Health and Social Care Committee

Meeting Venue:
Committee Room 3 - Senedd

Meeting date:
Thursday, 19 March 2015

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
Llinos Madeley
Committee Clerk
0300 200 6565
SeneddHealth@Assembly.Wales

Agenda

1 Introductions, apologies and substitutions (09.00)

2 Safe Nurse Staffing Levels (Wales) Bill: evidence session 14 (09.00 - 10.10)

Kirsty Williams AM, Member in charge of the Safe Nurse Staffing Levels (Wales) Bill
Lisa Salkeld, Legal Services, National Assembly for Wales Commission
Philippa Watkins, Research Service, National Assembly for Wales Commission

Safe Nurse Staffing Levels (Wales) Bill

Explanatory Memorandum

Break (10.10 - 10.15)

3 Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: general and financial scrutiny (10.15 - 11.45) (Pages 1 - 77)

Mark Drakeford AM, Minister for Health and Social Services
Vaughan Gething AM, Deputy Minister for Health

Dr Andrew Goodall, Director General, Health & Social Services
Albert Heaney, Director of Social Services & Integration
Dr Ruth Hussey, Chief Medical Officer
Martin Sollis, Director of Finance

4 Safe Nurse Staffing Levels (Wales) Bill: evidence session 15 (11.45 - 12.25) (Pages 78 - 95)

Melanie Minty, Care Forum Wales
Anne Thomas, Linc Cymru and representing Care Forum Wales
Michele Millard, Spire Cardiff Hospital and representing Welsh Independent Healthcare Association
Simon Rogers, Welsh Independent Healthcare Association

5 Motion under Standing Order 17.42(vi) to resolve to exclude the public from items 6, 7 and 12 of the meeting and for item 1 of the meeting on 25 March 2015 (12.25)

6 Safe Nurse Staffing Levels (Wales) Bill: consideration of evidence received (12.25 - 12.30)

7 Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: consideration of evidence received (12.30 - 12.35)

Lunch (12.35 - 13.30)

8 Inquiry into alcohol and substance misuse: evidence session 7 (13.30 - 14.10) (Pages 96 - 126)

Sue Goodman, the Wallich
Antonia Watson, the Wallich

Break (14.10 - 14.15)

9 Inquiry into alcohol and substance misuse: evidence session 8 (14.15 - 14.55) (Pages 127 - 133)

Stephen Coole, NUS Wales
Lucy-Ann Henry, NUS Wales

10 Inquiry into alcohol and substance misuse: evidence session 9 (14.55 - 15.45) (Pages 134 - 145)

Inspector Nick McLain, Gwent Police
Paul Roberts, Her Majesty's Inspectorate of Prisons
Assistant Chief Constable Jon Stratford, Association of Chief Police Officers

11 Papers to note (15.45)

Minutes of the meeting held on 5 March 2015 (Pages 146 - 149)

Supplementary Legislative Consent Memorandum - Small Business, Enterprise and Employment Bill: correspondence from the Presiding Officer (Page 150)

Correspondence from the Petitions Committee: P-04-625 Support for Safe Nursing Staffing Levels (Pages 151 - 155)

12 Inquiry into alcohol and substance misuse: consideration of evidence received (15.45 - 16.00)

Agenda Item 3

Document is Restricted

SCRUTINY SESSION WITH THE HEALTH AND SOCIAL CARE COMMITTEE – 19 MARCH 2015

NATIONAL ASSEMBLY FOR WALES: HEALTH AND SOCIAL CARE COMMITTEE
Date: 19 March 2015
Venue: Senedd, National Assembly for Wales
PART 1: GENERAL SCRUTINY SESSION

Purpose

1. This paper provides an update on key priorities across the Health and Social Services Ministerial portfolio, with specific reference to those areas of interest identified by the Committee in Annex A of their letter of 30 January. A separate paper (Part 2) covers our response on financial matters.

Overview of recent progress and achievements, and portfolio priorities

2. Since my last attendance at the Committee general scrutiny session on 18 September 2014, continued progress has been made in taking forward the Health and Social Services contribution to the **Programme for Government**. The latest progress report was published in June 2014 and work is in hand to inform the health and social service contribution to the 2015 report which will set out the detailed progress being made on health and social services commitments.

3. In terms of portfolio priorities much of the detail is set out later in the paper but continued delivery of the actions contained in **Together for Health** and **Sustainable Social Services: A Framework for Action** remain relevant and at the forefront of our work. However, as would be expected in a changing policy and fiscal environment there is a need continually to adapt so that we can respond to current challenges. Therefore, my priorities are driven by a growing emphasis on **prudent healthcare**; an increased focus on a **shift to primary care;** effectively utilising our new approach to **three year integrated planning** and our ongoing development of the **quality and safety** agenda.

4. Added to these priorities and in the context of the overarching framework of Together for Health and Sustainable Social Services, **tackling poverty** remains a key priority as we address health inequalities in line with the NHS-related commitments included in the *Building Resilient Communities: Taking forward the Tackling Poverty Action Plan*.

Session 1: General Scrutiny Issues

PRUDENT HEALTHCARE

5. Over the last 12 months as part of our continued response to the austerity challenges facing the NHS and social services, work has been undertaken to develop, codify and embed prudent healthcare principles into health services across Wales. Effort is being concentrated on the things that make a real difference and make the most effective use of resources. In doing so, it is clear that a renewed effort is needed to embrace a preventative, primary and community care-led NHS which is integrated with social care, and delivers as much care as possible closer to patients' homes, shifting the balance between primary and secondary care.

6. The latest set of chapters describing how prudent healthcare could work in Wales became available on the 'Making Prudent Healthcare Happen' online resource www.prudenthealthcare.org.uk in January 2015 at the annual Welsh NHS Confederation Conference. The first set of chapters, videos and case studies were made available on the website in October 2014.

Bevan Commission

7. The Bevan Commission has undertaken a further piece of work, published in January, to finalise the prudent healthcare principles for Wales, to help ensure that everyone involved in securing a healthier future for the population of Wales follows a common set of principles.

8. The Bevan Commission's final four principles are:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence based practices consistently and transparently.

9. The further prudent healthcare concept of 'only do what only you can do' remains a powerful one, especially for a prudent health and social care workforce for the future. It will therefore be important to maintain the concept that no professional should routinely be providing a service, which does not require their level of clinical ability or expertise – only do what only you can do – as Wales continues its prudent healthcare journey.

Next Steps

10. The Welsh Government and NHS Wales will focus on four key areas where putting the prudent healthcare principles into practice will be especially important in the year ahead. Together we will:

- Continue to put primary care in the driving seat of the NHS in Wales;
- Re-design the workforce for the future and redeploy our most precious resource;
- Maintain the impetus in remodeling the relationship between the people who use health services in Wales and those who provide them, including support for the Academy of Royal Colleges of Wales *Choosing Wisely Cymru* campaign; and
- Mobilise our thinking about the way we provide care for people.

11. To support this, the Welsh Government will host its first prudent healthcare conference this summer, which will be opened by the First Minister. It will have an international reach and involve key partners who are furthering the prudent healthcare movement, including health boards and NHS trusts, the Royal Colleges, NICE and the BMA.

TOGETHER FOR HEALTH DELIVERY PLANS

12. Delivery Plans for Cancer, Mental Health and Stroke were published in 2012, and Plans covering Respiratory Health, Oral Health, Eye Health, Heart Disease, Diabetes, Neurological Conditions, End of Life Care and Care for the Critically Ill have been published within the last 18 months. A delivery plan for Liver Disease has been developed and following a public consultation period, is being finalised to take account of feedback received.

13. National Clinical Lead posts have been established for diabetes, stroke, end of life, unscheduled and planned care with implementation groups meeting on a regular basis to take forward the actions in the plans.

Cancer

14. We are making good progress in implementing the Cancer Delivery Plan. Our third annual report published in January 2015 highlighted progress made in cancer services over the past 12 months and identified areas for future improvement.

15. The Cancer Implementation Group was established to ensure that the requirements of the Cancer Delivery Plan are delivered, and has an important role in monitoring progress. The Group is chaired by Paul Roberts, Chief Executive of Abertawe Bro Morgannwg University Health Board and is made up of senior clinicians and Welsh Government officials.

16. The transparent publication of national and local annual plans and reports means local communities, organisations and other groups are able to challenge health boards on progress. We have accepted the Committee's recommendation to strengthen these arrangements further to drive faster progress.

17. The five priorities for the next year are: the organisation of cancer support services to ensure improved services; delivery, planning and performance; primary care oncology; the development and piloting of a single urgent cancer

pathway; patient experience including the delivery of consistent key worker policy, improving patient information and a national focus on lung cancer.

Diabetes

18. The Diabetes Delivery Plan was published in September 2013. It picked up the recommendations made by the Committee as part of its Inquiry into the National Service Framework (NSF) for diabetes. The first national annual report on the Diabetes Delivery Plan was published in January 2015 and shows how diabetes services are improving and what challenges remain to be tackled.

19. The Diabetes Implementation Group, chaired by the Chief Executive of Cardiff and Vale University Health Board, has met quarterly, and is taking forward the Diabetes Delivery Plan and the recommendations from the Committee's inquiry into the delivery of the Diabetes National Service Framework.

20. Progress is being made on the recommendations, and a detailed update progress against each of the Committee's recommendations is attached at **Annex A**.

Respiratory Conditions

21. Following the publication of the Respiratory Health Delivery Plan in April 2014, health boards have developed their local delivery plans, which were peer reviewed at the Implementation Group meeting on 20 January. Common issues across the plans were consideration of Chronic obstructive pulmonary disease (COPD), asthma, Interstitial lung disease (ILD), sleep, pneumonia, lung cancer and bronchitis; as well as provision of smoking cessation, end of life care, pulmonary rehabilitation, vaccination and psychological support.

22. An addendum to the delivery plan is being developed to focus on paediatric respiratory services and a subgroup to the Implementation Group is also to be established on this issue. The addendum will take into account the recommendations of the National Review of Asthma Deaths report, which highlighted specific issues relating to paediatric care.

Liver

23. Deaths in Wales from chronic liver disease have more than doubled in the last twenty years. A delivery plan for liver disease has been developed and following a public consultation period, is being finalised to take account of feedback received. The plan is expected to be published by the end of April.

Mental Health Strategy

24. The second annual report on progress against the Together for Mental Health Delivery Plan (2012-16), was published in January 2015, and set out the progress made in the second 12 months in delivering against the commitments.

Mental Health (Wales) Measure (2010)

25. The recommendations of the recent Health and Social Care Committee's post legislative scrutiny of the Measure reflect the work that is being undertaken in the overall Duty to Review the Measure. The final Duty to Review report will be published later this year. In the new local primary mental health support services over 75% of people have assessments within 28 days and over 90% of people in need of therapeutic interventions are seen within 56 days. Now that over 90% of people in secondary mental health services have a care and treatment plan, our focus has turned to the quality of those plans and a service user satisfaction survey and quality audit will be undertaken this year. Work will continue to ensure that the intentions of the Measure, to provide better and more accessible services, continue to be supported and promoted across all sectors in Wales.

Mental Health Ring-fence

26. Mental health accounts for the largest single area of health expenditure in Wales. Our continued commitment to mental health is demonstrated by ring-fenced funding (which has increased from £387.5 million in 2008-09 to £587 million in 2014-15. We have committed to review the effectiveness of the Mental Health ring-fence in our *Together for Mental Health* Strategy and I expect to receive a report on this shortly.

CAMHS

27. The Service Improvement plan was developed in 2013, bringing all CAMHS issues and areas requiring further attention together. The Plan was developed in response to a range of concerns reported to Welsh Government, including those contained in the WAO/HIW December 2013 review of CAMHS safeguarding.

28. To support the implementation of the plan we have established a CAMHS project steering group, chaired by the Welsh Government.

29. More generally, the NHS is leading service change and development within CAMHS, this work formally commencing in February and running throughout 2015. The Welsh Government is supporting this work through the appointment of Professor, Dame Sue Bailey, who will provide the external advice, support and scrutiny to the NHS.

Dementia

30. Over 30% of GP practice teams in Wales have now completed the Wales Mental Health in Primary Care Network dementia training, with 97% then agreeing a dementia lead and action plan. This should result in real improvement in

diagnosis rates as well as provision of care. We are also actively exploring ways of improving diagnosis rates in care settings.

