



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

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

Dydd Iau, 30 Ionawr 2014
Thursday, 30 January 2014

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Motion under Standing Order 17.42 to Resolve to Exclude the Public for the Remainder of the Afternoon's Business

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd.

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Leighton Andrews	Llafur Labour
Rebecca Evans	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales

**Eraill yn bresennol
Others in attendance**

Polly Ferguson	Swyddog Nyrsio Iechyd Atgenhedlol Menywod Nursing Officer for Women's Reproductive Health
Yr Athro/Professor Jean White	Prif Swyddog Nyrsio Cymru Chief Nursing Officer for Wales
Helen Whyley	Swyddog Nyrsio Gweithlu, Addysg, Rheoleiddio a Diogelwch Cleifion Nursing Officer for Workforce, Education, Regulation and Patient Safety

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

Chloe Davies	Dirprwy Glerc Deputy Clerk
Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Llinos Madeley	Clerc Clerk

*Dechreuodd y cyfarfod am 13:02.
The meeting began at 13.02.*

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

[1] **David Rees:** Good afternoon and welcome to the members of the committee to this afternoon's session of the Health and Social Care Committee. The meeting is bilingual and headphones can be used for simultaneous translation from Welsh to English on channel 1, or for amplification on channel 0. Please turn off your mobile phones or other electric equipment that may interfere with the broadcasting equipment. There is no scheduled alarm today, so, should you hear the fire alarm, follow the directions of the ushers. We have received apologies from Darren Millar and Elin Jones, and from Kirsty Williams, who hopes to be back from the Welsh Affairs Committee in London this morning, but we are not sure of her travel arrangements.

13:03

Sesiwn Graffu Gyffredinol gyda'r Prif Swyddog Nyrsio
General Scrutiny Session with the Chief Nursing Officer

[2] **David Rees:** I welcome Professor Jean White, Chief Nursing Officer for Wales; Polly Ferguson, nursing officer for women's reproductive health; and Helen Whyley, nursing officer for workforce, education, regulation and patient safety. I thank you for your written evidence, which the committee has received. I remind Members that, in fact, the purpose of this afternoon's session is to explore the priority areas for the chief nursing officer's remit, to seek an update on specific work that has been undertaken and to ensure appropriate nurse staffing levels in hospitals and other settings, because that was part of the evidence and submission as well. In that sense, we will start with William.

[3] **William Graham:** Good afternoon. I will start by asking about the staffing principles. We understand that there is a variance between current ward staffing and the Welsh Government staffing principles. Could you explain that to the committee?

[4] **Professor White:** Certainly. Thank you very much. The work to set safe and what I would say are quality staffing levels in Wales has been a journey for us over the last two years. In 2011, when we started talking about this, we set a number of principles for the medical and surgical wards across Wales. We looked at best practice across the UK, and we recognised then that, in some areas of Wales, the best practice evidence that we were having was greater than that which was on the medical and surgical wards. So, each of the health boards agreed an action plan, and they are working towards implementing the principles by the end of March to the beginning of April of this year. We monitor those action plans on a regular basis, particularly since the Minister gave additional funds to support the action plans that the service had.

[5] In our most recent update to do with progress against these principles, we found that the health boards were at varying stages of implementation. So, for example, Hywel Dda health board has mostly complied with the principles that have been set, but, in some areas, not all of its ward sisters are supernumerary for the duration of the week's rota; they will be it for a part. Other areas, like Betsi Cadwaladr health board, have been attempting to recruit additional staff, but they are finding it quite difficult to fill their vacancies. So, we are finding variations, if you like, across the country against what we set out as a set of principles to work towards.

[6] The second thing I should say about the principles is that they are there to help professional judgment. They are not the be-all and end-all, because what will happen is that, in some areas, the principle of 'so many staff to a bed' would not be enough. So, working on that, the staff in the area have to make a decision, looking at patient outcomes, patient needs and their dependency, by asking, 'Okay, what is safe and what is ideal for these patients right now?'. There is a real danger in setting any blanket set of principles, because you need to have variation. So, we said in the principles that you must make sure that you use professional judgment in determining what is appropriate.

[7] **William Graham:** Thank you. It was put to me by a constituent who is a sister in the Royal Gwent Hospital that one of her main difficulties in terms of staffing was when she had a large number of high-dependency patients and the health board was very slow to respond. Will these recommendations address that?

[8] **Professor White:** The principles are there to try to get the establishment correct—that is the funded establishment—so that it is consistent throughout the year. What we will always find is fluctuation in demand, and when we approach the health boards in relation to this work, we ask about the mechanism from ward to board, so that the board knows what is going on. All of them describe to us various approaches to doing that. The lag that your

constituent is talking about is when you want to increase the establishment, because you have to go out to recruitment, and vacancy management takes a while. However, all of the health boards use bank and agency staff to flex their workforces. So, for example, in winter pressures, as we all know, demand goes up in service, and, therefore, you would not want to have a very high establishment throughout the year if it is for only a part of the year that you are going to have a high demand. So, in her area, she should be able to report to the senior nurse, 'This week, my patients are a high need and I need to top up our establishment', and there should be a mechanism for doing that.

[9] **David Rees:** Thank you. May I ask a question on two points, before I bring Gwyn in on agency staff, which you mentioned? You talked about using professional judgment. Whose professional judgment? I think that is a crucial question. You also talked about your discussions from ward to board. Who do you discuss with—someone at board level or at ward level?

[10] **Professor White:** My conversations have been with the nurse directors because that is the level at which I interact, and with the assistant nurse directors. So, it is the senior staff. What I want to know is whether they have established systems to enable them to know what is going on at the grass roots—the ward level—in their organisation. So, whereas it is the ward sister's professional judgment about what her patients need right there and then—that is the professional judgment I am talking about—there is also the professional judgment of the senior nurse management within the organisation to look at patient outcomes, pressure ulcer development, infections, falls, and all of these things that indicate whether or not care is safe and of a high quality, and whether we are managing our workforce appropriately. So, the professional judgment is at two levels, if you like: it is the here and now and what is needed to manage the patients, and the more strategic issue of what is needed in the workforce, looking at the outcomes.

