Welsh NHS Confederation and its members are committed to working with the Welsh Government and its partners to ensure there is a strong NHS which delivers high quality services to the people of Wales.

Summary

5. As with our response to the earlier consultations on this Bill,[i] we feel it is important to highlight that the Welsh NHS Confederation wholeheartedly supports any initiative aimed at proactively improving patient safety. Our members are committed to delivering high quality care which results in the best possible outcomes for patients and their families. However, we must

emphasise that, while vital, nursing ratios and nurse staffing levels are one of many elements to consider - alongside technology, training, education, planning and good leadership - when it comes to patient safety.

6. It is also important to highlight the need for flexibility when it comes to staffing levels. The number of nurses required may vary depending on local need, the complexity of an individual patient's condition and the type of ward the patient is on. Any changes to nurse staffing should be evaluated on the basis of their impact on patient outcomes and patient experience.

7. Nurses, working as part of a wider multidisciplinary team, play a vital role in achieving the outcomes that we want for the NHS: an NHS that provides quality care and excellent outcomes for patients. Our vision for the NHS is that it meets the needs of the people it serves, and is ready to change to meet those needs in the future. This vision includes:

- Looking after patients as a 'whole person'. Patients are fully informed about their care and involved in decision-making.
- Supported self-care will be the norm for the 800,000[ii] people living in Wales with long-term conditions, with technology supporting choice, self-reporting, and monitoring.
- Everyone will receive fully integrated care, built around general practice and extended primary care teams alongside social care, the third sector and carers.
- Acute and elective episodes will be dealt with in a bed in hospital where necessary. Hospitals will be designed to be the most local they can be and be appropriately staffed and set up to be sustainable by working closely with local GPs, councils and community services.
- Specialist centres will be at the heart of delivering world class outcomes, leading the way in innovation, research and development and cutting edge medicine.
- There will be seven day urgent and emergency care because it shouldn't be the case that people are more likely to die in hospital on a Sunday than a Tuesday, or that when people fall in care homes the only place to take them is A&E.
- Nursing staff, along with other NHS staff should make every contact count, collaborating with individuals and the public in improving individual and population health outcomes.
- The effective commissioning of registered nurse training places will be key to meeting safe staffing targets in acute and community settings, thereby reducing the need for overseas recruitment.

8. To demonstrate that we have achieved our vision we must ensure:

- Positive outcomes for patients;
- A reduction in health inequalities;
- A passionate, highly-trained workforce; and
- Helping more people avoid hospital admission through improved community and social services.

9. Nurses play a vital component in this vision. However they are still only one part of a wider multidisciplinary team that can achieve this. We believe a more appropriate approach would be to ensure wards have both the right numbers of staff and skill mix to meet patients' needs, recruiting staff more on their values and better training for nurses to make sure all care is delivered in a safe and compassionate way.

Questions

i) Is there a need for legislation to make provision about safe nurse staffing levels?

10. Improving patient safety is the heart of the NHS in Wales but mandatory staffing levels cannot guarantee safe care. While it is absolutely the case that good nursing is vital if high quality care is to be delivered everywhere, it is too simplistic to say any issues with care can be resolved through increasing resources and safe nurse staffing levels. Overall we do not agree that introducing legislation that imposes a crude system of staffing ratios is the right way to tackle poor patient care, and inquiries, including the Mid Staffordshire Public Inquiry,[iii] found that minimum staffing levels do not necessarily improve patient outcomes.

11. The Mid Staffordshire Public Inquiry heard evidence from California, where minimum nurse to patient ratios were introduced in 2004. A research paper, presented by Leeds University professor Dawn Dowding, found no apparent difference in outcomes between California and other states that did not have minimum staffing levels. The report suggests that there are many other variables which have a high impact on the quality of patient care – such as quality of medical technology, culture, ongoing staff education and management practices.[iv]

12. Furthermore, when comparing the UK health systems with other countries in relation to equity and safe care, the UK ranks highly. The 2014 Commonwealth Fund report[v] compared the UK health system with the healthcare systems of eleven other countries (including Australia, Canada, Germany, Netherlands, New Zealand and USA), and the UK NHS was found to be the most impressive overall. The NHS in the UK was rated as the best system in terms of co-ordination, efficiency, effectiveness, safety and providing person-centred care.

13. There is the potential for safe nurse staffing levels to be further implemented through other ways rather than legislation. Safe staffing could become a Tier 1 standard/indicator that could be implemented with more speed than legislation. Further assessment of efficacy in delivering safe staffing levels could be introduced via the performance management mechanisms between Welsh Government and the Health Boards and Trusts**.**

14. Instead of introducing legislation, a better response could be ensuring we get the right staffing pattern and skill mix to meet patients' needs; to recruit staff more on their values; better training of nurses; the further commissioning of registered nurse training places and making sure all staff operate in organisations that value compassion and care.

15. There are also concerns about the proliferation of documentation that frontline nurses are now expected to complete in response to a range of national developments and programmes. All of these have value, but an unintended consequence of this administrative workload can detract from their ability to provide patient focused care. Overall we believe that any initiative to improve patient safety, whether legislation or otherwise, must be based on evidence that demonstrates the best results for patients.

ii) Are the provisions in the Bill the best way of achieving the Bill's overall purpose (set out in Section 1 of the Bill)?

16. Section 1 of the Bill states that its purpose is to ensure nurses are deployed in "*sufficient numbers*" to enable "*provision of safe nursing care to all patients at all times*". However, there is no definition of what would be regarded as "*safe nursing care*" therefore it is unclear what the overall purpose of the Bill is and what patient outcome it is attempting to achieve in practice.

17. While NHS Nurse Director's in Wales support the setting of safe staffing levels, they would stress that there needs to be clear professional judgment applied to ensure that flexibility in staffing remains a critical part of meeting patient needs. The use of workload and acuity tools should help inform the setting of staffing levels.

18. Already in Wales, in response to the Francis Report,[vi] there is an assessment process to determine staffing levels on wards, based on the severity of patients' conditions (acuity) rather than solely patient numbers. The core principles, developed by the Chief Nursing Officer and issued to all Health Boards in Wales in 2012,[vii] include:

- the number of patients per registered nurse should not exceed seven by day;
- a night time ratio of one nurse to 11 patients;
- the skill mix of registered nurse to nursing support worker in acute areas should generally be 60:40.

19. In July 2013 the National Assembly for Wales Research Service produced a research note[viii] which highlighted that most Local Health Boards in Wales are meeting, or exceeding, these ratios.

iii) What, if any, are the potential barriers to implementing the provisions of the Bill? Does the Bill take sufficient account of them?

20. One of the potential barriers to implementing the provisions of the Bill is that it takes little consideration for the workforce needed for the future and how it links with patient outcomes. When considering the best outcomes for patients, we need to help create a workforce that is fit for the future, including the nursing profession. The healthcare system must be redesigned around the service user, supporting people to maintain their own well-being and staying as healthy as possible and utilising community and local services rather than going to hospital or to a GP surgery.

21. The population of Wales is projected to increase by 4% to 3.19m by 2022[ix] and we have a rapidly ageing population, with the number of people over 65 in Wales set to rise to 26% of the total population by 2033.[x] The NHS will need to respond to significant future challenges in respect of high rates of chronic conditions, long-term limiting illness, obesity, poverty and health inequalities. Demand for services is set to increase significantly and the NHS workforce must be ready to change, respond and react to the challenges ahead.

22. The NHS will always need to treat people with high level, emergency, specialist and intensive care. However, there is a need for system-wide changes if models of care that are more community based are to be implemented.As the Welsh NHS Confederation discussion paper 'From Rhetoric to Reality - NHS Wales in 10 years' time'[xi] highlighted: "*With ongoing financial constraints, the previous growth in the workforce has ceased. Yet the future supply and availability of clinical staff is crucial to the quality, range, shape and organisation of health services as we seek to do more with fewer staff. Delivering more of the same through traditional roles and ways of delivering care will not be an option. NHS Wales and its staff will simply have to work differently to meet increasing demands, and to be responsive to needs at the same time as ensuring high quality, compassionate, effective care.*"

23. There is a need to think radically about the workforce of the future, the skills that NHS Wales will need and who will be the key decision makers in patient pathways, coupled with the need to design workforce models which are deliverable and the impact of 'prudent healthcare'. We need

help to build consensus around what a sustainable future workforce will look like and how it will be developed.

24. A workforce that is fit for the future must include people who can work effectively across professional and organisational boundaries - including across health and social care; and harness and promote innovation and technological development. The need to balance the development of generic skills required to provide care to an ageing population and recognition of the place of self-care in developing models will all impact on how we think about and plan the workforce. More generalist and less specialist competencies are needed throughout the workforce to support the increasing number of people with complex health and care needs.