31. The Alzheimer's Society has now recruited more than 300 Dementia Champions and over 8,000 Dementia Friends across Wales: Welsh Government is funding the charity to continue this important work in Wales. We are also committed to the further development of Dementia Supportive Communities in Wales, to increase understanding, compassion and tolerance about dementia at a community level. Twelve months ago there were two pilot communities active; now there are ten communities at different stages of development, and plans are underway for a further three.

32. We are now working with key stakeholders in Wales to update *Dementia – How to reduce your risk* guidance. We will develop a tailored communication strategy to raise awareness of the new guidance with a focus on physical activity. The Caerphilly Cohort Study is increasing our understanding of the steps one might take to reduce risk, and the Blackfriars Consensus – which the Welsh Government signed up to last year - commits us to tackle the lifestyle choices that could reduce the risk of dementia emerging in later life.

33. Following on from the *Trusted to Care* spot-checks which took place in the summer of 2014, a series of randomly selected spot-checks of older people's mental health wards took place in November and December. I issued a Written Statement on 4 March setting out the progress of this latest round of spot checks. This is in line with the same process used for Trusted to Care spot check visits.

34. The Welsh Government has also recently provided £1.1million from the *Invest to Save* funding to assist Cwm Taf University Health Board in establishing a consultant-led Psychiatric Liaison Service for older people with mental health needs and a new Acute Assessment Service covering unscheduled care activity between 9am and 6pm.

<u>Support for Veterans</u>

35. The Welsh Government continues to meet its Programme for Government commitment to meet the mental health needs of veterans through support for Veterans NHS Wales, which provides dedicated veteran therapists in each health board, with £485,000 of Welsh Government funding.

36. Since its inception the service has received 1,115 referrals, an average of 278 per year. In 2013-14 the service received 395 referrals. Recognising the need to ensure timely access to treatment, in June 2014 the Welsh Government announced an additional £100,000 investment in the service during 2014-15 to reduced waiting lists.

37. This investment has enabled all health boards to reduce waiting times to access treatment considerably. As at December 2014, these ranged from no waits at Betsi Cadwaladr UHB to a maximum of 17 weeks at Cardiff and Vale UHB. This is within the Royal British Legion's General Election Manifesto, which is calling on

the future UK Government to commit to a maximum of 18 weeks wait for veterans to access mental health treatment.

38. In 2014, the Welsh Government also commissioned a review of the Veterans NHS Wales service, undertaken by Public Health Wales. The review made a range of recommendations to improve the service. Officials are currently working with the service and health boards over the detailed implementation of the proposals.

HEALTH SERVICE PLANNING

Integrated Medium Term Plans

39. Over the last 12 -18 months, the planning arrangements across NHS Wales have been strengthened. *The NHS Planning Frameworks* (2014/15 and 2015/16), underpinned by the *NHS Finance (Wales) Act,* set out the ambition for the new planning arrangements. All NHS Wales organisations are required to set out how resources will be used over a three year period to: address areas of population health need and improve health outcomes; improve the quality of care; and ensure best value from resources.

40. Four organisations secured Board and Ministerial approval for their integrated medium term plans (IMTPs) in the first planning cycle (2014/15). The remaining organisations agreed one year plans with their Boards and set out the steps they would take to strengthen their medium term plans for submission in January 2015. Delivery against all plans is being tracked through the national performance and delivery arrangements including, where appropriate, use of escalation and intervention arrangements.

2015/16 Integrated Medium Term Plans

41. All health boards and trusts submitted their 2015/16 IMTPs to the Welsh Goverment on 30 January. The assessment of 2015/16 IMTPs builds on the approach taken to the 2014/15 planning round.

42. Following a series of IMTP review meetings with all NHS organisations during late February and early March I will make a further announcement on approved plans/next steps by the end of April.

Service Change

Mid and West Wales

43. In the Hywel Dda University Health Board area, maternity services transferred successfully in August and the changes have worked well. The midwife-led unit in Withybush Hospital has exceeded expected usage, with positive feedback. Neonatal services in the region are now compliant with many of the all-Wales neonatal standards, which was not previously the case. Staffing is more sustainable and there has been successful recruitment to training posts.

44. The same is true for paediatric services, which were reconfigured in October 2014. Inpatient care is provided at Glangwili Hospital, with a high dependency unit on site. There is a 7 day a week, 12 hour children's assessment unit at Withybush Hospital (most emergencies needing this service happen during the day) and the emergency department has a paediatric nurse supporting the other staff out of hours. This offers an appropriate and responsive service that is based on the health board's analysis of need and service demand, and represents effective use of resources.

45. The safety-net measures required have been implemented, including the dedicated ambulance for transferring mothers, babies and children which has had ample capacity. The health board is monitoring the new arrangements continuously to ensure they are providing a safe and effective service, and this information will be fed into a full independent review of the first year of the newly configured maternity service.

North Wales

46. Betsi Cadwaladr University Health Board is continuing to implement changes to health services in North Wales. A number of old and outdated community hospitals, which were not capable of providing the levels of care necessary for local communities, have closed or partially closed. Project teams are working with partners and stakeholders to develop replacement primary care resource centres which are currently being considered as part of the capital business programme. These new facilities will ensure more care is provided closer to patients' homes in these areas.

47. On the basis of clear clinical advice, the health board has decided to make interim changes to obstetric and gynaecology services in North Wales. Inpatient consultant–led maternity services will, therefore, be suspended temporarily at Ysbyty Glan Clwyd in the interests of patient safety.

48. The health board is expecting all the interim arrangements to be completed by May this year. We expect the Health Board to carry out continuous widespread public engagement on their proposed new service models.

49. This decision will not affect the long term plans for the Sub Regional Neonatal Intensive Care Centre (SuRNICC) at Ysbyty Glan Clwyd and its support services announced by the First Minister in May last year.

50. I have written to the chair and chief executive of Betsi Cadwaladr University Health Board, to secure assurances on the decision taken by the board. The health board's response has now been published on their website.

South Wales Programme (SWP)

51. As a result of working together through the South Wales Programme and now the Acute Care Alliances, the NHS Wales chief executives are developing the NHS Wales Health Collaborative to take forward a number of strategic programmes, which cross health board boundaries. It will bring together the work

of the South Wales Health Collaborative, the programme management unit and the chief executive support office. The NHS Wales Health Collaborative will be led by Bob Hudson and will be established from April.

Mid Wales Healthcare Study

52. On 23 October the Welsh Institute for Health and Social Care (WIHSC) published the findings from its independent study of healthcare in Mid Wales, which provides a comprehensive analysis of the issues and opportunities for providing accessible, high-quality, safe and sustainable healthcare for people living in Mid Wales.

53. I have now received formal board-level responses to the report from the chairs of the Welsh Ambulance Services NHS Trust (WAST) and the three health boards covering the Mid Wales area (Powys Teaching Health Board, Hywel Dda University Health Board and Betsi Cadwaladr University Health Board).

54. I recently announced the appointment of Dr Ruth Hall CB and Mr Jack Evershed as independent co-chairs for the Mid Wales Health Collaborative which is being established through the three health boards and WAST. This formally sets in motion the first key recommendation made by Professor Longley.

55. The Mid Wales Rural Healthcare Conference – another recommendation of the Study Report - will be held at the Cefn Lea Conference Centre in Powys on 12 March. This will be an excellent opportunity to bring together leading thinkers and those with experience of providing innovative service models in rural areas.

Lessons Learned Review

56. Ann Lloyd's report of lessons learned following the first phase of service reconfiguration was published on 10 November. The report made a number of recommendations to reform the current system of engagement and consultation. In particular, continuous engagement by health boards should become the main vehicle for service change in the future and CHCs should immediately begin forging closer links with their respective local services boards to discuss matters of mutual interest and concern.

57. Officials are leading a Task and Finish Group of key stakeholders to revise the national guidance on service change in line with Mrs Lloyd's recommendation. It is expected that the revised guidance will be published in June this year.

IMPROVING NHS PERFORMANCE

58. We are exploring new outcome indicators that will result in better outcomes for patients. We need to develop measures and outcome indicators that identify and quantify clinical benefit and outcomes for patients, and we need to communicate these better to the public.

59. Current performance against our existing targets is set out below:

Unscheduled care

A&E Performance

60. 82.0% of patients to access Emergency Departments in January 2015 were admitted or discharged within 4 hours, a rise of 1.0 percentage points on the previous month. The quarterly A&E statistics show that A&E departments in Wales in December 2014 had the highest number of patients aged 75 and over since the current data recording system began.

61. This spike in demand will have had lasting implications for hospitals' ability to discharge in a timely way, given elderly patients tend to have longer stays in hospitals and can require more support following their discharge.

62. Pressures on emergency care and hospital services over the winter period are a UK-wide problem, linked to an increase in the number of elderly patients with complex needs requiring hospital care. Overall, Welsh A&E departments are seeing more patients; around 116,000 more patients compared to 1999 figures

63. The number of patients who waited over 12 hours in an Emergency Department before admission or discharge was 3,051 in January 2015. The number of patients waiting over 12 hours is unacceptable and we expect health boards to work with local authorities and other partners to ensure that patients can be treated, admitted and discharged appropriately and receive safe and effective care.

Emergency Ambulance Service

64. Improving emergency ambulance responsiveness is a priority for the Welsh Government. We expect health boards and the ambulance service to work together to improve performance.

65. The latest published performance data for January 2015 shows 48.5% of Cat A calls were answered within 8 minutes, an improvement of 5.9 percentage points compared to December 2014. There were 14,635 cat A calls in January 2015, an increase of 900 (7%) compared to January 2014.

66. The performance of the Welsh Ambulance Service is not where the public, health boards, the ambulance service or we want it to be.

67. These figures should be seen in the context of the significant pressure NHS Wales was under in January. The ambulance service responded to a 24% increase in the most serious calls compared to January 2014. However, there has been an improvement in performance on December's figures. There is a clear expectation that this improvement will continue.

68. The £11m package of investment announced in January underlines the Welsh Government's commitment to support improvement to ambulance performance. This will allow the ambulance service to purchase 17 new additional frontline emergency ambulances. A further £8m will ensure the ambulance service is in a better position to provide a swift response to life-threatening calls across Wales.

69. This package complements the extra £7.5m investment from the Emergency Ambulance Services Committee to employ 120 additional frontline emergency ambulance staff this financial year.

70. The McClelland review clearly highlighted there is little clinical evidence to support the eight-minute response time target for the vast majority of 999 calls, which are currently classified as "life threatening".

71. The eight-minute response time target was initially developed in 1974 and does not reflect the breadth of clinical care ambulance clinicians are able to provide at the scene of an incident and before a patient reaches hospital – in many cases a patient may never need to go to hospital. The ambulance service has moved on significantly in the past 40 years but the way we measure the quality of service delivery has not.

72. Following the announcement of two ambulance response time pilots in England and after receiving representations from the medical director of the Welsh Ambulance Service about the clinical validity of the eight-minute target, Wales will also test new ambulance response measures for category A calls. These will be developed in conjunction with clinicians and will be informed by the approach taken in England. I expect to receive further advice from clinicians about making best use of resources and improving clinical outcomes in coming weeks.

73. In the first instance, the Welsh Government will publish more data relating to the ambulance speed of responses to those patients who are classified as having the most life-threatening conditions, where there is clinical evidence to support an eight-minute response – known as Red 1 calls. This data will be included in the official ambulance response statistical release from 25 March 2015.

74. More clinically focused measures of the clinical care delivered by WAST have already been introduced and are being published on *My Local Health Service*. These reflect the critical role paramedics play in the treatment of a sick or injured person. The results of this work show that 95% of stroke patients are successfully receiving a specific package of care measures from administered with the stroke care bundle by paramedics in Wales and up to 86% of patients with a fractured hip received immediate pain relief in line with clinical guidelines in 2014-15.

<u>Patient handover</u>

75. As well as expectation for ongoing improvements in the ambulance response times, the Welsh Government continues to expect individual health boards to focus on handover times so that ambulances can be back on the road as quickly as possible. A new handover policy has been developed by the Improving Unscheduled Care Programme and was distributed across NHS Wales for

implementation on 25 February 2015. The guidance sets out 10 key actions for Health Boards and Trusts to incorporate within their existing protocols intended to ensure timely handover.

76. Improving handover improves the resilience and performance of the system and helps to understand when plans are working well to stay ahead of pressures. This remains a key measure of unscheduled care performance for Welsh Government.

Winter pressures

77. Quarterly Seasonal Planning meetings were held in March, June, September and December 2014 with a focus on lessons learned and actions for NHS to take to improve delivery of services when under pressure. While the improved, integrated approach to the winter planning process has appeared to have resulted in an increased resilience in the system, managing peaks in pressure remain a challenge.