[11] **David Rees:** Okay, thank you. Gwyn will ask about agencies, and then we will go on to Lindsay.

[12] **Gwyn R. Price:** Good afternoon. To what extent are bank and agency staff used by the health boards to address gaps in the current staffing levels, and are the gaps among any particular part of the organisation, such as care workers, senior registrars or supervision specialists, et cetera?

[13] **Professor White:** Would you mind if I invited my nursing officer to answer that?

[14] **Gwyn R. Price:** You obviously play rugby; you have passed it over.

[15] **Professor White:** Yes, it is one of those passes.

[16] **Ms Whyley:** Thank you very much. The chief nurse would not be aware of the use of locum staff in the medical directorates. The bank and agency issues that we would be aware of would be specifically in the nursing profession. Obviously, it is a matter for health boards as to how they utilise their budgets or staffing. We do not collate on an all-Wales basis the different uses in different areas. We do, however, input into an all-Wales group that is led by assistant nurse directors who look at the amount of bank and agency workers utilised across NHS Wales and try to do things to make it more cost-effective. So, for example, there is an agency contract for Wales that that group monitors and supervises.

[17] **Gwyn R. Price:** We have noticed in the past that witnesses have said that the amount of money spent on agency workers to top up is a great deal more than what is spent on the nurses, doctors et cetera.

[18] **Professor White:** Perhaps I could come in there to say that, you are quite right, a few years ago there was almost a free-for-all with the use of agency contracts, and we brought in the national procurement of nursing contracts. There are certain providers that meet particular requirements. That initial work dropped the budget by approximately £20 million. It was a huge amount. Unfortunately, the current contractors that we have in this all-Wales agency budget do not necessarily cover all of the needs. So, on occasion, the health boards will still have to go out to agencies that are outside the national contract. In recent years we have been trying to encourage all of the health boards to use bank staff, which is their own existing staff who do extra sessions or choose to work in a part-time way. We do not monitor this closely, but the health boards do. The nurse directors have regular reports on their usage. So, that is kind of where we are at the moment. We do not personally know, particularly on a day-to-day basis, what is used.

[19] **Gwyn R. Price:** In your opinion, is there any specific area where there are specialists that we cannot get hold of?

[20] **Professor White:** The most challenging area for us is intensive care. If we are trying to flex up—. If you take the winter pressures right now, for example, you will see that there is a lot of demand on intensive care beds. Frequently, they are all full, and we have to make additional, expanded provision into recovery units and so on. It is very difficult to conjure up a lot of bank staff, and you have to go to agencies. That is when they tend to go off-book to whatever agency that can offer them the staff. If you like, that is a pinch point, because they are so specialised as a group.

[21] **Lindsay Whittle:** Good afternoon. You have come on a day when we have all had some financial scrutiny training; so, you have picked the wrong day, I am afraid. [*Laughter.*] I just wanted to touch on value for money and the use of resources. Are they used efficiently? We know that there is a lot of pressure on our nursing staff in particular. The Royal College of Nursing's report this very week highlighted serious concerns about the pressure on nurses. Could you perhaps help us by saying what, in your opinion, is wrong? Do you work with the RCN to identify the issues in order to relieve the pressure on these nursing staff? For most of the patients, it is mainly the nursing staff they come into contact with. I do not mean this in a derogatory way, but consultants come in, give their advice and are quickly gone. So, it is mainly the nursing staff who you remember about your stay in hospital.

[22] **Professor White:** Perhaps I could start, and then I will bring in my colleagues if they have comments to make. I meet with the director of the Royal College of Nursing on a regular basis, as does the Minister and the chief executive of NHS Wales. We do talk about staffing, and we also discuss staff morale and the changes brought about by the reconfiguration of services and the implications of it. So, on a one-to-one level, we have a very close working relationship with the RCN, and, on occasion, it will bring to our attention something that its members will have said, such as, 'This is a challenging area on which we've got some particular problems'. So, there is an exchange of information that we find very useful. Would you like to add your perspective, Helen?

13:15

[23] **Ms Whyley:** Yes, certainly. There are several things that we do in terms of supporting nurses out in the workplace. We have the post-registration career framework for nurses, which is a framework that allows them to look at how they can develop their careers and what aspects of skills or training they might want to rely upon in order to take up a promotion, for example. That also allows them to maintain their continuous professional development. There is a variety of tools that we have provided that could be used at ward level. One emanates from 'Free to Lead, Free to Care', which is an initiative by the chief nursing officer for several years, which actually came about as a piece of joint work with the

RCN-chaired empowering ward sisters programme, which again allows nurses to have some tools to utilise to improve patient care and, ultimately, to improve their ways of working together in teams. The last one I wanted to mention was the work of the 1000 Lives Plus programme on transforming care, where nurses can utilise that information—things like safety crosses et cetera—to be able to have evidence to go to their management and senior nurses and say, ‘These are areas we can now identify are an issue and we want to improve them’ and then work together to do that.

[24] **Lindsay Whittle:** If I may just ask a follow-up question, how do you monitor the outcomes of all this?

[25] **Professor White:** In a number of different ways. We have an annual fundamentals of care audit, which I think I referred to in my evidence. We have recently reviewed the number and range of questions that are being asked and we are expecting to have the 2013 audit data sent to us to review. In the past, I have looked at the trends within these reports and initiated national work. So, for example, over a few years, we had very poor results to do with oral health and hygiene. It was the lowest of the grading. So, we initiated a multiprofessional piece of work with dentists, dental hygienists and nurses and came up with an all-Wales oral health and hygiene pathway. So, we use the data gathered at ward level to inform what might be national programmes. We have done similar things around continence care. We are looking at nail, foot and hair care at the moment. So, we use it for that sort of thing.