25. Further information about the future workforce will be highlighted in a briefing produced by Welsh NHS Confederation, NHS Wales Employers and Workforce Education Development Services. The briefing is due to be published at the end of January and will provide a summary of the key issues facing the NHS Wales workforce based on the elements of Integrated Medium Term Plans produced by Health Boards and Trusts, together with a high level review of other UK and Wales data and information sources.

iv) Are there any unintended consequences arising from the Bill?

26. There is some concern from NHS Wales Nurse Directors that mandatory staffing levels may result in less flexibility, a lower value and reliance on professional judgment and may mean that staffing levels do not respond to changes in patient acuity and dependency.

27. Other unintended consequences arising from the Bill includes:

a) While Section 10 (A) (5) (e) states that the guidance to health service bodies in Wales *"must include provision for ensuring that the recommended minimum ratios are not applied as an upper limit in practice"* it is unclear what this provision will be and therefore minimum staffing levels could be interpreted as maximum which potentially puts additional stress into clinical areas regarding safe staffing levels.

b) Clear consideration needs to be given to circumstances where recruitment into posts is a key constraining factor. Already nurse supply and demand issues are proving challenging for a number of NHS organisations across the UK at present. Recently NHS Employers conducted a survey[xii] for Health Education England to gather robust and timely intelligence from employers in England about the current nurse workforce demand and their views on supply issues. Of the 90 organisations surveyed, 83% reported that they are experiencing qualified nursing workforce supply shortages, and of 49 organisations surveyed 45% had actively recruited from outside of the UK in the last 12 months to fill nursing vacancies.

c) Each NHS hospital and service has different demands on its services. Arbitrary ratios could limit organisations' ability to plan care in a way that is best for the patient and limits the way we use the skills of other staff like physiotherapists and occupational therapists.

d) There is potential for one part of the system, nurses in adult acute wards, to be prioritised in relation to staffing above others. One example is that community nursing could see reductions in staffing in order to comply with legislation in hospital settings.

e) The role of nurses could be adversely modified to take on broader roles which would not have ordinarily be seen as nursing, thus impacting on the time to care of registered nurses in particular. There is already some evidence that nurses are utilised for many differing roles

including, for example, bed management and patient flow, presenting a challenge to direct clinical care.

f) There is potential diversion of funds away from other members of the healthcare team that play an important role in patient care. Nurse numbers and ratios do not take into account the role of speech therapists, occupational therapists, physiotherapists, dieticians and others. Will vacancies be held in these staff groups to pay for more nurses? This would be significantly detrimental to holistic patient care and outcomes.

g) Any legislative framework is likely to become outdated over time. This may be more prominent in relation to staffing where models of health and social care are changing, as highlighted above in response to question iii.

h) Having more staff does not equate to a more productive service. As highlighted within a recent report by The King's Fund,[xiii] on the future financial sustainability of the NHS in Wales, increased funding over the last decade has allowed the Welsh NHS to employ more staff, and in general to produce more activity. However, productivity, measured by hospital activity per head of staff, has fallen among medical staff. While activity among medical staff has also fallen in England over the same period, the decrease has not been as great, and nursing productivity, which has remained stable in Wales, has increased across the border. Many of the most significant opportunities to improve productivity will come from focusing on clinical decision making and reducing variations in clinical practice across the NHS, and shifting the focus away from hospital-led, acute services. Reducing variations in clinical service delivery and improving safety and quality should be key priorities for providers.

v) The duty on health service bodies to have regard to the importance of ensuring an appropriate level of nurse staffing wherever NHS nursing care is provided?

28. Health Boards and Trusts presently take full responsibility for the quality of care provided to patients and for nurse staffing capacity and capability. Health Boards and Trusts ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day and night. This includes identified time set aside for nurses to have continued professional development.

29. The current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales is adequate and appropriate. Most areas are utilising rostering systems that support a focus on staffing levels to meet the requirements of individual wards and can be used for monitoring purposes (planned versus actual staffing). These also help to identify the level of additional/flexible staffing required such as bank or agency staff.

30. In addition, currently there are periodic but regular reports into Welsh Government in relation to the implementation against the Staffing Principles for acute medical and surgical wards.

vi) The duty on health service bodies to take all reasonable steps to maintain minimum registered nurse to patient ratios and minimum registered nurse to healthcare support workers ratios, which will apply initially in adult inpatient wards in acute hospitals?

31. As highlighted previously, it is essential that professional judgment and the use of acuity type tools help inform decisions locally regarding staffing levels. It's not just about numbers but the right staff with the right skills within the service.

vii) The fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

32. There is clear evidence that staffing levels in acute medical and surgical settings impact upon care quality and patient outcomes. However, there is not as much evidence to support this in other settings.

33. Safe staffing levels should only be developed with the use of professional judgment and a risk balanced approach to settings other than acute medical and surgical wards. The development of community services will require, for example, sufficient numbers and skill of community nurses often within and as part of multi-professional and multiagency teams. Other settings include mental health, learning disabilities, health visiting and critical care settings for example. In some areas of practice Royal Colleges and other professional associations (such as neonatal) already produce guidance in relation to staffing and the use and emphasis on these could be more useful.

34. It is imperative that safe staffing plans are also developed for community hospital, community health, mental health and child health services.

viii) The requirement for the Welsh Government to issue guidance in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:

35. It is important to emphasise that each hospital and service has different demands on its services and often it is down to professional judgement to make sure organisations have the ability to respond to these demands. Although section 10 (5) (b) says guidance would specify the minimum nurse to patient ratios, *"which individual health service bodies may adjust so as to increase the minimum numbers of nurses for their hospitals,"* mandatory staffing levels may result in less flexibility than the current system.

36. Section 10A (1) (6) (b) of the Bill says the guidance must *"allow for the exercise of professional judgement within the planning process."* However there is concern from Nurse Directors that the setting of staffing levels will lower the value of this professional judgement. As a result, staffing levels may not be able to respond to changes in patient acuity and dependency.

ix) Sets out methods which NHS organisations should use to ensure there is an appropriate level of nurse staffing (including methods set out in section 10A(6) inserted by section 2(1) of the Bill)?

37. As highlighted previously it is important that when considering safe staffing it is important to involve the use of evidence-based and workforce planning tools, allow for the exercise of professional judgement within the planning process, makes provision for the required nursing skill-mix needed to reflect patient care needs and local circumstances. Many of these methods are already being implemented across health services in Wales.

38. Staffing agreements should be based on a triangulated approach, including professional judgement and an acuity tool. The acuity tool currently being tested has shown variable and some unexpected results; further validation would be welcome to demonstrate its reliability as a workforce tool. Until the acuity tool is finally validated nursing principles should remain in place.

x) Includes provision to ensure that the minimum ratios are not applied as an upper limit?

39. The setting of minimum nurse to patient ratios should not be read to mean 'maximum'. There is a concern that this Bill may have unintended consequences in that the minimum may well be applied as the maximum. Although section 10 A (1) (5) (e) says the guidance must include a provision for ensuring that the recommended minimum ratios are *"not applied as an upper limit in practice"* there are questions over how this will be monitored. Also, each ward should have flexibility depending on the needs of its patients. Many of the most significant opportunities to improve productivity will come from clinical decision making and reducing variation in clinical practice across the NHS, which will also improve safety and quality.

xi) Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?

40. NHS Wales has become more transparent and accountable and is further developing a culture of honesty and openness so the service can learn from mistakes and improve activities. Increased transparency is a key driver in improving quality across the NHS as a whole, highlighting both those areas where good practice is in place and those where there is scope for improvement. All Health Boards and Trusts are improving visibility and ease of access to information to ensure that patients and the public are informed. Adopting an approach where organisations volunteer such information as part of quality improvement should enable a clear move in the direction of full openness and transparency.

41. While we are in support of the publication of information, the value of publically available reports would not be in simply publishing how many staff are on duty, but rather the numbers of occasions where safe staffing could have been compromised and the outcome. This must engender a collective responsibility and consideration of the actions that brought about a 'shift of concern', sending a clear message to staff of the commitment to ensure staffing meets the patient needs on a risk balanced and professional judgment basis.

xii) Includes protections for certain activities and particular roles when staffing levels are being determined?

42. As highlighted previously, it would be difficult to protect certain activities and particular roles when staffing levels are being determined because each NHS hospital and service has different demands on its services and patients have different clinical needs.

xiii) The requirement for Welsh Ministers to consult before issuing guidance?