78. Local Health Boards (LHBs), Welsh Ambulance Service NHS Trust (WAST) and Local Authorities (LAs) are expected to regularly keep their joint plans under review to understand how they impact on their performance over the winter period, and Welsh Government officials will provide scrutiny on a regular basis for assurance (through weekly calls).

79. The Welsh Government continue to monitor pressures via weekly Chief Executive and Executive level calls; daily Executive level emergency pressures conference calls; and through the NHS Wales Unscheduled Care dashboard which provides live data and information on a range of indicators, including bed capacity, handover delays and escalation levels.

80. Maintaining and building on the successes of last year, health and social care organisations implemented many positive actions over winter including:

a. stronger joint working with GP Out of Hours services;
b. extended working hours to include weekends and evenings;
c. increase in 7-day working;
d. increasing community resource team capacity;
e. increased consultant cover, strengthened senior management and clinical presence (including therapy and social workers);
f. a focus on reducing DTOCs and Lengths of Stay; and
g. maximising MIUs and increasing use of discharge lounges.

81. We have seen periods of higher activity reflected in record levels of increases in GP out of hours activity; and the impact of older and complex patients being cared for and admitted through A&E Departments. Alongside this we saw a 24% increase in life-threatening calls to the ambulance service in January.

82. Pressures and demand have continued throughout winter, but we have seen some signs of improvement over recent weeks and weekends with reduced reported escalation levels at the majority of Emergency Departments. This

reflects an ongoing focus and attention from health boards, trusts and their clinical teams and staff supported by the winter plans that have been developed since March 2014.

83. There will continue to be times when the demand places services under great pressure, needing local escalation. We have not however seen a major incident declared in a Welsh hospital as a result of winter pressures.

Additional resource

84. On 15 January, the Finance Minister allocated an extra £40m to the NHS in 2014-15 to support winter pressures. This extra investment, which comes from the Welsh Government's reserves, follows the announcement that an additional £200m was being allocated to the NHS in 2014-15.

85. With the exception of an immediate allocation of £8m to the Welsh Ambulance Service Trust (WAST), the remaining £32m funding will be held as a contingency reserve.

86. The pressures in the ambulance service are well known. An additional £8m ring fenced funding for Ambulance services has been provided to ensure the Emergency Ambulance Services Committee, health boards and WAST continue to focus on maintaining and improving services during this difficult period.

87. The Committee will be aware that the Deputy Minister and I have been holding NHS organisations to account for the delivery of Board plans approved in 2014/15. This approach reinforces the continued improvement in financial management arrangements recognised by the Auditor General for Wales in his latest published NHS Finances report.

Lessons learned

88. NHS Wales and social care partners will build on the winter plans put in place for this year and lessons learned from this challenging period.

89. The first national winter planning forum of 2015 reviewing the experience of 2014/15 and planning for 2015/16, with representation from all Welsh health and social care organisations, will take place on 29 April.

90. Challenges, lessons learned and potential resolutions will be discussed and will inform organisations' integrated winter plans for 2015-16.

Waiting times

91. In January, All-Wales RTT delivery was 84.3%, against a target of 95%. The median wait remains 11 weeks with the majority of patients continuing to wait less than 26 weeks. We have made it clear to health boards that progress on removing 36 weeks breaches is not optional. [*The January data will be published on 12 March 2015 – a verbal update will be provided at the meeting*].

Diagnostic waiting times

92. In January All Wales Diagnostic delivery was 70.6% against a target of 100% waiting less than 8 weeks. Additional money, over £4 m has been provided to health boards to support improvement against this measure at the end of March. There is expectation of further removal of all waits over 8 weeks for the reported diagnostics. 8,000 waits over 8 weeks have already been removed since January 2014. *[The January data will be published on 12 March- a verbal update will be provided at the meeting].*

Ophthalmic waiting times

93. In January All-Wales delivery of ophthalmology in regards to breaches over 36 weeks was 4,790 against a target of zero. Health boards are expected to target capacity to manage follow-up care for high risk patients from clinical harm and make progress on the overall 36 weeks backlog.

94. The two pilots in Abertawe Bro Morgannwg University and Betsi Cadwaladr University health boards have shown an improvement in the reduction of long waits for high risk ophthalmology follow-up care. This has been achieved by targeting resources based on clinical need and improving the use of the total workforce capacity including specialist nurses and primary care optometrists to better manage patient care. These are key principles of prudent health care in action.

95. Through the Planned Care Programme a national Ophthalmology plan has been published to direct health boards how to plan and deliver sustainable services in the future. Each health board is required to demonstrate as part of their 3 year IMPT a more sustainable delivery model that demonstrates delivery of RTT as well as appropriate clinical management of follow-up care. This will support an improvement against the number of over 36 week breaches.

Cancer

96. The latest figures for December 2014 show that the health service in Wales is either hitting or is very close to achieving its targets in cancer treatment. For the urgent suspected cancer route, performance was 87.7%. This indicates that the NHS in Wales is moving in the right direction, as the health boards continue to work towards achieving the targets.

97. Although we cannot directly compare, 31 day performance in Wales for the third quarter of 2014/15 was 97.3%, compared with 97.7% in England; and 62 day performance in Wales for the third quarter of 2014/15 was 88.0% compared with 83.3% in England.

98. Over the course of the last 12 months (January 2014 to December 2014) there has been a 13% increase in the number of patients starting treatment within the 62-day target time – 651 more patients than the previous 12-month period (January 2013 to December 2013).

PUBLIC HEALTH

99. The Welsh Government commitment to supporting people to live more healthily is supported through a range of policies, programmes and legislation. In 2015, this will include a number of actions to reduce smoking and alcohol consumption, targeted public health campaigns, and progressing the Well-being of Future Generations (Wales) Bill and the proposed Public Health (Wales) Bill.

100. We have to work harder to create the conditions in which people are better able to take care of their own health and then explain the responsibility people have for creating conditions for good health in their own lives, effectively 'co-producing' good health in partnership with patients, the wider public and partner organisations. Each of us has a duty to look after ourselves - we must all become custodians of our own health, instead of handing ownership of our health to the nearest professional as we have traditionally done. At an individual level, the health professional and patient must work together, rather than the patient putting their health problem in the hand of the nurse, GP or consultant.

101. The promotion of good health is a joint responsibility between public health organisations, the Welsh people and public services. Where appropriate, we will use our legislative powers in Wales to focus on healthy lifestyles, as we have demonstrated our intention to do as part of our proposed public health legislation that we intend to introduce before the summer recess.

Preventative care

Immunisation and Vaccination

Measles-mumps-rubella (MMR) immunisation:

102. Measles infection can be prevented by a highly effective and safe vaccine which is part of the measles-mumps-rubella (MMR) immunisation. Uptake of 95% of the population or above with the MMR vaccine is crucial to establishing a level of immunity in the population which prevents major outbreaks. Since the low point in 2003, uptake of MMR has seen a sustained, upward trend.

103. The large 2013 outbreak of measles centred on Swansea provided a reminder of the importance of maintaining high vaccine uptake levels. The NHS Delivery Framework introduced in 2013, includes as a Tier 1 measure the need for 95% of children in Wales to be fully up to date with all scheduled vaccinations by the age of four years. Achieving this will ensure that uptake of both required doses of MMR will reach the target.

104. The annual (Coverage of Vaccination Evaluation Rapidly) COVER report for 2013-14 showed that annual uptake of the first dose of MMR at 2 years had increased to 96.5%, its highest ever level.

105. The latest quarterly COVER report, for July-September 2014, reflected a drop to 95.2%; this ranged by local authority from 93.2% (Cardiff) to 98.0% (Blaenau Gwent). Thirteen local authority areas achieved the target of 95% uptake.

Whereas the annual reports provide a more complete picture this target is being closely monitored.

Human Papillomavirus (HPV):

106. The Human Papillomavirus (HPV) national childhood vaccination programme was introduced in 2008 for secondary school year 8 girls (12-13 years of age) as a three dose schedule given within a six month period.

107. The latest COVER report found uptake for the first dose of the HPV vaccine in girls in the 2013-14 school year 8 was 89%, uptake of the second dose was 87% and uptake of the third dose was 80% at the time of data collection.

108. In March 2014, the Joint Committee on Vaccination and Immunisation (JCVI) revised its existing recommendation on the HPV vaccination programme for adolescent girls to change from a three-dose to a two-dose schedule. The change to the programme started in September 2014 at the beginning of the academic year.

Seasonal Flu:

109. Percentage uptake rates for the seasonal flu vaccination for at risk groups are similar to the position at the same time last season, but the number of individuals vaccinated has increased due to population growth. The overall trend in recent years is gradual improvement. At 17 February, uptake for over 65s across Wales was 68%, ranging from 64.9% in Hywel Dda UHB to 70% in Betsi Cadwaladr UHB;

110. Continuing from work started last season, PHW has instigated a number of actions to support GPs at individual practice level to increase uptake. The impact of these actions will be reviewed at the end of the season.

111. Flu vaccine uptake in health board employed health care workers increased to 41.7% in 2013/2014, up from 35.5% in 2012/13. Data for the current season is still being being collated but uptake has already reached 43.9%. Two health boards, Betsi Cadwaladr and Velindre, have achieved the 50% target in 2014/15. This significant improvement demonstrates that the additional emphasis and effort directed towards staff vaccination is continuing to have an impact. It is important that we continue to build on this progress to protect those most at risk of flu and its complications.

<u>Tackling poverty</u>

112. *Building Resilient Communities: Taking forward the Tackling Poverty Action Plan*, includes a number of NHS-related commitments which reflect the Welsh Government's commitment to use resources differently to help those most in need. There is a wide range of work being undertaken to support this, particularly the developing links between health boards, public health organisations, local authorities and primary care providers, contributing to the objectives of mitigating and preventing the impact of poverty by improving health and access to health

care. There is a more consistent understanding of the value of working with Communities First, Flying Start and Families First programmes.

113. Our central aim is to improve healthy life expectancy across Wales. There are significant gaps in healthy life expectancy between each income group, with the wealthier doing much better. We aim to close these gaps by an average of 2.5 per cent - by 2020. The Chief Medical Officer has ensured that all NHS chief executives are fully aware of the cross Government commitments to action on poverty and the responsibilities of health boards to contribute.

114. The latest data available to us shows that the gap is not yet closing, but nor is it getting worse. This should be seen in the context of the period of the recession where we would have expected a worsening of the gap. The target will remain in place with a much stronger focus on getting the NHS to take action as part of the new planning arrangements.

115. Health inequalities are one of the most stubborn and complex issues facing Wales and other countries. Tackling the inequalities gap requires concerted long term action across the breadth of society, not just by what we immediately think of as the 'health system.' Elimination and prevention of health inequalities can only be achieved when linked to the underlying inequalities of income, wealth and power across society. Five years into the age of austerity, the NHS and our social services see the impact on people's lives of income reductions and widening inequality.

116. We know we need to do more to reduce the inequalities which currently exist in the health outcomes of people of all ages living in poverty. In the short term, our approach to delivering this objective will be based on four elements. These are:

- Improving the quality of all services while ensuring people in greatest need get the most support;
- Giving every child the best start in life;
- Helping people get and remain fit for work; and
- Using the NHS's employment practices to help give skills to people from workless households.

117. We are taking forward these elements through primary care improvement, improved planning and continuing to embed prudent healthcare. We expect primary care 'clusters' to help provide clearer focus on tackling inequalities and poverty. We will carefully monitor the impact of clusters and aim to share learning.

118. The Welsh Government will continue to promote our Inverse Care Law Programme. The new Living Well Living Longer Programme in Aneurin Bevan University Health Board and similar work developing in Cwm Taf University Health Board will offer a working example of the needs-based approach which is informing our work in other areas. We will also ensure our maternity strategy and the developing Healthy Child Programme help all children during the early years develop sound physical and mental health in a manner sensitive to the needs of

particular groups and localities. We will continue with schemes to support the health of people in work.

119. To support all this, we will improve our information systems to pinpoint where needs are most acute and targeting services there, and move money nationally and locally to where it is most needed. This will engage Public Health Wales, the NHS, local government and the broader community, in efforts to reduce health inequalities. DHSS will work across all policy areas to seek and take up opportunities to reduce health inequalities. The NHS will work closely with people and communities to improve their health, and with other agencies to help people access whatever services best suit their needs. We will monitor progress through the NHS planning arrangements and by tracking progress in national outcomes frameworks.