[26] At the more severe end, we look at incident reporting, complaints coming through to us and serious and untoward events as an indication, and we might then refer back to the board for more information about how it is managing it. We look at the roll-out of transforming care, which is an approach to radically change practices within the ward, and I ask questions about how well that is being embedded along with 1000 Lives Plus. We have feedback data from the roll-out of things like the STOP campaign to stop using catheters and Venflons and other peripheral access equipment that can bring harm to patients if used inappropriately.

[27] So, we try to collate as much evidence as we can. Internally, we have a quality and safety group, which I sit on and which the medical directorate has officers on, and we look at the evidence coming in from the health boards and the trusts to see whether there is something we should be concerned about, whether there are themes emerging or issues on which we want to say, ‘We need to either look at the organisation or do something on a national basis’. We can then feed that quality and safety information up to our performance board and determine whether we need to escalate concerns and raise the temperature on the organisation in terms of performance.

[28] **Lindsay Whittle:** I have a quick final question. So, all of this statistical—it sounds like a statistical exercise to me, with respect—. How do those outcomes get fed back down the line to the nurses who are on the front line?

[29] **Professor White:** The fundamentals of the care audit tool were actually designed to help front-line staff work out what they should do. So, the way the audit is conducted is that they self-assess at a particular point in the year about their performance; they go to ask the patients in their care about what has been happening, and the audit tool allows them to create action plans for them to work on at the front-line level. A lot of the organisations have been working on developing real-time data collection. Audits are a snapshot in time once or twice a year. They have taken that principle and they now have what they call care metrics. So, every day, they can enter things about the care of their patients on the ground and they can work out, ‘So, how are we doing today in our own area?’, ‘Have our patients had nutrition assessments?’ or ‘Have we had a lot of pressure ulcers here?’, and they can put the data up in a public place so the relatives and patients on the ward can see as they walk into the

environment how we are doing.

[30] We are trying to move away from spot checks that happen just once to real-time data collection for front-line staff to be able to say, ‘What do I need to make clinical decisions right here and now?’ That has been a move of ours over, I would say, the last three years. It takes quite a long time to get the right measures in place on a system that everybody can access at the front line. We are very pleased that we have made big headway, and I think that we are probably the first country that has been able to do this on all of our in-patient areas.

[31] **David Rees:** Leighton has a supplementary question on this.

[32] **Leighton Andrews:** I was interested in the talk there about moving away from spot checks and those kinds of things. What is the nature of your relationship with Healthcare Inspectorate Wales?

[33] **Professor White:** It obviously has to be independent from the directorate where I sit, because it needs to be able to go out to independently look at how services are conducted. Healthcare Inspectorate Wales is a separate directorate within Government, as you probably know, which means that I meet with HIW at very fixed points. We have shared meetings—I think that it is once every two months; or is it once a month? It is on a regular basis, I cannot quite remember—

[34] **Leighton Andrews:** Not regular enough for you to remember.

[35] **Professor White:** Sorry—

[36] **Ms Whyley:** They are monthly, and I attend—

[37] **Professor White:** Yes, she goes for me most of the time. So, we have these regular meetings where we share intelligence. We get copies of all of their reports, and on a one-to-one basis I get to see the chief inspector on an ad hoc basis should there be a particular concern. I had a meeting with her not so long ago about a particular initiative that we wanted to drive forward, which was around things to do with fundamentals of care and rolling that out into the care home sector.

[38] **Leighton Andrews:** Could you let us have a note on where Healthcare Inspectorate Wales reports have informed your own practice?

[39] **Professor White:** Okay. At this precise moment?

[40] **David Rees:** No; you could send committee a note following this meeting.

[41] **Leighton Andrews:** It would be unfair to spring that on you.

[42] **David Rees:** That would be very helpful. Rebecca has the next question.

[43] **Rebecca Evans:** I would like to move on to midwifery and maternity care. I know from your paper that you chair six-monthly performance board meetings with the local health boards, where they have to demonstrate performance against Wales’s maternity service outcome indicators and NHS performance measures. Are there particular health boards or particular hospitals that give you cause for concern in terms of meeting the desired outcomes?

[44] **Professor White:** Could I invite Polly to lead on that?

[45] **Ms Ferguson:** They are all different. We have made some great headway with

maternity, but the biggest challenge is to have IT systems. I know that that sounds like not the most important thing, but unless we have that right, we do not know how well they are doing. Over the last 18 months we have really pushed health boards to sort out their ability to collect data so that we can measure what we want to measure. They are at different stages. There are seven health boards and there were five different IT systems, so it is difficult to standardise anything and say, 'You will collect like this'. So, we have insisted that they use their own systems. Whatever system they use, that is fine with us, as long as they can measure what we want to measure. Powys had a problem, because it did not have any IT system—it was all done by pen and paper, and by trawling through paper records to find the stuff that we wanted. However, it went online in October. It was probably the laggard, but it is online now. Betsi Cadwaladr is progressing. Of its three sites of maternity services, one now has an IT system in place to collect our data, and two are just about to introduce that.

[46] **Professor White:** In terms of some of the issues that you were talking about, and the sorts of things we are finding variation in, caesarean section rates are one of the things that we monitor very closely. It is a requirement from the public accounts committee on maternity services that we do that. What we have identified is that there are certain pockets of practice that seem out of step with other parts. If you take, for example, parts of Cwm Taf health board, you will see that its results are much higher than Cardiff and Vale's results, yet they are geographically very close, and there are no great dissimilarities in the population. So, when we have found those sorts of differences, we do ask the health board to do specific things. We ask it whether it is looking at feedback clinics, allowing vaginal birth after caesarean section by encouraging women who are confident to go back. It is that kind of thing that we pick up at the performance board meetings and allows us to say, 'This hospital is an outlier. What are you doing about looking at the practices there? What are you doing about doing work with others that have much better rates to look for good practice?', to encourage the sharing of good practice.

[47] **Rebecca Evans:** Could the level of access to consultant-led or midwife-led maternity care influence the rate of caesarean sections?

[48] **Ms Ferguson:** Yes, possibly. It tends to be higher in consultant-led services.

[49] **Rebecca Evans:** So, potentially, people who do not necessarily need them are being offered them just because they are available.