43. It is important that the Welsh Minister consults with Local Health Boards and Trusts, and others who are likely to be affected by the guidance. Due to some uncertainties within the Bill, for example what is the definition of *"safe nurse staffing levels"* the guidance will be key to achieving the Bill's overall purpose.

xiv) The monitoring requirements set out in the Bill?

44. The current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales is adequate and appropriate.

xv) The requirement for each health service body to publish an annual report?

45. Section 10A (10) of the Bill highlights the need for information to be made public and for each health service body in Wales to publish an annual report. As highlighted previously, the NHS in Wales is committed to transparency in the interests of accountability and has worked hard to improve this. A wide range of information, including performance data, mortality rates and inspection reports are all published in the public domain.

xvi) The requirement for Welsh Ministers to review the operation and effectiveness of the Act as set out in section 3?

46. In reference to some of the measures mentioned in the Bill under section 3 (5), there is concern about how these would be defined and monitored. For example, in terms of the number of falls on a ward, what would be the number that would be a cause for concern? Also in relation to mortality rates as a measure of hospital quality and safety, a number of reviews have highlighted that the measure is not always a meaningful measure of quality, and can be misleading.[xiv] There needs to be a multidimensional approach to measuring healthcare, given the complexity of this area. Furthermore, many of the measures listed in the Bill will depend on the kind of ward.

xvii) Do you have a view on the effectiveness and impact of the existing guidance?

47. The existing guidance is effective and does have an impact on staffing levels. The Chief Nursing Officer (CNO) together with Nurse Directors have embarked on a programme of work aimed at collating evidence regarding staffing levels that improve patient/client outcomes; and the application of evidence in the form of tools for calculating and implementing staffing levels. This work preceded that being undertaken by NICE on acute wards staffing and will be largely in line with timetables for other areas of nursing practice.

48. Regular monitoring of progress against the Nurse Staffing Principles for acute medical and surgical wards has been taking place by Welsh Government (via the CNO Office). This does not currently however form part of the Tier 1 indicators and measures of Welsh Government.

xviii) Do you have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

49. It is important that certain aspects of the Bill should be on the face of the Bill and not left to subordinate legislation and guidance, for example a clear definition of what is the "provision of safe nursing care" should be defined within the Bill and what it is attempting to achieve.

xix) Do you have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

50. This can only be truly understood when the scope of the Bill is clearly articulated, including the publication of the subordinate legislation and guidance. Not taking account of the above unintended consequences, and ensuring an equitable application of safe staffing levels in all settings, is likely to incur considerable costs. This would include additional data collection, collation, validation and publication.

51. As highlighted in our response[xv] to the National Assembly for Wales Finance Committee inquiry into Welsh Government draft budget proposals for 2015-16 the demand on the health service is growing and the rising cost of providing the service means that the NHS faces a significant funding gap, at the same time as an understandable expectation of improving the quality and safety of services. This means that the NHS will not be able to continue to do all that it does now, and certainly not in the same way.

52. The key critical factor when considering the financial implications of the Bill is whether the outcomes desired by this Bill can be achieved by means other than legislation. The cost and complexity of this Bill may mean that there are more cost effective and more rapid means of achieving the same outcomes.

53. There must be appropriate funding to ensure that safe nurse staffing levels are not resourced through the depletion of other services. There would need to be a clear commitment by the government that legislated staffing levels are also fully funded if safe staffing principles were to be implemented within Wales.

xx) Do you have any other comments you wish to make about the Bill or specific sections within it?

The importance of multidisciplinary teams

54. As previously highlighted multidisciplinary teams are vital to ensure that patients receive quality of care and receive excellent outcomes.

55. International evidence suggests that mandated registered nurse to patient ratios can improve nurse staffing and lead to better recruitment, generate a more stable workforce, and more manageable workloads for staff. The impact on patient outcomes is less clear but there is evidence that the resultant lower caseloads are related to lower levels of patient mortality. However, if we are to resolve possible issues within the Welsh NHS and improve patient care, we need to take a broad and deep view that looks honestly and openly at all aspects of the NHS, not just one group of staff.

56. Staffing levels may well be an issue in some parts of some hospitals in Wales, but it is not the case that we need more nurses everywhere. A better response would be to ensure we get four things right - the right staffing pattern and skill mix for each service, recruitment of NHS staff based more on their values, better training for nurses at the ward leader level, and ensuring nurses operate in organisations that value compassion and care. It is critical that we empower senior clinicians and managers at a local level to take greater responsibility for setting high standards of care, including determining the right staffing pattern for delivering these standards for their patients.

57. Multidisciplinary working has the opportunity to significantly reduce the strain on our services in the future, alongside building and learning new skills, we must collaborate and support our partners in other sectors, including social services, housing, education, transport and the third sector. This collaboration "*between specialists and generalists, hospital and community, and*

mental and physical health workers"[xvi] will play a big part in making sure our services are sustainable for the future.

Engaging with the public

58. To ensure positive outcomes for patients we must engage with the public and consider their views about staffing issues and the impact that improved nurse staffing levels have on their individual care.

59. We know that the NHS in Wales must do more to involve the public and patients, staff and partner services in explaining and working through the choices that need to be made. In our discussion document 'From Rhetoric to Reality - NHS Wales in 10 years' time'[xvii] we referred to building a new understanding of how the NHS should be used, embodied by an agreement with the public that would represent a shared understanding: *"Involving the public is central to realising an NHS where patients and the public are key and valued partners, where they are seen as 'assets'. "*We highlighted the importance that as time progresses we must ensure we work with the public to co-produce services and reduce demand, releasing capacity in the system. While some people will not want to engage, all have the right to be given the opportunity to do so.

60. Although co-design and co-production are beginning to happen in some parts of the public sector, the prevailing mindset in many areas is still one in which citizens and service users are passive recipients of services. In order to move towards the kind of engagement needed there is a major cultural shift required to move away from the view of public services as delivery agents to passive populations, to a greater focus on localities in which everyone does their bit.

61. The future success of the NHS relies on us all taking a proactive approach to health and ensuring that we create the right conditions to enable people in Wales to live active and healthy lifestyles. The sustainability of the NHS and other public bodies is the responsibility of everyone in Wales, but there appears to be a real lack of understanding that this is the case.

Integration

62. In addition to the role multidisciplinary health teams play in providing quality care and excellent outcomes for people, it is important that the role of other sectors should also be considered in people's well-being and care.

63. Integration and multi-agency working is key for the Welsh NHS Confederation because to tackle the culture of ill health in Wales we must recognise that health is much more than health services. As 'From Rhetoric to Reality – NHS Wales in 10 years' time'[xviii] highlighted, better health is the responsibility of all sectors and engagement is necessary with all our public service colleagues, from social care to housing, education and transport, to take us all from an 'ill-health' service that puts unnecessary pressure on hospital services, to one that promotes healthy lives. In serving the public the NHS must consider its own success with regard not only to treating healthcare needs, but more importantly, in relation to the ability of other sectors to impact on the quality of life for individuals. As the paper highlights: "*Health and healthcare must be premised on how we best support people to maintain their health, with the aim of eliminating or reducing their potential to require NHS services, and we must work in an integrated way with all sectors across Wales*."

64. The NHS must build on how it might improve its ability to work and support partners and colleagues in other sectors to reflect the multi-disciplinary demands required to run public services in a holistic way. There is a need for wholesale change to ensure that there are positive outcomes for patients, a reduction in health inequalities and to help people avoid hospital admission through improved community and social services. To achieve these outcomes it is vital that health is not seen as a stand-alone issue and that integration is prioritised. All public bodies in Wales must build on how we might improve our ability to work together and support our partners and colleagues in other sectors to provide the best outcomes for the people of Wales.

65. The Welsh NHS Confederation is already working closely with ADSS Cymru on the 'Delivering Transformation', previously 'Strengthening the Connections', project to take the practical steps required for the integration of health and social care services. Our close work with this body, and other key partners, is ensuring that there is no compromise in the quality of the service and the ability to safeguard individuals from the services operated by our members.

Conclusion

66. The Welsh NHS Confederation welcomes the debate on safe nurse staffing levels, but there are a number of important questions to be answered in order to determine whether legislation is the most appropriate approach.

67. Improving patient safety is at the heart of the NHS in Wales but mandatory staffing levels cannot guarantee safe care. While it is absolutely the case that good nursing is vital if high quality care is to be delivered everywhere, it is too simplistic to say any possible issues with care can be resolved through increasing resources.