120. In relation to the NHS as an employer, the Chief Medical Officer confirmed the NHS in Wales will provide 1,000 of the 5,000 opportunities to be delivered through the LIFT programme, which aims to offer training or employment opportunities to people living in workless households by the end of the 2017 calendar year.

Health checks for people aged over 50 - *Add to Your Life*

121. *Add to Your Life* aims to support and empower the public by giving them greater control over their health and well-being. It provides specific feedback to people aged 50 or over about areas of risk to their health and well-being, and gives them advice on the small steps they can take to help lower those risks.

122. The Programme is now in the user phase and current activities are focussed on encouraging people to use the website, as well as integrating Add to Your Life with preventative services (e.g. smoking cessation) and other on-line health portals such as *My Health Online*.

123. A wide range of roll out activities are taking place including a direct mail to members of the public around their 50th birthday (around 42,000 people turn 50 annually in Wales) who are registered with a GP. Since the beginning of October 2014 nearly 16,000 letters of invitation have been posted out in weekly batches.

124. Since Add to Your Life was rolled out nationally over 10,500 people have accessed the site with over 5,500 completed assessments undertaken.

125. Welsh Government officials are working with Public Health Wales to develop proposals for phase 2 of the programme.

Patient responsibility/Choosing well

126. In accordance with prudent healthcare principles, we continue to encourage patients to take personal responsibility for their own health and wellbeing and choose wisely to ensure they access the most appropriate service for their needs. This is supported by the roll out of the *My Health Online* resource, advice from NHS Direct Wales or local services such as pharmacies and the Choose Well

app, which have been proven to reduce unnecessary attendances to Accident and Emergency departments.

127. There is an ongoing collective effort with NHS Wales to deliver choose well messaging. The Deputy Minister for Health and the Chief Executive of NHS Wales have worked to strengthen our message about the need to choose well when thinking of dialling 999 and accessing an Emergency Department.

128. The Choose Well app has been downloaded by over 6,000 people, and there has been an approximate 900% increase in NHS Direct Wales web based activity since the campaign began in March 2011**.** This indicates the public are increasingly aware of the information available to guide responsible decision-making.

129. Campaigns that aim to change behaviour need to have a long term approach for the benefits to be realised and can be difficult to evaluate in the short and medium term.

QUALITY AND SAFETY

Independent external reviews

Trusted to Care

130. Considerable action has been taken in response to findings of the *Trusted to Care* review. All NHS organisations have been expected to reflect on the findings and take any action needed. Specifically, a series of unannounced spot checks to all acute hospitals were ordered to be assured that the failings in report relating to fundamental standards of care were not widespread.

131. A total of 70 wards were visited over a six week period and the findings were published in October 2014. Work is well underway to tackle areas of concern identified, specifically in the management and safe storage of medicines and in streamlining the documentation of patient records, especially nursing care.

132. Spot checks of older people's mental health wards followed in November and December 2014, and 22 of the 51 wards across all heath boards in Wales were visited. The spot checks were undertaken by peer review teams comprising senior older people's mental health nurses, pharmacists, occupational therapists and for some of the spot checks, an older people's psychiatrist was also available.

133. These visits revealed many areas of good and excellent practice right across Wales, as well as identifying some areas where improvements need to be made. There was considerable variation in standards and practice between and within health board areas. The issues identified which will require action from health boards for some wards relate to:

- prescribing and the storage of medication;
- the skill mix of staff available to provide the most appropriate care;

- staff training;
- the quality and 'dementia friendliness' of the ward environment;
- the application of mental health and mental capacity legislation in practice; and
- the provision of catering services.

134. Work is underway to prepare public facing reports of each of these visits, together with a national report, all of which will be published in due course.

135. A steering group chaired on my behalf by the Chief Medical Officer and Chief Nursing Officer is overseeing this work, as well as implementation of the specific recommendations made by Professor June Andrews and Mark Butler in their report. This includes meeting regularly with ABMUHB to monitor their progress ahead of a follow-up review this summer.

Using the Gift of Complaints

136. Keith Evans' review of how concerns (complaints) are handled in NHS reported in July 2014 and concluded that while the principles of *Putting Things Right* were sound, there was great variation in how the arrangements had been implemented.

137. Views on the report were sought over the summer period and analysed along with the concerns raised by the Committee. I published a Written Statement setting out the Welsh Government's response.

138. A sub group of the National Quality Safety Forum has led a series of work streams to take forward the review's recommendations. The work streams centred on complaints data/ information and publication; Putting Things Right guidance and communication; and learning from concerns, supported by a public engagement reference group.

139. The groups will be making a series of recommendations to the National Quality and Safety Forum in April. I plan to provide a further update following that.

Report on mortality data

140. Professor Stephen Palmer's review of the way in which mortality measures are collected and used was published in July 2014. The review focused on six hospitals with a Welsh Risk Adjusted Mortality Index (RAMI) score of more than 100 in the data published on Friday 21 March 2014.

141. Professor Palmer concluded that RAMI is not a meaningful measure of quality and advocated the use of case note mortality review alongside a more meaningful set of measures and information to describe quality. The Transparency and Mortality Taskforce, chaired by the Deputy Chief Medical Officer has been reconvened to take forward Professor Palmer's conclusions. They will report to me in the coming months.

Independent Review of Healthcare Inspectorate Wales

142. I published a Written Statement on 8 January setting out the Welsh Government's response to Ruth Marks' independent review of Healthcare Inspectorate Wales (HIW). The findings and recommendations provided in Ms Marks' report, *The Way Ahead: To Become an Inspection and Improvement Body,* give a timely assessment of where HIW's current regulatory and inspection work need to be reformed and improved.

143. The terms of reference for the review were designed to assess whether the regulatory and inspection functions of HIW needed to be reformed and improved. This was with a view to developing proposals to inform a Green Paper to encompass any legislative changes that may be required, but with the ability to make recommendations for any immediate actions that may be needed.

144. The report concludes the role and function of HIW is largely fit for purpose, though it acknowledges that HIW is a complex regulator, responsible for regulating and inspecting a substantial number and variety of health bodies across the NHS and the independent sector. Ms Marks also reminded us that the delivery of safe and effective care cannot be achieved by inspection and regulation alone – that it can be no more than a third line of defence.

145. The report made a total of 42 recommendations. Within those directed at Welsh Government, there is a strong emphasis on developing a more collaborative and integrated system of healthcare inspection. It is therefore my intention to bring forward a series of proposals to address these recommendations in a Green Paper focused on improving or quality system this summer. This will be the main vehicle by which response to the report will be made.

146. Many of the immediate actions recommended fall directly to HIW to consider. HIW has been on a journey of improvement and has made significant progress over the past year, achieving what it set out in its ambitious work programme. Many of the areas highlighted in the review are already being addressed. However I am assured HIW will use the review findings to inform its work programme for the coming year.

Fundamentals of Care National Audit 2013

147. The annual national audit of the Fundamentals of Care (2003) standards has been in place since 2009. The audit tool was reviewed and updated in 2013 and has been used by all NHS organisations for the annual national audit since that date. Data collection for the 2014 audit took place across Wales in October and November 2014 and will be published in May 2015.

148. In light of the significant revisions made to the format, number and types of questions included in the 2013 audit, no direct comparison can be drawn between the 2013 and previous annual audits. It is also important to note that the operational audit, patient experience and staff survey questions have been reviewed independently and not combined as in previous audits.

149. The NHS Healthcare Standards were reviewed in 2014/15 and the revised standards are scheduled to be published on 1 April 2015. The revised standards will, for the first time, incorporate the Fundamentals of Care standards and in future monitoring of fundamentals of care will form part of the overall monitoring of compliance with these revised Healthcare Standards.

Annual Quality Statements

150. All NHS health boards and trusts in Wales published their second Annual Quality Statement in September 2014 providing an account of their achievements, challenges and improvement priorities. These statements are designed to give the public an accessible, open and honest account of how well an organisation is doing.

151. An all-Wales Quality Statement will be published shortly which draws together the learning from local statements and captures the national priorities.

Cardiac care

Cardiac Surgery in Mid, West and South East Wales – improving outcomes and waiting times project

152. Health boards in mid, west and south east Wales, working with the WHSSC, have initiated a multi-faceted project to improve outcomes and waiting times for cardiac surgery in order to meet current and future demand.

153. Health boards have put in place additional short-term capacity for heart surgery, through a variety of internal arrangements and temporary outsourcing of patients to hospitals in England. They have also been working to increase cardiac surgery capacity in the medium to long-term.

154. Outsourcing patients from south east Wales has now completed. Cardiff and Vale University Health Board has continued to treat patients within the waiting times target since first achieving the target in October, and expects to sustain this position to March.

155. The waiting time position for Abertawe Bro Morgannwg University Health Board has improved in January, with the total number of patients waiting falling from 215 in December 2014, with 71 of those patients waiting over 36 weeks, to 165 in January 2015, with 31 patients waiting over 36 weeks.

156. There has also been a 60% reduction in the total number of patients waiting since March 2014, and a reduction of 69% in the number of patients waiting over 36 weeks over the same period.

157. Agreement has been reached to establish a referral pathway from ABMUHB to CVUHB to support delivery of recurrent demand in 2015/16 while capacity is increased at Morriston Hospital. Progress continues to be made towards a fully collaborative service across the two centres to support sustainability and resilience of cardiac surgery in south Wales.

Cardiff and Vale University Health Board – Royal College of Surgeons Report

158. At the end of January, there were 2 patients waiting over 36 weeks for cardiothoracic surgery within Cardiff and Vale UHB, out of a total of 301 patients waiting. The number of patients waiting over 36 weeks has fallen by 97% since March 2014, with the total number waiting falling by 25% over the same period.

159. In response to a visit by the Royal College of Surgeons in March 2013, Cardiff and Vale University Health Board and the Welsh Government have invested nearly £4m to tackle cardiac surgical waiting lists, dramatically to cut the time people wait for planned surgery. As indicated above this investment has seen a significant reduction in waiting times.

160. As part of the long-term plan, the health board have agreed through WHSSC a business case to increase capacity for major cardiac surgery which it is proposed will commence on 1 April 2015.

161. An internal project team has been established to manage the expansion, including timescales for recruitment of key posts, capital works required to expand the existing Cardiac Intensive Therapy Unit and procurement of additional equipment. There is also ongoing work with the Cardiac Network, WHSSC and referring Health Boards and Cardiologists to ensure that patients referred to Cardiac Surgery are assessed and referred in a timely fashion.

162. In addition, cardiac surgery mortality data is being captured monthly and is submitted to the Clinical Board and WHSSC. All case notes are reviewed and risk assessed to understand whether the death was avoidable.

163. The RCS has recently confirmed to CVUHB that since 2013 significant progress has been made to improve the management of waiting lists for cardiac surgery at CVUHB, including improved clinical engagement with the CVUHB's wider programme of work to improve patient services. They do not require any further assurance about the action plan put in place to address the concerns originally raised during the visit in March 2013.

DEVELOPING PRIMARY AND COMMUNITY CARE

Plan for Primary Care Services

164. In November 2014, we launched our national plan for a primary care service for Wales, backed by a £10 million primary care fund, building further on the £3.5 million provided to health boards in 2014-15. Following a period of further engagement and discussion, a refreshed second version of the plan has now been published.

165. The plan articulates what people can increasingly expect from primary care and identifies five priority areas for action up to March 2018. The aim is to draw in all those organisations and services which can help identify and meet local need

and to work collaboratively in planning and delivering more services closer to home and, very importantly, to develop and diversify the primary care workforce.

166. To support action locally to remodel the workforce, we are developing a national primary care workforce development plan. We are also refreshing our eHealth Strategy which will support action to modernise the way people access services in the future.

167. £6 million of the £10 million primary care fund for 2015-16 will support the 64 primary care clusters to implement their own local solutions to local challenges and this demonstrates the Welsh Government's commitment to the need to develop clusters to plan and meet need at very local level. £3 million will support strategic pathfinder schemes or allow health boards and their clusters to accelerate primary care service reform. £1 million is to be used to support a programme of work best done once for Wales, including training to remodel the local workforce and education and organisational development support.

168. The Welsh Government announced its plans for the use of the additional £70 million for health services from 2015-16. The majority of this funding, £50m - will directly support the delivery of our ambitions in the national plan for a primary care service for Wales of improved population health, reduced inequalities in health and better and more modern access to a preventative and integrated health and social care system.