[50] **Ms Ferguson:** I would not say that it is people who do not really need them. It happens when you start to intervene. If you bring a woman to hospital, that is an intervention. If she is a healthy woman with no risk factors, it is very safe for her to give birth in a midwife-led unit. However, we would obviously want a woman to choose that. Someone may feel vulnerable in a midwife-led unit, because there is no access to epidural analgesic, for example. So, lots of women choose not to go to a midwife-led unit because, rightly, they want some pain relief. However, the minute you have an epidural, you have increased your risk of having a caesarean section, because you are lying flat on the bed and are being monitored. There is a cascade of intervention. I am not saying that we are doing unnecessary caesarean sections, but we cause a cascade of intervention by admitting people to a consultant-led unit. That happens.

[51] **Rebecca Evans:** I want to take you back to the first question on data collection. What kinds of data are being collected? I know that there are different systems in place, but are the same data being collected?

[52] **Ms Ferguson:** Yes, absolutely.

[53] **Rebecca Evans:** Are we talking about data on maternal health?

[54] **Ms Ferguson:** We have standardised, for now, a set of outcomes and performance measures across Wales that we want to know, which are mostly in relation to the health of women, so that we have an idea about the extent of the challenges so that we can make sure that midwives are trained and able to give the right advice and guidance. We are asking about smoking, diet, exercise, weight—so, public health measures—because they have an impact on outcomes. We are also collecting data on caesarean sections, low-birth-weight babies, breastfeeding and satisfaction.

[55] **Professor White:** And staffing.

[56] **Ms Ferguson:** We also measure staffing at the performance boards. We require all health boards to be compliant with Birthrate Plus, which is a workforce planning tool for midwifery. We require them to be compliant, and we ask them about this twice a year at the performance boards.

[57] **Rebecca Evans:** Have they ever not been compliant?

[58] **Ms Ferguson:** Yes, at the very beginning, but we asked them to address it very quickly and now they are all compliant. At the first board, some of them were not compliant, but we have had three boards, and are just about to go into a spring maternity board, and they have all told us that they are compliant since then.

[59] **Rebecca Evans:** I have one last question.

[60] **David Rees:** Two more Members want to come in on this, so is your question on a different subject?

[61] **Rebecca Evans:** It is on the same subject.

[62] **David Rees:** Go on, then.

[63] **Rebecca Evans:** My final question is about your particular role in working with colleagues across the NHS in moving towards some of the specific targets that have been identified for improvement, such as ensuring that staff have competency to interpret electronic foetal heart-rate monitoring data and improving workforce planning generally. What is your role within that mix of responsibility?

[64] **Professor White:** I would just like to comment on foetal monitoring and then I will bring Polly back in. I worked with the Welsh Risk Pool Services last year and chaired a national group that was made up of doctors, midwives and Public Health Wales officials to develop the approach for training all midwives and obstetricians in using the foetal monitoring equipment. They should be compliant with that training by the end of March. We issued the guidance last year and it complies with the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives standards of training—it is their package. It has the ability to update people on a regular basis, which will then ensure continued good practice. It also sets out where various people of various grades should be within either understanding it or addressing when to call for help, or dealing with the issue. Polly, do you want to come in?

[65] **Ms Ferguson:** Yes, the e-learning package is progressing. We require everyone to have completed it by the end of March.

[66] On workforce plans, Birthrate Plus is the way in which we plan for maternity staffing. We require health boards to undertake an assessment. Birthrate Plus tells you how many

midwives you need, but of course that changes depending on the type of unit you are working in. We ask health boards to repeat that assessment and calculate how many midwives they need every three years, or earlier if there has been a service change. So, with the service changes that are going on at the moment, when we know exactly what the service changes are, we will require all health boards to reassess their midwifery staffing levels.

13:30

[67] **David Rees:** Before I ask colleagues to come in, have you done an analysis of what effect the revalidation of midwives might have upon that? Is there going to be an issue within the revalidation requirements?

[68] **Ms Whyley:** Revalidation of midwives is not a devolved issue; nurses and midwives are regulated by the Nursing and Midwifery Council. The NMC is currently consulting on a way forward. The consultation asks anyone who is interested to respond to think about the format of nurses or midwives validating themselves as being fit to remain on the register, and to have some sort of third-party confirmation. The council is currently consulting on what that third party means: does it mean a service user, a relative, a peer or a line manager? So, the NMC is currently going through that process, with which the chief nursing officer's office has been actively engaged. When we know more about what the model will look like, we will have a better idea about what that will mean.

[69] In terms of midwifery, midwives already have a statutory requirement for supervision, so they are, in many ways, ahead of the game. There is already a standard from the NMC, called the 'post-registration education standard', which everybody has to meet as well. That requires a certain degree of updating every three years. So, we are assessing what that might mean, but we have a very good working relationship with the NMC and its strategic groups and sub-groups to understand what that means, and that includes people from the service as well.

[70] **Gwyn R. Price:** You have answered my question a little bit there on minimum staffing levels for maternity wards. What checks are in place to make sure that maternity wards are staffed to the right levels?

[71] **Ms Ferguson:** That is about trust. We ask them whether they have done a Birthrate Plus assessment, how many midwives they need and how many they have. We would trust that they tell us the truth. I think that they do.

[72] **Gwyn R. Price:** So, there is nothing in place on your side that would highlight it if they are not telling the truth.

[73] **Ms Ferguson:** It is about the triangulation. I am not suggesting that they would absolutely know, but we would know from patient surveys if they were not satisfied with the care that they were getting. Patients are satisfied with the care that they are getting, but if they were not we would want to look at a health board.

[74] **Professor White:** If I go back to an earlier comment that I made about monitoring critical and serious incident reporting, that is one of the things that we ask when we see something come in. What was going on in that ward? Were they short of staff? This relates to midwifery and nursing. What was the context? What led to that particular problem? That is one end of the check, but Polly and I do not go out and look to see what their staffing levels are. We take their reports at face value.