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[i] The Welsh NHS Confederation, June 2014. Response to the 'Minimum Nurse Staffing Levels (Wales) Bill' and the Welsh NHS Confederation, September 2014. Response to the 'Safe Nurse Staffing Levels (Wales) Bill'.
[ii] Wales Audit Office, March 2014. The Management of Chronic Conditions in Wales – An Update.
[iii] Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009.
[iv] The Mid Staffordshire NHS Foundation Trust Public Inquiry (2010) http://www.midstaffspublicinquiry.com/inquiry-seminars/nursing
[v] The Commonwealth Fund, June 2014.Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally
[vi] The Mid Staffordshire NHS Foundation Trust Public Inquiry
[vii] Welsh Government, April 2012. Chief Nursing Officers Guiding Principles for Nurse Staffing in Wales
[viii] National Assembly For Wales, July 2013, Nurse staffing levels on hospital wards
[ix] Nuffield Report, June 2014. A decade of austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26.
[x] National Assembly for Wales, 2011. Key issues for the Fourth Assembly.
[xi] The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.
[xii] NHS Employers, May 2014. NHS Qualified Nurse Supply and Demand Survey – Findings.
[xiii] The King's Fund, 2013. A review of the future financial sustainability of health care in Wales.
[xiv] Stephen Palmer, June 2014. A Report to the Welsh Government Minister for Health and Social Services to provide an independent review of the risk adjusted mortality data for Welsh hospitals, considering to what

extent these measures provide valid information, focusing initially on the six hospitals with a Welsh Risk Adjusted Mortality Index (RAMI) score of above 100 in the data published on Friday 21 March 2014.

[xv] The Welsh NHS Confederation, September 2014. National Assembly for Wales Finance Committeecall for information into Welsh Government draft budget proposals for 2015-16.

[xvi] Kings Fund, July 2013. NHS and social care workforce: meeting our needs now and in the future?

[xvii] The Welsh NHS Confederation, January 2014. From Rhetoric to Reality – NHS Wales in 10 years' time.

[xviii] Ibid

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Thursday, 29 January 2015**
Meeting time:	**09.02 – 15.58**

This meeting can be viewed on Senedd TV at:
http://senedd.tv/en/2667

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Alun Davies AM** **Janet Finch-Saunders AM** **John Griffiths AM** **Elin Jones AM** **Darren Millar AM** **Lynne Neagle AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM (for items 9 – 14)** **Peter Black AM (In place of Kirsty Williams AM for items 1 – 7)**
Witnesses:	**Tina Donnelly, Royal College of Nursing** **Lisa Turnbull, Royal College of Nursing** **Rory Farrelly, Abertawe Bro Morgannwg University Health Board** **Ruth Walker, Cardiff and Vale University Health Board** **Dr Phil Banfield, BMA Cymru Wales** **Dr Victoria Wheatley, BMA Cymru Wales** **Dr Rhid Dowdle, Royal College of Physicians** **Dr Sally Gosling, Chartered Society of Physiotherapy** **Philippa Ford, Chartered Society of Physiotherapy**

	Dr Alison Stroud, Royal College of Speech and Language Therapists Dr Charlotte Jones, BMA Cymru Wales Dr Philip White, BMA Cymru Wales Dr Peter Horvath-Howard, BMA Cymru Wales Dr Paul Myers, Royal College of General Practitioners Dr Rebecca Payne, Royal College of General Practitioners Mary Beech, Wales Deanery Dr Martin Sullivan, Wales Deanery
Committee Staff:	Llinos Madeley (Clerk) Helen Finlayson (Second Clerk) Christopher Warner (Clerk) Sian Giddins (Deputy Clerk) Rhys Morgan (Deputy Clerk) Sian Thomas (Researcher) Philippa Watkins (Researcher) Gwyn Griffiths (Legal Adviser) Enrico Carpanini (Legal Adviser)

Transcript
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 There were no apologies.
1.2 For items relating to the Safe Nurse Staffing Levels (Wales) Bill, Peter Black substituted for Kirsty Williams.

2 Safe Nurse Staffing Levels (Wales) Bill: evidence session 2

2.1 The witnesses responded to questions from Members.

3 Safe Nurse Staffing Levels (Wales) Bill: evidence session 3

3.1 The witnesses responded to questions from Members.
3.2 Rory Farrelly agreed to supply the Committee with additional information regarding Abertawe Bro Morgannwg University Health Board's recent recruitment plan to fill the 140 nursing vacancies reported within the Health Board. Rory Farrelly also agreed to clarify the relevant closing dates for applications and the number of applications received.

4 Safe Nurse Staffing Levels (Wales) Bill: evidence session 4

4.1 The witnesses responded to questions from Members.

5 Safe Nurse Staffing Levels (Wales) Bill: evidence session 5

5.1 The witnesses responded to questions from Members.

6 Motion under Standing Order 17.42(vi) to resolve to exclude the public from items 7 and 8

6.1 The motion was agreed.

7 Safe Nurse Staffing Levels (Wales) Bill: consideration of evidence received

7.1 The Committee considered the evidence received.

7.2 The Committee agreed to seek additional information about the arrangements in place in Scotland to mandate safe nurse staffing levels without legislation.

8 Regulation and Inspection of Social Care (Wales) Bill: preparation for scrutiny

8.1 The Committee noted the Business Committee's decision in principle to refer the Bill to the Health and Social Care Committee for Stage 1 and Stage 2 scrutiny and agreed to write to the Business Committee to indicate that it had no significant concerns about the proposed timetable.

8.2 The Committee agreed to write to stakeholders about the introduction of the Bill.

9 Inquiry into the GP workforce in Wales: evidence session 1

9.1 The witnesses responded to questions from Members.

10 Inquiry into the GP workforce in Wales: evidence session 2

10.1 The witnesses responded to questions from Members.

11 Inquiry into the GP workforce in Wales: evidence session 3

11.1 The witnesses responded to questions from Members.

11.2 The witnesses agreed to provide the Committee with additional information regarding:

- an outline of the costs associated with increasing the GP training recruitment target from 136 spaces to a minimum of 200 (as recommended by the British Medical Association) or to a number that they felt would be realistic; and

- a breakdown of the areas and localities in Wales where training spaces have not been filled over the past 3 years.

12 Papers to note

12.0a The Committee noted the minutes of the meeting on 15 January.

12.1 Legislative Consent Memorandum: Medical Innovation Bill: correspondence from the Minister for Health and Social Services

12.1a The Committee noted the correspondence.

12.2 Correspondence from the Petitions Committee: P 04-600 Petition to Save General Practice Wales

12.2a The Committee noted the correspondence.

13 Motion under Standing Order 17.42(vi) to resolve to exclude the public from the remainder of the meeting and for item 1 of the meeting on 4 February 2015

13.1 The motion was agreed.

14 Inquiry into the GP workforce in Wales: consideration of evidence received

14.1 The Committee considered the evidence received.

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Cymru
Royal College of Nursing
Wales

Royal College of Nursing
Ty Maeth
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Tina Donnelly CBE, TD, DL, CCMI, MSc (ECON), BSc (Hons), RGN, RM, RNT, RCNT, Dip N, PGCE
Director, RCN Wales

Telephone [redacted]
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3 February 2015

Mr David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales
Cardiff
CF99 1NA

Dear David Rees

Inquiry into GP Workforce in Wales

We understand that the Health & Social Care committee is currently undertaking an Inquiry into the GP workforce in Wales specifically examining;

- barriers to GP recruitment and retention;
- whether the commissioning and delivery of medical training currently supports a sustainable GP workforce; and
- the actions needed to ensure the sustainability of the GP workforce.

There can be no doubt that some regions of Wales are really struggling to recruit sufficient numbers of GPs and this is an important area of policy for the Committee to address.

Continued.....

Accessible primary care services are vital, both to the improving the health of the public and ensuring the effective operation of secondary care services (including emergency care). GP surgeries are at the heart of the primary care system and their sustainability is essential.

The RCN are sure Committee members are well aware that GP surgeries must work closely with Community Pharmacy, Colleagues in Secondary Health Care and the Community Nursing Service, in order to deliver effective care to the patient. However they may be less aware that even a 'traditional' GP surgery is an effective multi-disciplinary team led by the GP and including practice nurses and health care support workers and increasingly pharmacists.

Practice Nurses undertake a huge range of tasks, addressing public health, travel health, the management of long-term conditions and cervical cytology. Registered nurses can undertake a two year postgraduate course to become Nurse Practitioners and would be senior nurses within the practice responsible for nurse led clinics, minor illness, triage, supplementary or independent prescribing.