169. Examples of primary care service reform expected from this new funding include:

- New ways of providing ambulatory care for chronic conditions;
- Community based eye care;
- Non medical clinical support for GP services by increased clinical capacity from other professionals working in GP practices or elsewhere in the community;
- Education and training to up skill professionals to undertake advanced practice and expanded scope roles; and
- Extended community nursing

<u>GP access</u>

170. Work is underway to offer working people a wider choice to access GP services more conveniently during the day/late evening. A key example of this work is the out of area unregistered day patient pilot scheme which is currently being undertaken within four health board areas.

171. The pilot scheme started in December 2014 and provides access to GP services to a person living outside the participating GP practice boundary area, present in the participating GP practice area for less than 24 hours (for example, as a commuter who travels into and out of the area each day) and who wishes to remain registered with their current practice. 14 GP practices are participating in the scheme - 3 in Swansea; 3 in Wrexham; 3 in Newport; and 5 in Cardiff.

172. GPC Wales and health boards have agreed a service specification for the scheme, including clinical governance arrangements. The roll out of the out of area pilots are at an early stage. The pilots are envisaged to run for a period of 12 months.

173. As part of the work to develop a 111 service for Wales a sustainable model for primary care out of hours is also being planned from October 2015.

WORKFORCE AND ORGANISATIONAL DEVELOPMENT

National Workforce Plan

174. The Welsh Government has confirmed that it will prepare a 10 year national workforce plan for the NHS. This will include consideration and action on how to train and recruit sufficient doctors, nurses and other health care professionals to ensure that health and social care across Wales is ready for the future.

175. This work presents an opportunity to bring together a range of work that is already in hand in respect of planning for the workforce of the future, chief amongst which is the need fully to embed the principles of prudent healthcare which must increasingly govern how NHS Wales plans the commissioning, education and use of its workforce.

176. The Bevan Commission, are also due to consider workforce planning in NHS Wales as part of their 2015-16 work plan.

177. In addition to the 2015/16 NHS integrated medium term plans the national workforce plan will be informed by the two areas of work below:

Primary Care Workforce Plan

178. Workforce related actions required to support the delivery of the Welsh Government's plan for a primary care service in Wales up to 2018 are being developed and will be set out in a workforce development plan to be published for consultation with the service before the summer.

179. This plan will tackle a number of the immediate issues faced by the primary care workforce in Wales including what can be done to support local health boards to resolve difficulties in GP recruitment and retention. Alongside this, it will set out investment in the wider primary care team and emphasise the importance of a multidisciplinary approach and the role that can be played by enhanced roles and advanced practice.

180. It will also take a longer term view of how the onward development of clusters can be supported by local health boards, the Welsh Government and other partners, and what actions are required to make better use of data in primary care as well as how workforce planning can be improved in partnership with education commissioning.

Independent Review of the NHS Wales Workforce

181. The creation of a time-limited independent review of the NHS Wales workforce was a key component of the Agenda for Change pay agreement for 2014-15 and 2015-16.

182. The Review will gather evidence and make recommendations for the consideration of Welsh Ministers on matters arising from the Nuffield Trust's 2014 report *A decade of Austerity in Wales*, and will be led by a small panel of experts, academics and other professionals who are familiar with the areas of investigation and who are independent of the Welsh Government.

183. An announcement on the Review membership and terms of reference will be made shortly, but I have appointed David Jenkins, Chair of Aneurin Bevan University Health Board, to Chair the Review. The Review will produce a report at the end of 2015 / beginning of 2016, and will be publically available.

Health Professional Education Investment Review

184. The Health Professionals Education Investment (HPEI) Review was established in August 2014. The review considered a range of issues including the suitability of the current education commissioning arrangements, the investment made in health education in Wales at present, the approach to workforce planning and the potential use of incentives to attract NHS employees and students to Wales and to retain them in both primary and secondary care once their training has been completed.

185. The final report from the Health Professional Education Investment Review Panel is currently being finalised. Party Health spokespeople will be provided with an opportunity to meet with the panel to raise any questions they may have on the issues covered by the review prior to the final report being submitted. A period of wider engagement will then take place which is expected to last for 6 weeks and focus on specific questions arising from the report.

186. This work will inform the way forward for the £350m education investment the Welsh Government makes in medical and non medical training each year.

European Commission consultation on the working time directive

187. On 5 February a telephone conference was held with officials from the UK Department for Business Innovation and Skills (BIS) and Welsh Government officials from a number of portfolio departments, including Health and Social Services. The discussion was led by officials from Economy Science and Transport (EST) and focussed on the process being followed.

188. BIS have confirmed that they will be submitting a UK Government-wide response on the consultation. The response will primarily be based on the UK National Implementation Report 2014 and the evidence obtained. I understand that BIS will be submitting the proposed response to the European Affairs Committee (EAC) and will copy it to Ministers in Scotland and Wales.

189. BIS have not yet confirmed when the EAC and Welsh Ministers will receive the proposed response to the consultation of the Working Time Directive.

Doctors in training and consultant contracts

190. Formal negotiations commenced in September 2013, with the aim of agreeing a new contract for doctors in training by the end March 2015. The BMA withdrew from doctors in training contract negotiations. As a result of this withdrawal, the Review Body on Doctors' and Dentists' remuneration (DDRB) has been remitted to make recommendations on contractual arrangements and pay for doctors in training.

191. As is the case with the doctors in training negotiations, the BMA have also withdrawn from the consultant contract negotiations for England and Northern Ireland on the basis that the proposals from management side could undermine patient safety. This is disappointing as Heads of Agreement were due to be finalised by the end of October 2014. However, the BMA made it clear that they wanted significant concessions that went above and beyond employers' 'red lines'.

192. Moving forward, the Department of Health has confirmed that it has also written to the DDRB asking them to make observations on pay related proposals for the consultant contract. This is in the context of the policy aim to deliver financially sustainable seven day services, reviewing the payment of clinical excellence awards and linking pay progression with responsibility and performance. The same observations will extend to Wales.

193. The DDRB will report after the UK general election.

Recruitment

Nurse Staffing Levels

194. The responsibility for determining a safe, appropriately skilled workforce lies with NHS organisations. However, in this instance a partnership approach across NHS Wales and the Welsh Government has been established to develop tools to assist individual organisations in this area.

195. The Welsh Government has not set mandatory minimum ratios of registered nurses to support staff, nor minimum numbers of staff per in-patient bed. However, in May 2012 the Chief Nursing Officer (CNO) and health board chief executives agreed a set of principles for nurse staffing levels to be used during the time it would take to develop, fully test then implement a workforce acuity and dependency tool for adult in-patient wards. It was agreed at that time to establish a programme of work to develop a suite of tools that will ensure staffing levels and skill mix are tailored to meet the specific needs of patients in each care setting.

196. In May 2012, chief executives also agreed to develop individual organisational plans to comply with the nursing principles for medical and surgical wards over a

three-year period. In July 2013, following publication of the Francis Enquiry into Mid Staffordshire Foundation NHS Trust, I allocated an additional £10 million (recurring) funding to support these plans.

197. These principles are:

- Professional judgement will be used throughout the planning process;
- Ward activity and demand will be considered when establishing staffing levels as well as the number of beds, environment and ward layout;
- Nursing establishments on acute wards should not normally fall below 1.1 Whole Time Equivalent (WTE)/bed including a head-room of 26.9% (to cover annual leave, mandatory training, etc.);
- Numbers of patients per Registered Nurse should not exceed 7 by day;
- The skill mix of Registered Nurse to Health Care Support Worker in acute areas should generally be 60/40; and
- The Ward Sister/Charge Nurse should not be included in the numbers when calculating patients per Registered Nurse ratio.

198. Health boards have been asked to provide regular progress reports to the CNO including details of their compliance with these principles, utilisation of the additional funding, and of the assurance frameworks or processes they have in place for continued safe nurse staffing levels. The latest set of reports was provided in December 2014.

199. Monitoring of the compliance of the principles has been on-going since 2012, and during this period, health boards have continued actively to address nurse establishments in adult acute medical and surgical wards. They have also made significant improvements to the number of wards with more that 1.1 WTE nurse/support worker per bed, with some areas now reaching 100% compliance. All organisations have assurance frameworks and action plans to continue to ensure appropriate safe staffing levels. Skill mix has improved significantly with the majority of wards with a 60:40 registered nurse to support worker skill mix.

200. Some areas have not managed to recruit to the establishments identified, and have had to consider their recruitment plans in an increasingly competitive global market for nurses.

201. There has been an improvement in the compliance of their medical wards; in respect of no more than 7 patients per nurse, the number of compliant wards has increased by up to 75% in some health boards.

<u>Acuity tool</u>

202. The acuity tool is being validated for use in adult acute medical and surgical wards. It is supported by the following NHS documents:

- *Fundamentals of Care System User Guide: Adult Acute Nursing Acuity & Dependency Tool; and*
- *Adult Acute Nursing Acuity & Dependency Tool Governance Framework.*

203. The acuity tool for adult acute medical and surgical in-patient settings was rolled out in April 2014. This tool works as a forward planner which measures acuity and dependency of patients to help health boards plan for future workforce requirements. It is not as a day-to-day allocator of nurses. It is essential, therefore, that along with use of the tool, professional judgement and nurse sensitive indicators, such as the number of patient falls, should be used to consider the correct staff establishments.

204. Two validation runs are needed before the results of the acuity tool can be relied upon, and the first of these was undertaken in June 2014. The second was undertaken in January 2015. The results will inform the triangulated approach used to determine staffing levels at local level.

205. Once data has been captured and validated within the national system, organisations should develop local reports which triangulate local workforce data and nursing metrics to provide intelligence which can be used to support local decision-making about deployment of nursing resource within the overall workforce planning process.

206. Research shows that the issue of nurse staffing levels is a complex one and therefore use of a triangulated methodology is advocated.

GP Recruitment

207. Changes to the GP contract for 2014-15 strengthen local collaborative working between GP practices linking with community nursing teams and social care partners to provide more care in the community and/ or closer to home.

208. Since 2003, investment in general practice has increased by £147m, rising from £322m to £469m in 2012-13. As a result, GP numbers have increased by 11.2% between 2003 and 2013, resulting in the number of patients per practitioner falling by 5.4% over the same period.

209. Whilst GP numbers have increased, an ageing GP workforce in Wales (at 2013, 23.1% of GPs in Wales are aged over 55 years), together with changes to GP UK pension arrangements, has contributed to GP recruitment difficulties in Wales. These recruitment difficulties, however, are not unique to Wales. In England, at 2013, 22.3% of the GP workforce were aged over 55 years ; 19.5% of the GP workforce in Scotland were aged over 55 years; and 24.8% GP workforce in Northern Ireland were aged over 55 years. GP recruitment challenges in Wales, and indeed, across the UK, are further accentuated given that other countries in Europe are also experiencing GP shortages, resulting in an increasingly competitive global market for GPs.

210. We continue to work in collaboration with the RCGP, the Wales Deanery, GPC Wales and health boards to promote Wales as an attractive place to live and work. Alongside work being undertaken by health boards, a number of actions are being taken forward at a national level to address the difficulties in GP recruitment. These include helping GPs who wish to step back from full time work to be retained in the workforce on a different basis; making it easier for GPs

to return to work in Wales; reforming the incentives regime to try to retain more GP who train for general practice in Wales to stay in the Welsh workforce.

211. Consideration is also being given to make it easier for GPs, based in England, to work in Wales by amending the GP Performers' List (Wales) Regulations to allow GPs, who are on a Performers List in England, to be able to work in Wales for up to six months (in a 12 month period) without the need to complete the full (extensive) application process to be placed on a Performers List in Wales. The intention is to develop these proposals and others, as part of the workforce development plan to underpin the plan for a primary care service in Wales for engagement over the coming months.

212. Through the Welsh Risk Pool, arrangements have been put in place to make it easier for GPs to work in Out of Hours by including sessional GPs professional indemnity arrangements within the scope of the NHS indemnity arrangements. In addition, new GP contractor models will drive new and innovative ways of delivering services using other or new professional roles are being considered to allow GPs to develop a more effective skill mix across GP practices and to encourage GP practices to work together, for example, as a federation of practices or as part of a primary care cluster network.

213. Investment in primary care health services has been increased significantly. A further investment of £3.5m for primary health care services for 2014-15 was announced to target action to improve health and reduce inequalities in the most deprived communities, develop primary care teams and provide eye care services closer to people's homes. This is in addition to the recent announcement of a £10m primary care fund for 2015/16 to support delivery of the primary care plan for Wales. This investment will result in a wider range of healthcare professionals delivering care in or close to people's homes, freeing up GPs' time and expertise to care for people with more complex needs.