[75] **Ms Ferguson:** I work very closely with the heads of midwifery; I meet them every two months. They share those challenges with me, because they are pretty passionate about

wanting safe staffing levels. So, they would discuss with me if they were having challenges.

[76] **Gwyn R. Price:** I was wondering about the pressure that they are under, and whether they are telling you, ‘We are a bit short; can we have some more?’

[77] **Ms Ferguson:** Absolutely. They tell me.

[78] **Lynne Neagle:** I have a supplementary question on that, and I also wanted to ask about neonatal care. In relation to what you said about patients not giving feedback, community health councils do ward rounds and talk to patients. Have any concerns been flagged up with you by any of the CHCs about nurse staffing levels?

[79] **Professor White:** No, not reported to me in that way. The relationship with CHCs tends to be through the board. So, if they go in to do inspections and so on, they normally tell them at the board level rather than come to us as the Welsh Government. So, I would not necessarily know if they raised things on the ground when they were walking around.

[80] **Lynne Neagle:** So, you would not expect, if the CHC had made a report to the board about concerns, that the board would notify you.

[81] **Professor White:** That is right. They do not currently do that.

[82] **Lynne Neagle:** May I just ask about neonatal services, linked to midwifery and maternity services? This has been a long-standing area of concern in the Assembly. When the Children and Young People Committee did its inquiry, one of the areas that we were worried about was nursing, because we were hearing about shortages, difficulties in recruiting and severe difficulties in allowing nurses who were on the wards to go off to do the training that they needed to develop their skills. Are you able to provide any update on how things are going in that area, in terms of compliance with the standards set for neonatal care?

[83] **Professor White:** I think that it is a good news story. We have the neonatal network, as you know, which supports the NHS, and it has recommended that all the neonatal units should comply in staffing terms with the BAPM standards—I can never remember what BAPM stands for—

[84] **Ms Ferguson:** It is the British Association of Perinatal Medicine standards.

[85] **Professor White:** It is the professional gold star. All health boards that have a neonatal service have been looking at their workforce, and we have seen increases in nursing recruitment right across Wales. There are still some that need to continue with that, but the numbers are very small compared to what they were when we started this journey, because it was quite significant. The other area that we are negotiating and debating is advanced practice within neonatal units. One of the key areas of excellence in Wales at the moment is setting out what advanced practice within nursing, midwifery and allied health professionals should be. We have been sending folk to centres of excellence in order to do that. The numbers are too small for us to run a programme ourselves, but we commission and pay for people to go on advanced practice programmes, and that is taking us in a positive direction as well. Polly, I do not know if you want to add anything?

[86] **Ms Ferguson:** No, that is good news.

[87] **David Rees:** Do you want to ask about school nursing?

[88] **Lynne Neagle:** Now?

[89] **David Rees:** Yes, it follows on from that.

[90] **Lynne Neagle:** I have some questions on Flying Start. Your written evidence talks about the work that is nearing completion on the development of the all-Wales healthy child programme and also the common assessment tool for health visitors. Are you able to tell us when that is going to be rolled out in Wales, and also how that will fit in with the significant expansion that we are going to see of Flying Start? Is everything keyed up for that?

[91] **Ms Ferguson:** We are planning that the healthy child programme will be agreed by health visitors, paediatricians and stakeholders by the end of March. So, that is the programme agreed. Then, we have to give it to health boards to implement it. There will be some training required for delivery, so we will then have to talk to health boards about how long they think it will take, but it will be soon. It will not take long. It will be written by the end of March. What else did you ask me?

[92] **Lynne Neagle:** I asked about the fact that we are going to have a big expansion of Flying Start at the same time as we are rolling out these new initiatives.

[93] **Ms Ferguson:** I think that the other bit of good news is that we are really keen to make sure—obviously, Flying Start is a separate programme and it is measuring outcomes in a very particular way, which is great—that generic health visiting services measure in the same way, so that we can compare and contrast. There is no point in making up different outcome measures for different parts of Wales, so we have worked really closely together so that, as Flying Start expands, it will just be an expansion of something that has been standardised in terms of outcome measures. Clearly, Flying Start has more input, but we want the same outcomes for all children.

[94] **Lynne Neagle:** May I just ask about school nursing, particularly the health needs of children in special schools? We have had the report that you commissioned on the health needs of children in special schools and I understand that that has been completed and is with the Minister. Are you able to tell us what the key recommendations coming from that report are, and when you expect the Minister to take a decision on this?

[95] **Professor White:** I will answer the latter part first. It will be in our next year's work programme. We have to have the budget confirmed to do that. So, the roll out of what we do next, and how we pilot the wrapping arrangements around the family-type approach that we want to test, will be after April. So, that is the kind of general direction of that. Polly, do you want to share some of the feedback from the—

[96] **Ms Ferguson:** Yes. This is not such a good news story, whereas the rest have been good news stories. This is the first look at special schools since the school nursing framework was set up. We had not really looked at special schools and, now that we have, we realise that it is a little bit muddled. There is some duplication of care and there is a lack of care, which is basically a lack of co-ordination between health services and all the key workers in health, education—because education provides care for those children—social services, and therapies. It is not a great picture, but we think that there is something that we can do about it by looking at developing a team around the child approach, with all key workers sharing a single vision for where we want to get to and working out who, for each child, is the lead professional. It is complicated. Some children have emotional needs. That would not necessarily be a matter for a health visitor. Some have physical needs, which might be a matter for a children's nurse. All children need that public health generic look, which is a matter for a health visitor. It is a matter of thrashing out what each child needs and who the key co-ordinator is. Although one child might need the care of a children's nurse, that nurse could provide a health visiting service. She could also provide the public health immunisations, and the heights and weights checks. She could do everything. We need not

bring in lots of different nurses for one child, particularly a child who might feel quite vulnerable to have lots of people caring for him. So, it is a matter of looking at a new model for school nursing, which we want to do from April.

[97] **Lynne Neagle:** Okay, thanks.