The Welsh Government published its plan for a primary care service in Wales up to March 2018 and the Ministerial states clearly:

At a time of such pressures we have to use the clinical skills and abilities of all members of the primary care team to their maximum. No GP should routinely be undertaking any activity which could, just as appropriately be undertaken by an advanced practice nurse, a clinical pharmacist or an advanced practitioner paramedic. No advance practice nurse should routinely be undertaking activities which could be, equally successfully, be undertaken by a healthcare support worker.

This approach means that considering GP recruitment – and assuring potential future GPs of a modern and effective working environment needs to be considered as part of a wider professional workforce plan.

The Royal College of Nursing believes that in some areas it will be suitable for the Welsh Government to develop primary care centres/surgeries which employ salaried GP and nurse practitioners. There is considerable evidence that advanced nurse practitioners benefit patient care and at the same time support the GP in providing a more effective service. Nurses who can independently prescribe can speed up

Continued.....

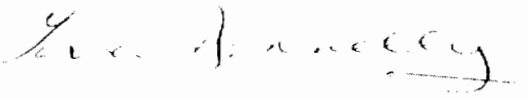
patient care considerably and also strengthen the clinical accountability for prescription. Based in general practice specialist nurses and nurse consultants should be able to lead diagnostic clinics with the ability to admit directly to hospitals

The Committee may be particularly interested in the primary care projects currently being developed in ABMU to support GPs including a Chronic Conditions Nurse, a Continence Service and development of training for practice nurses and a course for advanced nurse practitioners.

I hope this information and perspective is useful to the Committee in its deliberations on the GP workforce and I look forward to results of your Inquiry in the hope it will stimulate a wider discussion on mechanisms for improving primary care.

Kind regards

Yours sincerely



TINA DONNELLY
DIRECTOR, RCN WALES

Agenda Item 7.2

Kirsty Williams AM

David Rees AM,
Chair, Health and Social Care Committee,
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5 February 2015

Dear Chair,

Safe Nurse Staffing Levels (Wales) Bill

Thank you for your correspondence of 22 January, and for the opportunity to present evidence to the Health and Social Care Committee on the Safe Nurse Staffing Levels (Wales) Bill at your meeting of 15 January.

In your correspondence you asked if I could supply the Committee with an outline of which of the safe nursing indicators outlined in section 3(5) of the Bill were derived from the CNO's guidelines, the NICE guidelines and which were included as a result of the responses to your consultations on the Bill. I have set this out in the table below:

Indicator	Source
(a) mortality rates	▪ Wide range of academic research (much of this referred to in the EM) ▪ Consultation responses
(b) readmission rates	▪ Academic research[1] ▪ Consultation responses, including from the National Specialist Advisory Group for Diabetes ▪ NICE safe staffing guideline - Resource impact commentary
(c) hospital-acquired infections	▪ CNO care quality indicators[2] ▪ NICE safe staffing guideline - Resource impact commentary

[1] **For example, *RN Staffing Affects Patient Success After Discharge* (Health Services Research journal, April 2011)**
[2] **A number of Care Quality Indicators are set out in the CNO's Adult Acute Nursing Acuity & Dependency Tool Governance Framework (the document identifies these indicators as being linked to nurse staffing issues).**

	▪ Consultation responses ▪ Perfectly resourced ward pilot (Aneurin Bevan)
(d) medication administration errors	▪ CNO care quality indicators ▪ NICE safe staffing guideline ▪ Consultation responses
(e) number and severity of falls	▪ CNO care quality indicators ▪ NICE safe staffing guideline
(f) number and severity of hospital-acquired pressure ulcers	▪ CNO care quality indicators ▪ NICE safe staffing guideline ▪ Consultation responses
(g) patient and public satisfaction with services	▪ CNO care quality indicators ▪ NICE safe staffing guideline ▪ Consultation responses ▪ Perfectly resourced ward pilot
(h) nursing overtime and sickness levels	▪ NICE safe staffing guideline ▪ Consultation responses ▪ Perfectly resourced ward pilot
(i) use of temporary (agency and bank) nursing	▪ NICE safe staffing guideline ▪ Consultation responses ▪ Perfectly resourced ward pilot

In your correspondence you also asked why some of the safe nursing indicators contained within the NICE guidelines are not contained in section 3(5) of the Bill.

The NICE indicators that are not included on the face of the Bill are missed breaks and compliance with mandatory training. However, there is nothing to prevent these indicators also being used to measure the impact of the Bill if the Welsh Government considers this appropriate. Indeed, the Bill states that the list of indicators of safe nursing is not exhaustive.

For clarity, the majority of indicators identified by NICE are included in the Bill's list (falls; pressure ulcers; medication administration errors; nursing overtime; use of temporary nursing). The NICE safe nursing indicator 'Adequacy of meeting patients' nursing care needs' relates to patients' experiences of care (NICE suggests this could be measured through patient surveys). The Bill includes patient and public satisfaction with services as an indicator. The NICE guidance also includes as an indicator the planned, required and available nurses for each shift. The provisions of the Safe Nursing Levels (Wales) Bill will necessitate the recording and monitoring of this information.

Finally, you asked if I could provide written responses to the questions listed in Annex A of your correspondence. I have detailed answers to these questions at Annex A of my own correspondence.

Yours sincerely

Kirsty Williams
Assembly Member for Brecon and Radnorshire

Annex A

1. **Can the Bill as drafted realistically deliver on its policy objectives [especially given that the minimum ratios are not specified on the face of the Bill]?**

Yes, it can.

This Bill will provide a statutory basis for the planning and delivery of safe nurse staffing across NHS Wales, including delivery of **minimum ratios and accompanying guidance for adult acute inpatient settings. This legislation would guarantee** results and safeguard patient outcomes, when guidance alone has not succeeded. The Bill would ensure the delivery of safe levels of nursing care, consistently, across all hospitals in Wales.

But this doesn't mean stripping away guidance altogether.

What is required is not a simple set of inflexible hard-letter targets, specified on the face of the Bill. Concerns have been raised about such an approach both within the Assembly, and in response to my own consultations on the Bill.

Rather, what is needed is a statutory set of principles, which underpin and enforce the delivery of guidance (including, but not limited to, minimum ratios). These principles are reflected in two clear duties in new section 10A(1)(a) and (b), each of which will be enforceable in accordance with the principles of administrative law; there is every reason to believe that they will be effective in ensuring that staffing levels are given proper place among the other considerations that are required to influence policy and operations decisions within health service bodies.

I am also conscious that prescribing staffing levels on the face of the Bill could hinder future service development. Setting the ratios (and methods to determine appropriate nurse staffing locally) out in statutory guidance, rather than on the face of the Bill, will ensure that NHS Wales has the flexibility to respond to changes in service provision and delivery of care. Guidance can be more easily kept up to date than legislation, and can be more responsive to relevant developments, such as technological advances. It is also important to note that the ratios and methods, set out in such guidance, will be determined by relevant experts in the field and be evidence-based.

2. **Is it valid to directly apply international evidence on minimum staffing ratios to Wales given the differences in the healthcare systems?**

For clarity: this Bill is based on the known situation in Wales and the UK, and the evidence base that already exists here to support its implementation. This evidence base highlights:

- problems with nurse staffing in acute areas;
- that nursing jobs have been cut to save money; and
- the relationship between nurse levels and patient outcomes.

The evidence base also highlights that work has already been undertaken, in the UK, to develop tools and guidance which will support the implementation of minimum ratios in acute settings, but that the delivery of such guidance is not currently supported by any legislative requirement.

As such, international evidence simply provides additional examples and learning. It demonstrates that ratios have been effectively implemented in some areas of the world already (for example California, Victoria (Australia), Japan), and provides information on the successful implementation and impacts of nurse ratio legislation.

It also demonstrates (via the 2014 major European study published in The Lancet) that the same, fundamental relationship exists between nurse staffing levels and mortality rates, regardless of the differences in health service structures and financing between different countries. It is a staggering statistic that for each extra patient a nurse is responsible for, the likelihood of an inpatient dying within 30 days of admission increases by 7 per cent.

3. **Why has a definition of an 'acute hospital' not been provided on the face of the Bill given the absence of a generally applicable definition?**

Section 2 of the Bill which will insert Section 10A (5) (d) into the National Health Service Wales Act 2006 provides for the guidance which Welsh Ministers must issue to define the terms, or include provision to be used in defining the terms in in new section 10A (1) (b). This will include a definition of 'acute hospital'.

It may also be noted that the term 'acute hospital' is commonly used within the health sector. In drafting legislation I believe it is important to use phrases which resonate with their principal target audience (in this case the healthcare sector). Notably, the CNO and NICE define adult acute wards as being medical and surgical wards that provide overnight care for adult patients in "acute hospitals" (this should be taken to exclude critical care, maternity, and mental health services).