214. Changes to the GP contract for 2015-16 were announced on 2 March and provide a good platform to continue the improvement of the provision of core services provided by GPs. These changes directly address GPs' concerns about unnecessary bureaucracy. They place more trust and reliance on the professionalism of GPs to use their clinical judgement and allow GPs to spend more time caring for the most vulnerable people with complex care needs, in particular, the frail and elderly.

NMC Nurse Revalidation

215. The NMC is committed to commencing some form of revalidation for nurses and midwives by December 2015. The Council set out a model to be tested in pilot sites in early 2015 at their December meeting. The Chief Nursing Officer has set up the Wales Revalidation Steering Group, with representation from stakeholders and the NMC. Aneurin Bevan UHB will pilot the revalidation model for NHS registrants and practice nurses from January 2015.

216. At the January 2015 Council meeting the NMC accepted the report by Kings Fund on the regulation of midwives. It has agreed to cease statutory supervision

and is now seeking primary legislative change with the Department of Health, which may take 1-2 years to introduce.

IMPROVING ACCESS TO MEDICINES

Wales Patient Access Scheme

217. The balance of cost against clinical benefits is a key element of appraisal and we actively encourage the pharmaceutical industry to engage with AWMSG and submit an application to the Welsh Patient Access Scheme. This initiative was established in April 2012 to encourage manufacturers to offer a cost discount with their submission for appraisal; ensuring the reduced price can be considered by AWMSG during the appraisal and increasing the likelihood of a positive appraisal recommendation. There are currently eleven new medicines available in Wales using the Wales Patient Access Scheme.

Orphan and Ultra Orphan Medicines

218. Following the independent review of the appraisal process for orphan and ultra orphan medicines, AWMSG have been developing a new, whole-system approach to the identification, appraisal and monitoring of this group of medicines; the aim being to ensure that patients with rare diseases have fair and equitable access to appropriate, evidence-based treatments.

219. AWMSG have worked closely with a wide range of interested parties in developing the new process, including clinicians, patient groups and the pharmaceutical industry. The new appraisal process is currently being introduced and will come into full effect in September 2015.

Independent Patient Funding Request (IPFR) Process

220. In November 2014, a Welsh Government Written Statement announced next steps for implementing the report's recommendations. That work is underway, led by the All-Wales Therapeutics and Toxicology Centre (the executive arm of AWMSG) in collaboration with health boards and the Welsh Health Specialised Services Committee (WHSSC). Key areas of work include increasing the appraisal capacity of AWMSG and developing a robust, evidence based mechanism to make one-Wales IPFR decisions where there is an identified patient cohort.

Access to medical technologies

221. The Efficiency through Technology Fund will support organisations to develop and implement new service models using the latest technologies and solutions, across a range of infrastructure and activity themes.

222. As part of an additional investment of £70million allocated to help NHS reform in 2015-16, £10m has been allocated to this area. This additional funding will be prioritised based on evidence and results, to support the demonstration and

scaling up to national adoption of technological or innovative solutions that demonstrate significant measurable impact on costs and outcomes.

223. Examples include:

- Wet AMD partnership at the Lakeside Ophthalmology Unit, UHW;
- 3D scanning and bespoke implants pilot project;
- Mobile lymphodaema service;
- Telemedicine platforms and projects; and
- Redefining orthopaedics surgery pathway.

LEGISLATIVE PROGRAMME

224. We have continued to make good progress in delivering the health and social service contribution to the Welsh Government legislative programme.

Public Health White Paper

225. The Public Health White Paper consultation summary report, together with the individual responses, was published on 6 November 2014. The proposals stimulated lively debate on a number of important issues, and attracted over 700 responses from a range of stakeholders and members of the public. There was particular debate regarding the proposals to restrict the use of e-cigarettes in enclosed public places, introduce a minimum unit price for alcohol, and improve provision and access to toilets for public use.

226. The responses to the consultation illustrated general support for what we are trying to achieve, and for the principle of utilising legislation as a mechanism for further improving and protecting health in Wales. A full spectrum of responses was received on every issue, ranging from those suggesting that the proposals should go even further, to those calling for more modest reform.

227. We have continued to reflect on the responses received to the consultation as detailed work on each topic has progressed in recent months. I aim to bring forward public health legislation for consideration by the National Assembly for Wales before the summer recess, and look forward to discussing the detail of the legislation with the Committee at the appropriate time.

Regulation and Inspection of Social Care Bill

228. In Wales, the latest figures show there are 1,780 regulated social care and support settings, which fall within the scope of the current regulatory regime. More than 70,000 staff work in the sector.

229. The Regulation and Inspection of Social Care Bill rebalances accountability in the social care system, away from just those working on the frontline to ensure employers and company owners and directors also share the responsibilities in law. Each service provider will be required to designate an owner or board member as a ‘responsible individual’ as part of their registration, ensuring a clear line of sight from the boardroom to the frontline.

230. It will also introduce a new model of regulation, which will allow regulators to press for improvement across one care setting site or across a provider's entire range of services – including care homes - if deemed necessary. It will make it easier for the regulator to act where care is considered beyond repair and, if necessary, cancel the registration of those providers, services and settings which fail to implement improvements. It also includes stronger penalties for certain offences.

231. The Bill was introduced to the National Assembly for Wales on 23 February and a date for Stage One scrutiny is expected over the coming months. If passed, the Bill will be implemented in 2017.

Implementation of the Human Transplantation (Wales) Act

232. A two-year public awareness and engagement campaign to ensure people are aware of the new law and their choices under it is now well into its second year. Specific engagement work is being undertaken with students, BAME groups, workplaces and those with specific needs. The redevelopment of the Organ Donor Register, enabling it to record opt-out decisions, will be completed in summer 2015. The impact of the legislation will be evaluated in 2017.

233. Consultation on draft regulations finished in January. These cover materials which will be excluded from deemed consent, such as that used for face and limb transplants; appointed representatives; and living donors who lack capacity to consent to donation. When finalised, these regulations, together with the Human Tissue Authority Code of Practice will be put before the National Assembly for Wales for approval in early September 2015.

234. A Section 150 Order, which will allow organs removed under deemed consent in Wales to be used in transplants in the rest of the UK, will be discussed by a House of Lords Committee in March, followed by a debate in a Commons Committee.

Implementation of the Food Hygiene Rating (Wales) Act

235. Trade to trade food businesses have been included in the statutory scheme from November 2014.

236. Food businesses receiving "5" (very good) ratings increased from 2012 to January 2015, by over 24% from 32.2% to 56.6%. The percentage of food businesses receiving ratings requiring improvement fell by 12.9% between 2012 and 2015 from 19.2% to 6.3%. It is considered that the requirement to display the rating is a major motivation in this respect.

237. I agreed to develop further regulations to require certain food businesses to include a statement on their hard copy publicity materials that will assist consumers to find out their food hygiene rating. These regulations were consulted upon in 2014, and the responses received identified a number of issues that required further consideration. I therefore intend to introduce revised draft

regulations later this year that will retain the concept of a statement of hard copy materials, but will refine the details of the requirements in light of the consultation responses received. The regulations will also address any misuse of food hygiene ratings on certain food businesses publicity materials.

Implementation of the Social Services & Well-being (Wales) Act 2014

238. Arrangements are in hand to supplement the statutory framework established by the Act with regulations, codes of practice and statutory guidance on the various subject areas covered by the Act. We have consulted on the first tranche regulations, codes of practice and statutory guidance, covering general functions, assessing the needs of individuals, meeting needs, safeguarding and miscellaneous and general. The 12-week consultation ran from 6 November 2014 to 2 February 2015.

239. We are now in the process of analysing responses to prepare the final regulations, which will be laid before the National Assembly for Wales from May 2015. Each will be accompanied by an Explanatory Memorandum and at the same time we will publish full consultation summary reports.

240. The second tranche of regulations, statutory guidance and codes of practice, principally in relation to charging and financial assessment, looked after and accommodated children and co-operation and partnership. The regulations in relation to this tranche will be drafted by spring 2015, consulted upon during summer 2015 and laid in November 2015. At this time we will also lay the full suite of codes of practice and also publish the complete statutory guidance.

241. This work is being supplemented by a programme of awareness-raising and training for key staff. Local authorities and local health boards, working in partnership on the basis of the public sector delivery footprint, have undertaken a self assessment activity to review readiness. We have now received completed self assessment tools and the information provided is being considered in tandem with the outcomes of the tranche 1 consultations. The assessments themselves provide an evidence base for the work that needs to be put in place for the detailed implementation plans that are currently under development.

242. Successful implementation will require enhancing strong regional and local leadership bringing health, local authorities, the third sector and private providers together to co-deliver transformational change.

243. To support each region in completing the self-assessment of their readiness to implement the Act, a £1.5 million Delivering Transformation Grant has been made available to the six regional partnerships and selected national partners in both 2013-14 and 2014-15. This funding will double to £3 million in 2015-16 and is expected to remain at this level for 2016-17, with a view to transferring this grant in to the Revenue Support Grant from 2017-18 onwards. This transitional funding is specifically aimed at enabling local government and its partners to put in place the requirements of the new Act.

244. The Care Council for Wales has been asked to lead on development and implementation of a National Learning and Development Strategy, which is critical to the implementation of the Act. This work will be supported by £1m in 2015-16.

245. The Care Council will take this work forward with key stakeholders to develop a comprehensive approach to learning and development to ensure staff across the social care sector, and partners, have the knowledge and skills to deliver the new requirements under the Act. It will also ensure organisations are supported to make the culture changes that are necessary. The strategy itself will include a training deployment plan and development of a "one stop shop" information hub.

246. This cumulative activity will lead to implementation of the Act from April 2016.

SUSTAINABLE SOCIAL SERVICES

247. Social services support over 110,000 adults, providing statutory care for people with mental health problems, physical and learning disabilities and frail older people. There were 16,525 children in need and over 35,000 children referred to social services in Wales last year. Child protection registers record 3,135 cases of neglect, emotional, physical and/or sexual abuse. There are 5,703 looked-after children in Wales.

248. Gross public expenditure on social care was over £1.9 billion in 2013-14, with £0.3 billion raised in fees as many adult social services are means-tested. Demographic pressures through increasing life expectancy, both for older people and the severely disabled, together with a growth in demand for children's services has lead to a near doubling in social services expenditure since 2002-03.

249. Local authorities have the statutory duty to deliver social services and provision is a mix of direct delivery and commissioned services from independent providers. As demand and service user expectation increases, and budgets are constrained, the current approach to social services has to be redrawn.

250. The Welsh Government's principles and priorities for the delivery of social services in Wales are set out in *Sustainable Social Services for Wales: A Framework for Action*.

A New Accord (Leadership) for Social Services

251. This project has developed the leadership infrastructure and arrangements to support implementation. Work is currently focussed on developing guidance on the role of Directors of Social Services as part of the transformation, and on the duty on local authorities to promote social enterprises, co-operatives, user-led services and the third sector.

252. As part of the development of the commitment to strong national leadership set out in *Sustainable Social Services – A framework for Action*, collective leadership

arrangements were put in place. These go back to 2011, and have been reviewed and revised over time.

253. The leadership alliance includes:

- National Social Services Partnership Forum (Partnership Forum)
- National Social Services Leadership Group (Leadership Group)
- National Social Services Citizen Panel (Citizen Panel)

254. Key issues explored by the groups over the last few months as part of their leadership role in supporting the implementation of the Social Services and Well-being (Wales) Act, have been early intervention and prevention, new models of service, safeguarding paying for care and integration between health and social care. This work is important in securing the wider leadership and involvement cross sector in the implementation process.

255. The requirement for regional leadership arrangements to be put in place was announced in June 2014 and has been supported by the Delivering Transformation Grant. This has enabled an approach to leadership which has involved social services, health and the third sector. The requirement is to replicate the national arrangements at a regional level on the basis of the Public Services footprint, building on what is in place where there are appropriate arrangements.

Social Enterprise, co-operatives, user led services and the third sector

256. The Social Services and Well-being (Wales) Act 2014 places a new general duty on local authorities that will require them to promote models of service which are social enterprises, co-operatives, which involve people who need care and support in the design and delivery of their services, and the third sector. It requires local authorities to promote:

- social enterprises;
- co-operatives;
- the third sector; and
- involve people more in the design and operation of services.