[98] **David Rees:** Obviously, we have talked an awful lot about ward nurses and school nurses—I understand that—but clearly there is an increased pressure on the acute units. Part of that, therefore, looks at transferring patients to the community. So, in a sense we need to look at district nurses and community nursing. What analysis have you done of the workforce in those areas to be able to deliver the Government programme of increasing the amount of care being dealt with in the community itself?

[99] **Professor White:** Perhaps I could start the conversation and I will pull in colleagues as appropriate. The approach that is being taken by the health boards at the moment is to look at locality working. That means that they have to co-ordinate the services to meet the needs of the population. This is quite a different approach to what has been done previously. We recognise that different kinds of interventions will be necessarily. So, rather than looking at a one-size-fits-all solution across Wales for district nursing services or an outreach service in chronic conditions, we expect the health boards to determine what that population needs and then develop the skill mix and the service to meet that requirement. The reason why I am labouring that point is because it is very difficult then for us, as the Welsh Government, to say, ‘Yes, absolutely, we will need to have x number of people to deliver that’, because they are currently still doing the work on that.

[100] We are finding that there is a shift, if you like, from a reliance on having a district nursing service to more of a combination of different types of nursing roles in the community, which is actually a positive thing, to be honest, because it means that we are seeing the expansion of specialist and advanced roles of people who are in particular teams that work on target areas, whether it is frailty in the elderly, people living with chronic conditions, or having a crisis management team to enable people to stay at home rather than being brought into a hospice. When we look at the community service, we see that it is a much more complex picture than just saying, ‘Let’s just look at how many district nurses we’ve got’.

[101] Currently there is probably double the number of community staff nurses than there are district nurses. In the past—a few years ago—there was no real training for the community staff nurses. The training was designed to train district nurses. We introduced a modular community approach that allowed the nurses working in the community to have some training as a staff nurse, and they could, part-time, develop up to being a district nurse, as well as offering the full-time district nurse course that we always had. We have tried to look at having a more flexible training approach for meeting the needs of those people working in the community, whether they are community psychiatric nurses, community learning disability nurses, community children’s nurses, or community staff nurses working in an outreach team or a crisis management team. The picture is very complex. So, it is quite a difficult thing to answer in a simple way.

[102] **David Rees:** I have to bring in Lindsay and Rebecca in a minute. First, however, I understand the difficulty in answering that. However, I have received representations, as an Assembly Member, from district nurses on the pressures that they sometimes face. How are your discussions going with local health boards to actually ensure that those mechanisms are in place to support district and community nurses?

13:45

[103] **Professor White:** Okay. This is part of a much wider thing than just nursing, I should

say. The approach that we have been taking is to look at the integrated care model in the community, so there is a sort of policy drive from us to say, 'You must think on a locality basis'. This is from Dr Chris Jones's work in Cwm Taf some time ago about setting the direction for a community. So, that is the policy direction. However, what we were finding was that the integration of services between health and social care, which is all about enabling people to live safely in their communities, needed to be stepped up. In recent times, we have taken a much more integrated care approach to working with the health boards. So, whereas I may talk to the nurse directors about how they are developing and modernising their nursing workforces, it is actually one small slice of a much larger piece of work that Government is doing with community around what services you need, what staff you need and how you share information across the sectors and between the sectors and the hospital. Do you want to come in on that at all, Helen?

[104] **Ms Whyley:** I just wanted to add the role of workforce, education and development services on behalf of the Government. Its role is to commission the specialist training for community staff, such as district nursing, health visiting et cetera, as well as to commission preregistration courses across all the professions. So, on behalf of the Welsh Government, it has a range of tools that allow health boards to workforce plan and, as part of the assistance it gives the health boards in planning their workforces, it will be acutely aware of all the strategic drivers and different aspects that the health boards need to consider when they are considering, 'What does our workforce need to look like for the future, future patient need and the future service change?' So, there is a whole team of people that does that, and that information is shared across a stakeholder group, which includes unions, professional bodies, et cetera.

[105] So, we can come together on an annual basis and talk about what is being commissioned, whether it is right, whether they have thought about things like Flying Start or movement into the community, so that we are getting the training right, getting the workforce numbers right and not getting ourselves into a position where we will not have enough nurses or midwives et cetera into the future. That has been very successful over the last 10 years. You will see from our workforce statistics that, actually, the nursing and midwifery workforce is fairly stable. It has had a slight rise. We have not seen great big troughs like we had back in the late 1990s when we had to go overseas to find the right staff to deliver the services.

[106] The last thing I would add in terms of that group—the workforce, education and development services—is that it also works very closely with the deanery so that we can talk about how roles need to change and adapt and improve into the future.

[107] **David Rees:** I think that Rebecca has a quick question on this and then Lindsay wants to come in as well.

[108] **Rebecca Evans:** I just wanted to ask whether you have a list available for us of the kind of indicators that you look for or that you consider when determining the workforce plan, because what you have described is almost the opposite of what is happening with doctors, where we are hoping to allow doctors to see a much wider range of people and conditions. What you are describing makes it sound as though the nursing profession is moving into more specialist sorts of roles.

[109] **Ms Whyley:** The work is done on behalf of the Government by the workforce, education and development services and it contextualises the work each year. So, for example, for the commissioning rounds that are taking place this September, it will have looked at the requirement for Flying Start for health visitors. So, the indicators are not static, happening every year, but more about the context, that broader environment of what the requirements are of moving out into the community or what we are doing in terms of Government initiatives on school nursing or Flying Start. However, I am sure that we would

be able to provide some information about how it bases that critical friend role that it has with the service in the workforce planning process.

[110] **Rebecca Evans:** Yes, that would be interesting.

[111] **David Rees:** That would be interesting. Lindsay is next.

[112] **Lindsay Whittle:** Thank you. The emphasis is obviously on moving people out of hospital for their care and their recovery, or sadly not, to be at home. However, I want to ask whether the Welsh Government has got the investment correct? As I see the figures—and I can only go on what we have here—over a 10-year period, the number of registered midwives has risen as have as the numbers of healthcare assistants and health visitors. However, the number of qualified staff has only increased by 46 over 10 years, and yet the number of midwives lost over 10 years is 80. Are we going backwards? That is what I have to ask. Bearing in mind that our emphasis now is to care in the community, surely we need more district nurses.