Acute hospitals can also be distinguished from community hospitals, which generally offer rehabilitation following a period of acute care. The ratios will not apply to community hospitals (likewise, the July 2014 NICE guidance does not apply to community hospitals).

Not defining the term 'acute hospital' on the face of the Bill also provides greater flexibility for nuance and future adjustment in the light of experience. The ability to define and change definitions in guidance will provide the Welsh Ministers with the ability to respond quickly and flexibly to changes in service provision and delivery of care within the NHS in Wales.

We could provide a definition of "acute hospital" and preserve flexibility by giving Welsh Ministers a power to amend it by subordinate legislation if the definition becomes outdated: but it seems more sensible simply to leave it to health care bodies to apply the industry term as it is understood from time to time, in accordance with guidance.

4. **Why is the definition of terms in relation to the ratios reserved to guidance and what consideration was given to whether certain key definitions be included on the face of the Bill?**

A number of the terms used in new section 10A (1) (b) already have a definition. For example 'registered' in the context of a nurse already has a definition by virtue of Section 5 and Schedule 1 to the Interpretation Act 1978.

Because the Bill inserts provisions into the National Health Service Wales Act 2006, where appropriate it would also pick up existing definitions within that Act. For instance 'patient' is already defined by section 206.

Other terms such as 'healthcare support worker' and 'acute hospital' will require definition. Consideration was given to including the terms either on the face of the Bill or in regulations but this was not felt appropriate (for the reasons given in my response to question 3 above).

5. **Given the definition of 'health service body' as set out on the face of the Bill includes Welsh Ministers, the Bill as drafted makes it possible for Welsh Ministers to issue guidance to themselves. Is this the intention, and if so, why?**

Under the National Health Service (Wales) Act 2006, the duty to provide nursing services lies with Welsh Ministers. Local Health Boards are directed to exercise functions on their behalf and functions are conferred on NHS Trusts in accordance with their establishment orders. If for any reason there were no Local Health Boards or NHS Trusts, this duty would therefore lie with the Welsh Ministers.

It may also be noted that there are two parts to the new duty in new section 10A (1). The guidance will only apply to the more specific duty in new section 10A (1) (b). There is no reason why Welsh Ministers should not have regard to the more general duty (of 10A(1)(a)) when exercising functions. The Welsh Ministers will only be subject to guidance in the event that they are directly responsible for settings that fall within the definition of an adult acute inpatient ward. In the event that Welsh Ministers became directly responsible for such settings, there is no reason why such settings should not be subject to the guidance as other health service bodies.

It is by no means unusual for a minister or other public authority to be responsible for issuing guidance about the exercise of the authority's own functions. The purpose is to publicise and give legal authority to the principles determining the exercise of those functions.

6. **Why is there is a difference between the duty to maintain safe nurse staffing levels (which states that bodies are required to comply) and the corresponding reporting requirements (which state that bodies must report on how they aimed to comply)?**

The purpose of the reporting requirement is to obtain information in order to further the statutory objective of safe nurse staffing levels.

It is recognised that there may be occasions when it is not possible for health service bodies to comply with the duty.

The legislative intent of the Bill is to introduce the new duties as key and enforceable components of the professional decision-making process, not as hard letter targets.

A reporting requirement under which local health boards show how they have aimed to comply with the duty, will elicit far more useful information (in particular where there has been non-compliance) than a duty which simply requires health service bodies to detail compliance.

7. **Why is the power for Welsh Ministers to issue guidance limited to the duty in respect of minimum ratios and therefore does not apply to the wider duty for health service bodies to have regard to the importance of safe nurse staffing levels in exercising all their functions?**

The essence of the duty as set out in new section 10A(1)(a) is clear and does not require to be supplemented by guidance.

The principle of this Bill is to provide a statutory basis for the delivery of *existing* guidance on nursing in adult acute inpatient settings, and associated minimum ratios.

However, the CNO and NICE are working towards extending tools and guidance to other settings. The next phase of the CNO's work focuses on district nursing and health visiting, and mental health inpatient settings initially. During 2015, NICE intend to publish guidelines for maternity settings, A&E and mental health inpatient settings.

It is expected that the Welsh Government will take account of this work, and as such the Bill includes provision for 10A(1)(b) to extend to other settings and services, once the evidence to support this is developed. This will ensure that any minimum ratios developed will be the most appropriate for those settings.

8. **Is it the intention for health service bodies in Wales to comply with their duties in respect of minimum staffing ratios prior to the Welsh Government issuing the relevant guidance?**

No.

The fact that new section 10A(1)(b) includes an express reference to the statutory guidance shows that the duty is not to apply in the absence of guidance.

I would envisage that the Welsh Government guidance would be issued to coincide with Royal Assent and the Act coming into force. I would anticipate that Welsh Ministers would wish to make appropriate preparations to meet impending new statutory duties, as they commonly do with legislation introduced by the Welsh Government.

Assuming the general principles of this Bill are approved, I would look forward to discussing with the Welsh Government an implementation and pre-commencement timetable.

For clarity, I do not believe the requirement to issue guidance to be an onerous one, given that the Chief Nursing Officer's guidance and workforce planning tools are already in place on a non-statutory basis. Likewise, health service bodies should already be complying with the Chief Nursing Officer's guidance, and therefore this will not be a 'new' requirement for them. Indeed, Local Health Boards have been provided with additional funding to recruit additional nurses to meet the guidance, and they are budgeting in their three year plans accordingly.

9. **Has any assessment of the cost of extending minimum staffing ratios to additional settings been undertaken?**

Any proposals to extend the Bill to other areas of NHS staffing would need to be accompanied by a robust evidence base, with a costed impact assessment and subject to scrutiny by the Assembly. As this robust evidence base is not currently available in Wales, a detailed assessment of the costs of extending safe staffing legislation to cover other settings has not been undertaken at the current time.

Work is currently underway by the Chief Nursing Officer in Wales and NICE in England to develop tools and guidance for additional settings. I would expect that this work will contribute to the evidence base for extending minimum ratios and guidance to other settings.

10. **The Bill provides for ratios to apply to 'adult inpatient wards in acute hospitals'. Is it therefore your intention that they should apply to maternity in-patient wards; mental health in-patient wards within adult acute hospitals; critical care in-patient wards; specialist in-patient wards? If not, why is this not stated on the face of the Bill?**

The CNO and NICE's definition of adult acute settings is that they are medical and surgical wards which provide overnight care for adult patients in acute hospitals, which should be taken to exclude critical care, maternity, and mental health services.
I would anticipate that the statutory guidance required by this Bill would include a definition, to provide clarity.

Critical care, maternity, mental health and other specialist areas are likely to have very different requirements in terms of staffing levels, skill mix and skill sets needed.
The evidence base that would support the implementation of this Bill relates to adult general medical and surgical wards in acute hospitals.

11. Why is legislation needed in Wales given that England and Northern Ireland have achieved lower ratios of nurses to patients than Wales without using legislation?

Whilst figures published by the RCN[3] have shown that Wales has, on average, more patients per nurse than England, Northern Ireland and Scotland, this data was based on employment research undertaken in 2009. Without comparable up to date figures, it's not known whether this picture remains the same.

Also, what these figures do not show, is how much variation there is within each country. In England, for example, the recent work of Francis and Keogh clearly demonstrates that some areas may have significantly poorer nurse staffing levels than others.

This Bill aims to ensure safe, appropriate levels of nurse staffing consistently across all hospitals in Wales.

12. Is there enough nursing staff capacity to deliver what this legislation aims to achieve? If not, how long do you estimate it would take to build that capacity?

By placing safe nurse staffing on a statutory footing, the Bill aims to strengthen accountability for the safety, quality and efficacy of workforce planning and management.

A 2013 report by the International Council of Nurses describes how several countries have been turning to mandated ratios as a strategy to improve working conditions and facilitate the return of nurses to practice:

> "Shortly after the implementation of mandated ratios in Victoria, Australia - five thousand unemployed nurses applied to return to work and fill vacant posts in the health services" (Kingma 2006 p.225). Further, research commissioned by the Australian Nursing Federation (ANF) found that "more than half of Victoria's nurses would resign, retire early or reduce their hours if mandated, minimum nurse:patient ratios were abolished" (ANF 2004 p.1).

Similarly, the ratio legislation in California is considered to have achieved its goals of reducing nurse workloads and improving the recruitment and retention of nurses, as well having a positive impact on quality of care. (Linda Aiken et al 2010).