257. This work is directly linked to the population assessment and early intervention/prevention. In addition to the legislation and the development of further underpinning guidance, a specific action plan is in place to support local authorities in this duty and that will be continued in 2015-16.

A New Improvement Framework

258. Draft regulations and codes of practice to support the requirement for local authorities and local health boards to undertake a strategic population assessment of care and support needs (including the support needs of carers) as well as to provide preventative services has recently been subject to a 12-week consultation. The responses to that consultation are currently being considered.

259. The Social Services Complaints Procedure (Wales) Regulations 2014 and Representations Procedure (Wales) Regulations 2014 came into force on 1 August 2014. These regulations and supporting guidance provide for a new two-stage social services complaints procedure and brings the social services complaints process in line with the Model Concerns and Complaints Policy and Guidance adopted across public services, notably the NHS complaints process.

260. Linked to this, the first provisions in the Social Services and Well-being (Wales) Act 2014 were commenced on 1 November. These include provisions which enable the Public Services Ombudsman for Wales to consider complaints from adults who fund their own social care or palliative care for the first time.

A Strong Voice and Real Control for Citizens

261. Our approach to change in social services is to give a stronger voice and real control for citizens, putting them at the heart of their care and support, and promotes control through a reform of core processes to ensure that frontline services are coproduced with citizens.

262. We are delivering a new approach to: information, advice and assistance; eligibility and assessment; direct payments; and changing the way people pay for care. Draft regulations and Codes of Practice on these core processes were developed with the expert advice of Technical Groups and they have all been subject to a 12-week consultation. They set out how the new approach underpinning the Social Services and Well-being (Wales) Act will operate. We are currently analysing the responses from the consultation in detail so the final regulations and codes of practice take account of the comments received.

263. We are addressing improvement for children's advocacy through partnership with local government to develop a coherent national approach to deliver improved experience for service users. The key principles are similar to those for taking forward people advocacy under Part 10 during tranche 2.

A Strong and Professional Delivery Team

264. We are investing over £8m in the Welsh social care workforce to build confidence and competence, and further professionalise the sector and ensure that people are prepared for new models of care and support following the Social Services and Well-being (Wales) Act. We are working with the social care employers to ensure that this sector plays a full and active role in the economy of Wales, e.g. contributing to the Welsh Government's LIFT programme for creating employment opportunities in Communities First areas.

265. We are developing a workforce strategy to build up the quality of data on the workforce and address wider issues relating to the long term sustainability of the workforce.

A Stronger Framework for Safeguarding

266. We are strengthening the safeguarding of people in Wales and improving arrangements to ensure citizens remain free from exploitation and abuse. Most Adult Safeguarding Boards and Children Safeguarding Boards are making the transition from local to regional arrangements. We are monitoring the ongoing developments. Through the Social Services and Well-being (Wales) Act 2014 we are strengthening the protection of vulnerable adults particularly through the introduction of new duties to enquire; to establish Adult Safeguarding Boards and the introduction of Adult Protection Support Orders.

267. Consultation on the regulations and statutory guidance which will give legal effect to this framework ended in February. We are currently reviewing responses received.

Integrated Services

268. The revised *National Framework for Continuing NHS Healthcare (CHC) in Wales* was published on the 30 June 2014, with implementation from 1 October 2014. The Framework emphases the importance of CHC as an entitlement for those eligible to receive it and eligibility is to be determined by health need and not financial considerations.

269. The £50 million Intermediate Care Fund (ICF) for 2014/15 is being used to support older people to maintain their independence and prevent unnecessary hospital admission and delayed discharges. Additional funding of £20 million has been announced (as part of the overall £70 million) to take forward projects funded by the Intermediate Care Fund this year that have proven to be effective in linking out-of-hospital care and social care to strengthen the resilience of the unscheduled care system.

270. The Integrated Family Support Service (IFSS) was rolled out across Wales at the end of April 2014 and is now fully operational. The Integrated Family Support Service supports families when there are concerns about the welfare of children. IFSS teams work with families to help them to make positive changes, so that children can remain safely at home. They provide targeted support and help connect children and adult services, focusing on the family as a unit.

271. The National Adoption Service for Wales was launched on 5 November 2014. All five regional collaboratives are operational, and the central functions are being managed by Cardiff under the direction of Suzanne Griffiths, Director of Operations, and in line with the new Performance Management Framework.

272. The directions under Section 170 of the Social Services and Well-being (Wales) Act have been consulted on and will be issued in early March, thereby delivering on the commitment we gave during scrutiny.

273. The Welsh Government funds the Wales Adoption Register which was launched in June 2014, and the Independent Review Mechanism. Both are managed under contract by BAAF Cymru. The research we commissioned from the universities of Cardiff and Bristol (regarding adoption support and adoption

disruption) has been published and the findings are being used to shape the National Adoption Service.

274. The *When I am Ready* scheme, which allows young people in foster care to remain living with their foster carers once they turn 18 (up to age 21), has been successfully piloted in three local authority areas. Revised guidance for local authorities will be published in March, so that all authorities in Wales can develop their local schemes ready for when their new duties with regards to post-18 living arrangements come into force in April 2016. Two seminars have been arranged for local authorities and other key stakeholders in April 2015.

Preventative Services – Social Services

275. Prevention is at the heart of the Welsh Government's programme to transform social services. There is a need to focus on prevention and early intervention in order to make social services sustainable into the future. It is vital that care and support services do not wait to respond until people reach a crisis point.

276. Section 15 of the Social Services and Well-being (Wales) Act 2014 requires that local authorities must provide a range of preventative services. These services must seek to achieve various purposes, including:

- Contributing towards preventing or delaying the development of people's needs for care and support;
- Reducing the needs for care and support of people who have such needs;
- Promoting the upbringing of children by their families, where that is consistent with the well-being of children;
- Minimising the effect on disabled people of their disabilities;
- Contributing towards preventing people from suffering abuse or neglect;
- Reducing the need for care proceedings against children;
- Encouraging children not to commit criminal offences; and
- Enabling people to live their lives as independently as possible.

277. This requirement follows, and is linked to, Section 14 in the Act that requires local authorities to and health boards jointly to undertake an assessment of local care and support needs and support needs for carers. As part of that assessment, there is a need to set out the range and level of preventative services required to achieve the purposes set out above.

278. Additionally, Section 16 of the Act puts a duty on local authorities to promote social enterprises, co-operatives, user led services and the third sector. The duty in Section 16 offers an opportunity to consider alternative models in relation to early intervention and prevention, which are values based and give people who use services and carers a much stronger role.

Social Services Expenditure

279. The latest published figures on local authority budgeted expenditure for the current financial year show an increase of 2.2 per cent in overall social services

expenditure compared with 2013-14. Local authorities are in the process of finalising their budgets for next year.

280. Providing the majority of funding for local government through the settlement in the form of unhypothecated funding provides local authorities with the flexibility to deliver resources in the way that best meets the needs of that authority and minimises grant administrative costs. To maintain that flexibility, authorities have responsibility to demonstrate the delivery of shared outcomes.

OTHER PORTFOLIO ISSUES

Substance Misuse

281. The Welsh Government continues to invest almost £50 million annually to tackle drug and alcohol related harm in Wales. This funding has supported the implementation of a range of actions and we are making good progress in delivering the commitments in the Substance Misuse Delivery Plan 2013-15. The latest *Working Together to Reduce Harm Substance Misuse Strategy* annual report, which was published in October 2014, outlined the good progress that we have made in taking forward the current Delivery Plan.

282. The time that people have had to wait between referral and the start of treatment for substance misuse has continued to improve. In 2013/14, 87% of all clients commenced their treatment within the KPI target of 20 working days, an increase of 1.5% on 2012/13 figures.

283. Given the increasing levels of alcohol related harm, we are strengthening our response, using all the policy levers available to us. We are continuing to tackle alcohol misuse through our Change4Life campaign *Don't let drink sneak up on you*; our *Have a word* alcohol brief intervention training and our *Add to your Life* online health checks for the over 50s.

284. In addition, the Welsh Government is supporting UK Government initiatives such as the Local Alcohol Action Areas in Pembrokeshire and Swansea, and the Public Health Responsibility Deal Alcohol pledges through the establishment of the Welsh Government Alcohol Industry Network.

285. Despite the initiatives outlined above and other non-legislative actions, the Welsh Government believes that additional legislative measures in the form of a minimum unit pricing system in Wales are necessary to both help support and strengthen these actions. Inclusion of the proposal to introduce a minimum unit price for alcohol of 50p per unit within the Public Health White Paper was subject to a 12 week consultation, ending in June 2014. The consultation evidenced broad support for introducing minimum unit pricing in Wales and the Welsh Government is now taking forward this proposal through the legislative process. We are also continuing to press the case for the UK Government to agree the devolution of alcohol licensing.

286. The new Substance Misuse Delivery Plan for 2016-18 is currently in development. High level outcomes have been agreed and stakeholders will be

consulted on specific actions throughout the spring and Early Summer. The new plan is expected to be subject to formal consultation in the autumn.

Part 2: FINANCIAL SCRUTINY SESSION

1. The Committee will now have received the information requested in its letter of 10 December. A copy of my response is attached at **Annex B**.

2. The additional information requested in the Committee's letter of 30 January is given below:

LATEST END YEAR FORECAST OF THE BREAKEVEN POSITION OF LHBS AND TRUSTS

3. The following table sets out the end of year forecast position reported by each LHB and Trust as at 31st January 2015

NHS organisation	**End of Year Forecast £m**
Local Health Board	
Abertawe Bro Morgannwg	0
Aneurin Bevan	-2.2
Betsi Cadwaladr	-27.5
Cardiff and Vale	-24.9
Cwm Taf	0
Hywel Dda	-9.2
Powys	-2.0
Trust	
Public Health Wales	0
Velindre	0
Welsh Ambulance	0
Total NHS Wales deficit as at month 10	**65.8**

4. The Committee will no doubt appreciate that the Deputy Minister and I have been holding NHS organisations to account for the delivery of the plans their Boards approved in 2014/15. This tougher approach is in line with the continued improvement in financial management arrangements recognised by the Auditor General for Wales in his latest published NHS Finances report.

5. The deficit reported above is likely to reduce in future months as LHBs and Trusts manage their position to achieve the best position against their approved plan.

6. I have made it clear to all NHS bodies that they must achieve the above without compromising quality or patient safety. I currently have resources available in the form of generated central savings, some additional income and the extra Winter Monies to cover the above.

7. I will look to allocate any winter monies after the winter period and during the normal year end arrangements correctly to cover any specific winter pressures identified.

PROGRESS ON THE CONSIDERATION AND APPROVAL OF LHBS' PLANS FOR 2016-17 TO 2018-19

8. The progress on Integrated Medium Term Plans covering the period from 2015/16 to 2017/18 is set out earlier in the evidence paper.

9. The plans were received on 30 January and are still going through a thorough assessment and robust challenge process to ensure that the integrated plans cover service priorities, quality, and performance and workforce requirements within the resource envelope that was set out in the 2015/16 approved budget.

10. I would not expect to be asked to consider the approval of the LHB plans until the process outlined above is completed.