[113] **Professor White:** If I could start on that, what I was trying to allude to in my introductory comments on this was that the district nurses are not the main part of the community team. There are actually twice as many community staff nurses out there as district nurses—

[114] **Lindsay Whittle:** I do not have that figure here.

[115] **Professor White:** —and you would not necessarily see those in the headline figures because district nurses have to undertake a particular programme of training in order to be recognised as that. It is a specialist qualification that the Nursing and Midwifery Council recognises. So, if you like, the district nursing figures that you have in front of you give you a bit of a skewed picture of the number of nurses working within the community. There are a large number of nurses that have a variety of advanced or specialist roles, or who just work in crisis teams—step up, step down-type teams—as there is need for those individuals. They would not be district nurses. They would work alongside the district nurses as part of an approach for the locality. So, I am afraid that the headline figure that you have in front of you is probably giving you a little bit of a worse picture than it actually is.

[116] On whether or not we have the right number of district nurses, I think that is a fair question to ask. One of the things that we have identified in our acuity and dependency tool work is: how do we work out how many of these people we ought to have? That is a bit of a different question. At the moment, we are exploring how we can develop a tool for Wales that will help to give a professional judgment around community teams, nursing teams, in the same way as we have done for the medical and surgical wards in hospitals. It might be that we need some more district nurses, or it might be that the number we have is quite right. It is the reason we chose this as a priority area for us, to actually put some evidence base behind some of the local decisions that are being made by health boards, because what you will find from some of your conversations is that you will have varying caseloads for the district nurses, and who is to say, at the moment, whether one is too high or too low? We need to actually bring some system towards this to help the health boards to make better judgments around this, and to help them have the right workforce in place. So, I am not suggesting that it is not safe at the moment. What we want to do is do the same as we were doing for in-patients in the community to help them to make better decisions about the skill mix and the case load management for the community team. That is an important piece of work for us, to be honest.

[117] **Lindsay Whittle:** Through you, Chair, it might be useful if you could provide us with those figures, because to me, as a lay person, obviously, all the figures are increasing, and the population is increasing, certainly in the last 10 years, but the number of district

nurses has fallen by 80 across the whole of Wales, and that sounds worrying.

[118] **Professor White:** Indeed, I am happy to do that.

[119] **Lindsay Whittle:** Thank you very much.

[120] **David Rees:** May I ask about infection control? In your paper, you highlight that most health boards have transferred the responsibility of infection prevention and control to the nurse leader at the executive level, and you have indicated that you are developing a code of hygiene this year. Could you give us an indication as to when that will be available? We are seeing at the moment examples of wards being shut at hospitals because of norovirus, and therefore it is a major issue affecting both the care of patients in the hospitals and accessibility, because if wards are shut, that causes a difficulty in accessibility.

[121] **Professor White:** Unfortunately, it happens every winter; cold weather and the norovirus outbreaks go hand in hand. There is a direct relationship to that. We put out in December 2011 a commitment to purpose that set out for the health boards and trusts in Wales what they should be doing in both the community and hospital settings about driving improvements. In December of last year, we brought the health boards' executive teams together and spent a day and a half going through what it is they needed to focus on in order to drive improvements. The code that you referred to there is just one of a number of activities that we want to help the health boards to drive improvements in this area. We have seen a very positive step change in infection rates. It is becoming now more of a gentle slope than another step change down and what we want to do is re-energise the system. In England, they actually put out this code to be a mandatory one, and we are exploring putting it out in a similar kind of way. It is not quite the same, but it will be very clear what people's responsibilities are around hand hygiene, dress sense and how they should behave. We are expecting it to be done this year. Public Health Wales is leading on this piece of work for us. I am sorry, I do not know the exact launch date that we are requiring—I think that it is in the autumn, but I can confirm that for you, post-meeting, should you require it.

[122] **David Rees:** You also highlight in your written evidence that, in fact, it is wider than just hospitals and secondary care; it goes across the range. Are you, therefore, in discussions with Public Health Wales to ensure that that message gets out on a wider basis across all areas?

[123] **Professor White:** Indeed. One of the big challenges that we have is around antimicrobial prescribing at the moment. There are great variations, particularly within the general practice workforce, around prescribing in the community. So, whereas we are seeing real improvements in hospital-acquired infections, we need to now start focusing some of our attention on antimicrobial prescribing. So, on that side of my remit as the chief nurse, I work with the chief medical officer in this particular field, and it is a priority for us to make sure that we get prescribing right, because there is a direct correlation with things such as *C. difficile* outbreaks, which cause considerable harm to the people who suffer from it and incur costs, obviously, for the service.

[124] **David Rees:** I have another question, in that case. We have also heard of various examples of patients who have perhaps not been cared for because they either have learning difficulties or experience dementia. I notice in your evidence that you talk about a programme that has been in place since 2012, going up to 2015. What monitoring are you making of the progress of that to ensure that care is being delivered to those people?

[125] **Professor White:** The report that I was talking about there is actually a UK-wide initiative. It is called 'Strengthening the commitment', and we have a national work group for the Welsh element of this, because, as I said, it is a four-country piece of work. It produces

for me a report on a regular basis. There are 17 recommendations that it is working to, and I am happy to share with Members a copy of the December report—I think that it is the December report; I had it just before Christmas—around that. If you would like, I can give you some examples of the sorts of things that are being driven forward—I know that time is short, so I will keep the examples short—if that would be helpful.

[126] **David Rees:** Yes.