It has also been argued that a 'shortage' of nurses is not necessarily a shortage of individuals with nursing qualifications: rather, it's a shortage of nurses willing to work in the present conditions. The main causes of nursing shortages have been identified as inadequate workforce planning and allocation mechanisms, resource-constrained undersupply of new staff, poor recruitment, retention and 'return' policies, and ineffective use of available nursing resources through inappropriate skill mix and utilisation, poor incentive structures and inadequate career support.[4] The Bill will help address these issues.

[3] **Royal College of Nursing, *Guidance on safe nurse staffing levels in the UK*, 2010**
[4] **Buchan, J and Aiken, L, Solving nursing shortages: a common priority, 2008**

13. **What assessment has been made of the potential impact of the Bill on healthcare support workers if there are fewer of them needed on adult acute wards as a result of the Bill?**

Healthcare support workers have a vital role in supporting nurses.

Far from intending to reduce the overall number of healthcare support workers, by placing safe nurse staffing on a statutory footing, the Bill aims to strengthen accountability for the safety, quality and efficacy of workforce planning and management (incorporating workforce planning for healthcare support workers).

The Bill promotes the use of acuity tools and professional judgement to determine the required skill mix of nursing staff on wards (above the minimum level). This will ensure that no member of staff is undertaking tasks they are not appropriately qualified to do, and that the most effective use is made of staff resources, in line with the principles of prudent healthcare.

14. **Are you are confident that existing provisions for staff and/or patients to raise concerns are sufficient?**

Yes. The Bill will provide a statutory basis on which staff and patients can challenge poor levels of staffing both within health service bodies and with the Courts by way of judicial review.

I did give consideration to whether specific protection for patients and staff raising concerns should be included within the Bill, and I posed this question in my first consultation. A small number of respondents suggested that the Bill should include a specific protection, but there was a broader view that the correct mechanisms already exist.

As the Committee will be aware, work to strengthen the complaints arrangements is underway following Keith Evans' review of concerns in Welsh NHS last year.

15. **Have you considered that the requirement in the Bill for publication to patients of information on the numbers and roles of nursing staff on duty could also include a requirement to set out information about the existing mechanisms for patients and staff to challenge breaches of the guidance?**

The statutory guidance, required by the Bill, will need to balance patients and carers' need for information with the potential administrative burden of delivering such information.

However, it may be noted that it is already considered best practice to display pictures at ward level depicting the reporting chain (this was recognised early on in the 1000 Lives campaign).

16. **Does the 'perfectly resourced ward' pilot provide evidence that introducing safe nurse staffing levels would contribute to significant reductions in bank and agency staff costs, given that bank staff costs reduced considerably across both the pilot and control wards?**

The 2012 'perfectly resourced ward' pilot in Aneurin Bevan showed a reduction in bank and agency staffing costs of over 60%. There was also a slight reduction in the overall costs of running these wards while the pilot was being run. However, I believe the pilot's key finding was the positive impact on quality and patient safety. Wards were able to develop a seamless patient journey, positive patient experiences were reflected in patient surveys, and fundamentals of care standards were embedded within the wards. Staff satisfaction also increased.

17. **Could you provide further clarification about the intention of the reference to 'each financial year' in the commencement provision contained in section 4 of the Bill?**

The reference to 'each financial year' is included to make it clear (to health service bodies) that the new duties imposed by the Act will only take effect from the 1st April of the year following Royal Assent having been given. So, if for example, Royal Assent was given on 1 September 2015, the new duties imposed by this Act would only take effect from 1 April 2016. Likewise, if Royal Assent was given on 1 January 2016, the new duties imposed by this Act would take effect from 1 April 2016.

The annual reporting requirements would therefore cover a full financial year, rather than a partial year. The intention behind this provision is to make it easier for health service bodies to use existing structures to produce these reports at the same time as they are producing other reports.

New section 10A (10) would enable a report required by this Bill to be included as part of a wider report.

18. **It does not appear that the duty to maintain minimum ratios can be effective until the relevant Welsh Ministers' guidance has been issued. Should section 4 of the Bill deal with this?**

Please see my response to question 8.

Agenda Item 7.3

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

David Rees AM
Chair, Health and Social Care Committee
National Assembly for Wales

3 February 2015

Dear David,

I am writing to draw your attention to a Legislative Consent Memorandum which I laid before the Assembly on Friday 30 January. It is not normal practice for Ministers to write directly in this way, but for the reasons set out below I think it appropriate in this instance. A copy of the Memorandum is attached.

The Serious Crime Bill, currently before Parliament completed Committee stage in the House of Commons on 22 January, having been introduced in the Lords.

The Assembly has previously passed two Legislative Consent Motions in respect of amendments to this Bill, firstly in respect of an extension of the offence of child cruelty (at Report stage in the Lords), and secondly in respect of coercive or controlling behaviour (at Committee stage in the Commons).

A number of amendments were tabled by the UK Government on 8 January which required careful consideration as to whether they give rise to the need for the legislative consent of the National Assembly for Wales. Among these was an amendment creating an offence of sexual communication with a child, and the Memorandum I have laid sets out the reasons why this provision falls within the legislative competence of the Assembly.

I note that Business Committee has agreed this morning that the Memorandum will be considered in Plenary on 10 February. Given the late stage of the Bill in Parliament, timescales are exceptionally short. I wanted to ensure that you were made aware as early as possible.

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Correspondence.Mark.Drakeford @wales.gsi.gov.uk

I am also copying this letter to the Chair of the Children, Young People and Education Committee and to Elin Jones AM, Kirsty Williams AM, and Darren Millar AM as Party Spokespeople.

Best wishes

Mark Drakeford.

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

SUPPLEMENTARY LEGISLATIVE CONSENT MEMORANDUM
(Memorandum No.3)

SERIOUS CRIME BILL

1. This Legislative Consent Memorandum is laid under Standing Order ("SO") 29.2. SO29 prescribes that a Legislative Consent Memorandum must be laid, and a Legislative Consent Motion may be tabled, before the National Assembly for Wales if a UK Parliamentary Bill makes provision in relation to Wales for a purpose that falls within, or modifies the legislative competence of the National Assembly.

2. The Serious Crime Bill ("the Bill") was introduced in the House of Lords on 5 June 2014. The Bill can be found at:

   http://services.parliament.uk/bills/2014-15/seriouscrime.html

Summary of the Bill and its Policy Objectives

3. The Bill is sponsored by the Home Office. The UK Government's principal policy objective for the Bill is to ensure that law enforcement agencies have effective legal powers to deal with the threat from serious and organised crime.

4. The Bill is in six Parts:

   - Part 1 makes provision in respect of the recovery of property derived from the proceeds of crime.

   - Part 2 makes amendments to the Computer Misuses Act 1990.

   - Part 3 provides for a new offence of participating in the activities of an organised crime group and strengthens the arrangements for protecting the public from serious crime and gang-related activity provided for in Part 1 of the Serious Crime Act 2007 and Part 4 of the Policing and Crime Act 2009 respectively.

   - Part 4 provides for the seizure and forfeiture of substances used as drug-cutting agents.

   - Part 5 amends the law in relation to the offences of child cruelty and female genital mutilation, provides for female genital mutilation protection orders and creates a new offence of possession of "paedophile manuals".

   - Part 6 provides for or extends extra-territorial jurisdiction in respect of the offences in sections 5 (preparation of terrorist acts) and 6 (training for terrorism) of the Terrorism Act 2006 and confers Parliamentary approval (as required by section 8 of the European Union Act 2011) for

two draft Council Decisions under Article 352 of the Treaty of the Functioning of the European Union. Part 6 also contains minor and consequential amendments to other enactments and general provisions, including provisions about territorial application and commencement.

Provisions in the Bill for which consent is sought

5. The consent of the Assembly is sought for the amendments tabled by Karen Bradley, Minister for Modern Slavery and Organised Crime, in the UK Parliament on 8 January 2015, which introduce new provision relating to 'Sexual Communication with a Child'. Details of the amendment can be found in the Notices of Amendments tabled in Public Bill Committee; this list was tabled in Parliament on 8 January 2015.

6. The amendment was agreed to in Committee on 20 January and is included as Clause 67 in the Bill as amended in Public Bill Committee. This Clause provides for a new offence where an adult communicates with a child under 16 for the purpose of obtaining sexual gratification and the communication is sexual or intended to encourage a sexual response. The offence would be triable either way with a maximum penalty (on conviction on indictment) of two years' imprisonment.