[127] **Professor White:** So, for example, if we are looking at things to do with promoting making sure that people with learning disabilities have access to health checks, in the north, in Betsi Cadwaladr, there is a health liaison team that works collaboratively with primary and secondary care services right across Wales. The team provides quality checks for health screenings provided by general practitioners and they actively involve the rolling out of individual health action plans. So, it is determined by the person's need. These liaison nurses work across the three district general hospitals in the area, and the team has a gentleman who has learning disabilities himself to make sure that the way that it communicates with people is clear. That is part of the problem—our health services are very confusing to people, and how you articulate what they need to do in a non-threatening way is a key element. I have many pages of examples of the work being rolled out, and I know that time is short, so I am happy to share more if you are interested, but—

[128] **David Rees:** I think that Members will be happy to receive a copy of that. Thank you. Are there any other questions from Members? No? I will ask one final question then. You talked about the pinch point for bank agency staff, which is, basically, intensive care, earlier on, but, of course, there are other areas of specialised nursing, and we have often received representations about that area of nursing care. What progress is being made by the Welsh Government in developing more staff who will provide specialised care in particular fields, such as cancer care?

[129] **Professor White:** I think that one of the things that we have led on in Wales, which is being showcased right across Europe, is our approach to advanced practice. We are one of the few countries that have set out a framework for advanced practice. We held a celebration sharing event that the Minister chaired back in December, and it is that introduction of a concept that has really led to some significant service change. For example, in emergency departments that frequently have challenges in recruiting medical practitioners we have advanced practitioners who run minor injury units and are able to diagnose and treat patients without their necessarily having to be referred to a medical practitioner. We are seeing roles right across the specialist areas.

14:00

[130] In fact, Helen and I met this morning with representatives from the Consultant Nurse, Midwife and Allied Health Professionals Cymru group, which are the most senior of the clinical roles that we have in Wales. They are setting up and leading services in complete isolation to medical practitioners. I see this as a key development area for us. This year was the first time that the Welsh Government provided central funds to support the training of these individuals, because you cannot conjure them up overnight; it takes quite a long time to have somebody from an alternative background to diagnose and treat patients.

[131] This is a Master's-level education and is very highly technically skilled, and it is something that we are seeing as a major change for us. Wales is being looked to as leading the way. We often have requests from outside of Wales about our practice; the Royal College of Nursing is adopting our framework tool. I link with the World Health Organization's European region, which has asked for our work to be showcased. One of the things that I am very proud of in Wales is that we are doing things with our staff to make them more skilled

and able to lead and develop services. If any of you were watching TV last year, there was a Channel 4 programme called 'Nurses', which was filmed here in Cardiff. There were five hours showcasing advanced practitioner roles—everything from pop-up drug and alcohol treatment centres in the middle of Cardiff on rugby international days to a consultant nurse who runs a breast clinic in complete isolation, without referral to a medical practitioner in most of her work.

[132] **David Rees:** Rebecca, did you want to come in on this?

[133] **Rebecca Evans:** Yes. We hear frequently how difficult it is to attract doctors to work in certain parts of Wales. Are there similar difficulties in attracting advanced practitioner nurses to certain parts of Wales, or do you skill-up the staff that you have?

[134] **Professor White:** There is no recruitment problem. In fact, for training within Wales, we are very lucky that it is a very rich market. So, we have no difficulty getting people to train as nurses. We have no difficulty in getting people wanting to take on advanced roles. There is not an area in Wales that I would say I was concerned about. Whether people want to take on certain roles is a matter of choice, but we offer central funding for advanced practice roles and it seems to be well taken up. We are very encouraged by that. It is quite a lively community, I have to say. It is quite a pleasure to be the chief nurse, having such wonderfully motivated people.

[135] It is the same with midwives. If you look at some of the applications for midwifery training, you are talking about hundreds per place wanting to come to Wales to train.

[136] **Ms Ferguson:** Thousands per place.

[137] **Professor White:** Thousands per place. It really is quite a positive community, I have to say.

[138] **Rebecca Evans:** Lastly, I know that shift patterns and the threat of litigation puts off doctors from certain specialisms. Are there certain areas of nursing that people are put off from because of shift patterns or the threat of litigation?

[139] **Professor White:** Again, it is one thing where some of the flexibility that has been introduced helps. If you want to have a very flexible work pattern, you can work on the bank and say, 'Well, this week I'm going to work a couple of nights, next week I'm not going to do any, thanks very much, because I need to be with the kids'. So, you can go from that extreme to having a full-time job that has very regular hours. If you are working in a clinic, you can work Monday to Friday and so on. So, I would say that the arrangements within NHS around flexibility do not tend to cause us a major problem. Helen, I do not know whether you wanted to add anything.

[140] **Ms Whyley:** I am not aware of any particular specialties that find it very difficult to recruit. In the past, we have had some issues with intensive care, but those are much more minimal now. There are some good methods of allowing different shift patterns, et cetera. What we sometimes see that is particular parts of the workforce will favour working in various areas. If you take an age profile, you are more likely to find younger nurses wanting to work in the more acute—let us call them 'sexy'—areas, such as A&E, et cetera. However, nursing has the ability to allow for a career, so people move out into things such as district nursing or health visiting, et cetera. So, generally we find that we can recruit. Sometimes, there are some other issues that might lead to problems. For example, Betsi Cadwaladr University Health Board has some issues recruiting at the moment, but that has not been about the shifts or the specialties, et cetera.

[141] **David Rees:** As no Members have any further questions, I thank you for your attendance today and for the evidence that you have given; we greatly appreciate it. You will receive a copy of the transcript to correct any factual errors. Thank you.

[142] If it is okay with Members, I would like to move on to item 5 next, as it is papers to note, and I would rather look at these in the public session, rather than in private.

14:05

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

[143] **David Rees:** We have two papers to note. First, we have the minutes of our meetings on 16 and 22 January. I see that you are happy to note those.

**Cynnig o dan Reol Sefydlog 17.42 (vi) i Benderfynu Gwahardd y Cyhoedd ar
gyfer Gweddill y Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public for the
Remainder of the Afternoon's Business**

[144] **David Rees:** I move that

the committee resolves to exclude the public from the remainder of the afternoon's business in accordance with Standing Order 17.42(vi).

[145] Are Members content with that? You are. Thank you.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 14:06.
The public part of the meeting ended at 14:06.*