7. It is the view of the Welsh Government that new Clause 67 falls within the legislative competence of the National Assembly for Wales in so far as it relates to "protection and well-being of children (including adoption and fostering) and of young adults" (paragraph 15) under Part 1 of Schedule 7 to the Government of Wales Act 2006.

8. The provisions outlined above apply in relation to Wales.

9. The provisions outlined above do not include powers for Welsh Ministers to make subordinate legislation.

Advantages of utilising this Bill rather than Assembly legislation

10. It is the view of the Welsh Government that it is appropriate to deal with these provisions in this UK Bill as it represents the most practicable and proportionate legislative vehicle to enable these provisions to apply in relation to Wales. The inter-connected nature of the relevant Welsh and English administrative systems mean that it is most effective and appropriate for provisions for both to be taken forward at the same time in the same legislative instrument. This will enable the non-devolved partners of the Police and Courts to provide effective partnership and support in delivering a stronger child protection framework. We consider therefore that making provision for an offence which applies across England and Wales helps ensure a co-ordinated approach to the issue as senders and recipients of communications could be located in either country

Financial implications

11. There are no financial implications for the Welsh Government.

Mark Drakeford AM
Minister for Health and Social Services
January 2015

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref : SF/MD/312/15

David Rees AM
Chair of the Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff
CF99 1NA

Dear David,

3 February 2015

Health finances and reform

I refer to your letter of 10th December in which you ask for further information to help inform your decision on whether or not to undertake work on health reform before the end of this Assembly. To help inform your Committee's consideration of the Finance Committee's recommendations you have asked for further information as outlined below.

Current funding
Confirmation of whether plans are in place for the additional funding for 2014-15 and 2015-16 to be used to deliver health service reform or to maintain current service levels only

The independent report published by the Nuffield Trust in June 2014 clearly set out the future financial challenges facing the NHS. This report provided the main supporting evidence for the additional funding to be provided to the NHS. One of the main conclusions from the report was that the NHS in Wales is affordable in the future if it receives a share of national income and continues to deliver the productivity and efficiency gains it has in the past. These productivity and efficiency actions will continue, with further potential efficiencies coming from centralising highly-specialised services, providing more care in communities closer to people's homes, preventing people from being admitted to hospital for routine treatment, further increasing the integration with social services and pursing a prudent healthcare agenda across all services we deliver.

Consequently the additional funds announced in the draft budget will be used, alongside the totality of the healthcare budget to continue to deliver the high quality and safe services our patients expect while at the same time ensuring the whole budget is used in a way which contributes to reshaping and reforming the way we deliver our health services to ensure we are on a more sustainable footing.

The refreshed planning guidance, which was issued on 31 October 2014, clearly outlines our expectations in terms of what changes we expect to see. The extent of the reforms and changes NHS organisations are planning to make will be evident within their three-year integrated plans to be submitted by 30th January 2015. In order to obtain Welsh Government approval they will need to

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clearly demonstrate how such reforms will contribute to meeting the policy objectives and enable the continued delivery of sustainable services.

Confirmation of the planned or agreed distribution of the additional £200 million funding available to individual health boards and trusts in 2014-15, as soon as these figures are decided, including how these allocations were calculated

All NHS organisations are required to submit service and workforce plans in line with the new planning guidance and requirements. Whilst some organisations were unable to satisfactorily complete three-year balanced plans in accordance with the requirements, they must ensure they at least submit robust board-approved plans on a one-year basis.

It is important that organisations continue to be held accountable to deliver against the original planning commitments their boards approved. Consequently the additional £200m has been allocated in accordance with the original resource requirements outlined within their plans.

A proportion of the £200m is needed to cover the cost of the pay award, which will be distributed separately. The remaining £175 m has been allocated as follows:

Organisation	**Additional Allocation of**
	£m
Abertawe Bro Morgannwg University HB	26.100
Aneurin Bevan HB	26.700
Betsi Cadwaladr University HB	35.000
Cardiff and Vale University HB	15.500
Cwm Taf HB	8.000
Hywel Dda HB	38.700
Powys HB	25.000
Total	**175.000**

Confirmation of the additional funding available to individual health boards and trust in 2015-16, including how these allocations were calculated once available

I have previously informed the committee that additional allocations in 2015-16 would be based on an updated resource allocation formula. The £200m allocated in 2014-15 will need to be put into the baselines of NHS organisations on this basis.

As part of the 2015-16, health board revenue allocation letter, issued in December 2014 an additional £200 m was allocated as follows:

	Direct Needs Target Share - December 2014	**Additional Allocations - 2014**
	%	**£m**
Abertawe Bro Morgannwg University	17.908%	35.815
Aneurin Bevan	19.132%	38.264
Betsi Cadwaladr University	21.257%	42.515
Cardiff and Vale University	14.395%	28.789
Cwm Taf	11.112%	22.225
Hywel Dda	12.128%	24.255
Powys	4.069%	8.137
Total / Average	**100.000%**	**200.000**

The receipt of NHS organisations integrated medium term service plans before the beginning of next financial year will provide the further evidence required to inform the distribution of any additional allocations that may be made from the small DHSS contingency fund. This will support the additional financial flexibility which may be requested and provided under the new regime introduced following the NHS Wales (Finance) ACT 2014.

An outline of how the additional £70 million funding announced by the Minister for Finance and Government Business following the UK Government's Autumn Statement, will be targeted to "support the Welsh NHS to undertake the reform and the step change needed to secure the long-term sustainability of the health service in Wale" as set out in her written statement on 3 December

As detailed in the note I sent to you on the 28 January, I issued a written statement to all Assembly members on that day. The statement outlined how the additional funding from the Welsh Government to the NHS would be invested.

A summary of the key dates in the 2015 timetable for agreeing three year plans, to begin with the deadline for the submission of plans in January 2015.

The NHS Planning Framework issued 31 October 2014 included the following Plan Approval timeline.

Action	Timescale	WG	NHS
NHS Boards approve 'Final Draft' version of IMTP	January 2015		✓
NHS organisations submit the 'Final Draft' Board-approved plans to WG	31st January 2015		✓
WG scrutiny process	February – March 2015	✓	
Boards respond to feedback from scrutiny process and amend Plans accordingly. Boards then approve final versions	Prior to 31st March 2015		✓

Future funding and long-term sustainability

An outline of additional outcomes, if any, to be achieved with the additional funding in 2014-15 and 2015-16

As referred to above, the additional funding will enable the NHS to continue to deliver the services and positive outcomes our patients expect, whilst at the same time reshaping and reforming our services. The required delivery outcomes and the actions necessary to delivery these are/will be clearly set out in the NHS organisation's three-year integrated medium term plans.

An outline of the arrangements that have been or will be put in place to monitor the outcomes of this investment

We have a number of vehicles through which we monitor and oversee the performance of NHS organisations to ensure they are delivering against expectations and remain on track to deliver against their approved service plans.

These include:

- Monthly chief executive meetings where delivery and financial performance is scrutinised.

:

- Joint Executive Team meetings (JET) are held every six months with each health board and NHS trust and are attended by members of the executive director team

and the chief executive and the executive team of the individual health board or NHS Trust.

- The integrated delivery board (IDB) is held monthly and chaired by the delivery programme director or deputy chief executive of NHS Wales. This meeting monitors the progress of health boards and NHS trusts' performance against the delivery and outcome framework and their integrated medium term plans.

- The quality and safety assurance group is held monthly and chaired by the deputy CMO. This meeting monitors the progress of health board / NHS trust performance against WG quality and safety delivery requirements.

- Quality and delivery meetings are held monthly, although they can be less frequent when organisations are considered to be delivering on performance and quality.

- Detailed submission of monthly financial monitoring returns. Where the financial performance is reviewed in detail and explanations sought for any adverse variances from plan.

In addition we also have escalation and intervention arrangements developed in agreement with HIW and the WAO, where information on the performance and progress of NHS organisations is shared.

An outline of any plans the Welsh Government has in place to assess whether services are being reformed and also the levels of funding required for the health service beyond 2015-16 to ensure that the delivery of services remains sustainable

One of the main ways in which we will examine whether services are being reformed is through the medium term plans. The assessment of whether services are being reformed will be undertaken through the formal review, scrutiny and approval of the integrated medium term plans, with performance and delivery of those service reforms managed through the main performance management arrangements detailed above.

The levels of funding required for the health service beyond 2015-16 is clearly a matter for Welsh Government to consider in context of the settlement from the UK Government. The Nuffield Trust report "A Decade of Austerity in Wales?" published in June 2014 is a key independent assessment of the funding requirements and challenges.

Best wishes,

Mark

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Agenda Item 10

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