Annex A

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

Original recommendation	Original Response	2015 Update
Recommendation 1 We recommend that the Welsh Government should ensure implementation of the National Service Framework through strengthened oversight and monitoring arrangements, as a priority in the forthcoming delivery plan. We believe this should include a national leadership post to coordinate health boards' progress in delivering the NSF, and to facilitate the sharing of experiences and good practice between health boards.	The Welsh Government remains committed to the implementation of the 12 standards set out in the National Service Framework for Diabetes in Wales (NSF) and the Diabetes Delivery Plan will include as a priority the development of effective oversight and monitoring arrangements. My officials will work with the Local Health Boards (LHBs), the Diabetes delivery Plan Implementation Group and the Diabetes National Specialist Advisory Group (NSAG) to develop robust and effective monitoring arrangements both for the implementation of the plan the continued establishment of the NSF standards. A national diabetes clinical lead role will be developed to support both the delivery of the plan and to support Local Health Boards in the continued implementation of the NSF standards. The national lead will need to work closely with the Implementation Group to facilitate the sharing of experiences and best practice between LHBs.	The Diabetes Delivery Plan included a series of actions to take forward areas of the NSF that had yet to be delivered. Following the launch of the delivery plan, an NHS-led Implementation Group was established and has been supporting health boards to deliver the actions in the national delivery plan. The National Clinical Lead for diabetes, Dr Julia Platts, has been appointed and is working across the health boards to drive consistency and quality in the diabetic patient pathways. Good progress has been made against some standards, for example paediatric diabetes departments have participated in a peer review process to ensure the best possible service provision. National audits in areas such as inpatient care and pregnancy in diabetes have provided information to shape service improvement on a national and local level. Implementation priorities for each year have been agreed with detailed recommendations for action by the health boards.
Recommendation 2 We welcome the forthcoming delivery plan for diabetes, and recommend that the Welsh Government commits to taking appropriate action should	The implementation of the Diabetes Delivery Plan falls to the NHS in Wales and at a local level to each individual LHB. In addition to monitoring progress, the Welsh Government and the Implementation Group will support	All health boards produced delivery plans last year in line with the requirements of the Together for Health Delivery Plan; these were peer reviewed through the diabetes implementation group and

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

health boards fail to deliver the services outlined in the plan.	LHBs through identifying opportunities for actions at an all Wales level and through facilitating the sharing of best practice through peer review. The Diabetes Delivery Plan will require each LHB to produce a local delivery plan to address progress against the plan, as well as continued implementation of the Diabetes NSF standards. LHBs will be held to account on their progress by the Welsh Government as well as by the local populations that they serve, and to facilitate this public accountability LHBs will be required to publish details of their progress on their websites. Appropriate action will be taken to challenge health boards which fail to deliver the services outlined in the Delivery Plan.	feedback given to each health board. Health boards were expected to produce their diabetes annual report by September 2014; but a number of health boards did not provide them in time and the matter has been escalated. Health boards are now in the process of updating their delivery plans and these are to be completed in March 2015. Each health board should also include diabetes as part of their Integrated Medium Term Plans, which are approved by Welsh Government. Welsh Government is also working with Diabetes UK to introduce a new performance management approach to diabetes; we expect this will be introduced later this year.
Recommendation 3 We recommend that the forthcoming delivery plan should include a requirement for all GP practices to participate in the National Diabetes Audit.	Participation in the National Diabetes Audit (NDA) has been a crucial tool in developing improved diabetes services in Wales and continued, full participation will be a priority in the Diabetes Delivery Plan. Welsh GP participation in the Adult NDA has improved to over 80%, from about 50%, in the latest audit round, and the Diabetes Delivery Plan will instruct LHBs to continue to build on this improvement. It is the clear expectation of the Welsh Government that GP practices in Wales should participate fully in the National Diabetes Audit.	The Delivery Plan includes the requirement for all health boards, which are integrated primary and secondary care organisations, to participate in all aspects of the National Diabetes Audit (NDA). All health boards have participated in the audit, which was last published on 29 January 2015. The NDA Report 1: Care Processes and Treatment Targets 2012-2013 published on 2 October showed around 70% of GP practises in Wales participated. More than 80% participated in the previous round, but one

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

		health board missed the cut-off for the submission of 2012-13 data and therefore numbers are lower this time. This problem will not occur in future rounds as the manually extracted data system used by the health board is currently being phased out.
Recommendation 4 We recommend that the Welsh Government's delivery plan should require that all diabetes patients are offered all 9 key annual health checks, and that health boards' performance in meeting this requirement should be monitored through full participation in the National Diabetes Audit.	The Delivery Plan will have as a key priority that all patients are offered all 9 key annual health checks. These health checks are established indicators under the Quality and Outcomes Framework (QOF) as well as being monitored as part of the National Diabetes Audit (NDA). The NDA is currently working to ensure that the QOF and NDA measures are aligned, which would allow the monitoring of this to be conducted using either of these processes. As part of their work, he Implementation Group will consider the most appropriate way forward to ensuring compliance with the Delivery Plan, which will include the optimal approach towards monitoring progress. Full participation in the NDA will be a priority under the Diabetes Delivery Plan.	The Annual Report reiterated every person with diabetes should receive a planned programme of nationally recommended checks each year. This is part of the personalised care planning that enables them and their healthcare professionals to jointly agree how they will manage their diabetes. There are nine key care processes that all adults with diabetes should receive annually; the NDA and the delivery plan annual report describe compliance against this standard. The 2015 report showed 40% of adults with type 1 diabetes and 67% of adults with type 2 diabetes are having all the annual tests and investigations associated with national standards (not including retinal screening). This testing bundle hides the high rates of provision of HbA1c testing for under 25s (98.9%), foot examination (91%) and retinal screening (93%). The Implementation Group, diabetes network and the NDA clinical leads will be looking at the reasons all

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

		care processes are not being undertaken more consistently and leading action to improve performance.
Recommendation 5 We recommend that the forthcoming diabetes delivery plan should ensure that local Diabetes Planning and Delivery Groups' relationships with health boards are formalised. Health Boards should demonstrate how they take account of DPDG recommendations and fully engage with their work. Arrangements should be put in place to adopt a national approach for DPDGs, to include national terms of reference for their operation and a requirement to meet with each other to share best practice.	Each LHB has established a local DPDG as part of the implementation of the Diabetes NSF and these groups will be vital in assisting LHBs in the development of their updated local delivery plans; which need to take account of the needs of their local population. The Diabetes Delivery Plan will require LHBs to formalise their relationships with their DPDGs, and to include their DPDGs terms of reference (ToR) as part of their updated local plans. The Implementation Group will take forward a peer review approach to share best practice and DPDGs will be included in this process; including consideration of the development of a common set of ToR principles that all LHBs might adopt for their DPDGs.	All health boards, including Powys, have diabetes delivery groups and patient reference groups in place. The implementation group has yet to peer review and standardise their working; this work is expected to commence later this year.
Recommendation 6 We recommend that the introduction of an integrated diabetes patient management system should be a priority for the Welsh Government. We note the commitment already made to introduce such a system, and recommend that a clear timetable for its introduction is included in the forthcoming diabetes delivery plan.	The development of an integrated diabetes patient management system will be important for long term improvements in health care outcomes for people with diabetes in Wales. The Diabetes Delivery Plan will have the development of such a system as a key strategic priority for the NHS in Wales. The development of a patient management system will fall to the NHS Wales Informatics Service and my officials will work with this agency to finalise a timetable for its implementation.	A patient engagement exercise has been undertaken to determine the delivery requirements of the system. An outline business case was taken to the National Informatics Management Board in September 2014 for discussion; the Board prioritises national investment in IT infrastructure. It agreed further clarification is required about whether or not existing systems are able to meet this need. The final business case is expected to go before the Board in March for

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

		authorisation and prioritisation.
Recommendation 7 We recommend that future public health campaigns on diabetes should reflect the need to raise awareness of the risk factors associated with – and the early symptoms of - diabetes.	Prevention and early detection of diabetes are clear priorities for this Government and will be included in the Diabetes Delivery Plan. Any future public health campaigns will need to include raising awareness of the risk factors associated with diabetes, and early symptoms of the disease. Also, public health campaigns linked to lifestyle behaviours need to stress the risks associated with such behaviour, such as the links between obesity and diabetes.	The delivery plan includes commitments to reduce the risk factors for diabetes. A number of all Wales programmes are being delivered outside the scope of the Implementation Group, such as the Obesity Pathway and Change4Life. However, the Implementation group has also agreed to prioritise prevention and is examining 'information prescriptions' for people at risk of developing diabetes, and to examine risk identification through community pharmacies.
Recommendation 8 We recommend that the Welsh Government and health boards work together to expand the role of pharmacies in conducting risk assessments, to help improve early identification of people with diabetes. Pharmacies should also play a direct role in future public health campaigns. We believe the Welsh Government should specifically consider the value of including the HbA1c test for existing patients as an enhanced service as part of the Community Pharmacy Contractual Framework.	The early detection of diabetes will be a key theme of the Diabetes Delivery Plan and risk assessments have an important role to play. The Welsh Government will introduce an over 50s health checks programme to provide an online resource for people to assess their health and wellbeing. It will help identify risks to their health and provide advice on actions to reduce those risks and improve their health. It will also sign-post people to the most appropriate local support for changing lifestyle behaviours, and where appropriate direct them to seek advice from their GP, or other health professional. In addition, with regards to diabetes specific risk assessment, the Implementation Group will be tasked to look at all Wales solutions to this issue. They will bring forward recommendations on the most	Over recent years community pharmacy has participated in two national public health campaigns involving diabetes and screening. There are three national public health campaigns a year that engage with community pharmacy and the topics for 2015/16 have already been agreed with Public Health Wales. The annual report highlights the important work Diabetes UK and community pharmacy have been doing to risk assess people in the community. An estimated 30,000 assessments have been undertaken through the UK pilot and thousands of people have been referred to their GP or for further testing. The Implementation Group is establishing a

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

	appropriate and effective way to deliver diabetes risk assessment to the people who need it; where they need it. A key factor in any such solution will be community pharmacies. Due to their close community links, pharmacies need to be considered in the development of any new public health campaigns. The Welsh Government will also task the Implementation Group to specifically consider the value of including HbA1c testing in pharmacies as part of their work on developing all Wales solutions to diabetes specific risk assessments.	small sub group to look at a pilot project in Wales, as part of work involved in its current priority area about preventing diabetes. However, the latest audit findings show 98.9% of under 25s received their annual HbA1c test. Therefore, testing should be extended to community pharmacies as part of an integrated treatment and management pathway agreed in collaboration with relevant cluster, according to local needs.
Recommendation 9 We recommend that the Welsh Government should urgently address the variances in the provision of structured education for people with diabetes. The forthcoming delivery plan should require all health boards to provide NICE-compliant structured education programmes and ensure equality of access to appropriate, timely education for all patients across Wales.	Patient empowerment is crucial to improving health care outcomes for people with diabetes and education is a vital part of developing patient empowerment. The provision of NICE compliant diabetes structured education programmes will be a priority under the Diabetes Delivery Plan. The Quality and Outcomes Framework for 2013/14 has established an indicator for referral to a structured education programme within 9 months of entry onto the diabetes register and LHBs will need to ensure that programmes are available for people who are referred to them. In addition to people with newly diagnosed diabetes having access to NICE-compliant structured education, the Implementation Group will consider other ways of delivering effective education to people with diabetes	SDE is crucial to the self management of diabetes and the avoidance of additional morbidity. A new diagnosis is a vital opportunity to influence lifestyle and educate people about their diabetes. The latest annual report showed 7.6% of newly diagnosed patients received structured education in 2012-13, although this has increased from 5.8% in 2011-12. The Implementation Group has made provision of SDE a priority area, has reviewed the available SDE resources and is considering all-Wales provision of an agreed package, which includes phased improvement of uptake.

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

	through the most appropriate and effective channels. Every opportunity needs to be taken to educate the person with diabetes if we are to improve health care outcomes for this sector of the population.	
Recommendation 10 We believe that insulin pump therapy and the necessary accompanying education should be available to all suitable candidates to improve their quality of life. We recommend that the Welsh Government's forthcoming delivery plan include a requirement to improve the availability of education and training on the use of insulin pumps.	The Diabetes Delivery Plan will set out to achieve significant progress in patient access to intensive insulin therapy as there is evidence that such treatment reduces microvascular complications in type 1 and type 2 diabetes. Any provision should be evidence based and take account of patient choice, but the plan will set as a priority the provision insulin pump service in line with NICE guidelines.	The annual report recognises that access to insulin pump treatment is much lower in Wales than countries such as Germany and Austria. It highlights the need to implement the NICE technology appraisal regarding pumps fully and equitably across all health boards in Wales. The Implementation Group will be taking this work forward in the coming year.
Recommendation 11 We recommend that the Think Glucose programme should be introduced in all health boards across Wales.	Think Glucose is a commercial product and the 1000 Lives Plus programme is currently considering options for the introduction of a similar, non-commercial, pan Wales programme. It will be the remit of the Implementation Group to consider all Wales solutions for improvements in diabetes health care, and one of its first tasks will be to consider the most appropriate programme to implement; whether that be Think Glucose or a Welsh developed programme under the auspices of 1000 Lives Plus. The effectiveness of Think Glucose has highlighted the benefits of introducing such a programme across all LHBs in Wales. Therefore, an appropriate	Hywel Dda University Health Board has implemented the Think Glucose programme across all its main sites and one community hospital. This includes one referral form, hypoglycaemic guidelines, medication chart and self management plans. The Implementation Group has received costings to roll the programme out nationally and is considering how best to fund an all-Wales programme.

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

	programme should be introduced at the earliest opportunity.	
Recommendation 12 We recommend that the Welsh Government undertake an audit of the number of diabetes specialist nurses in post across Wales, and the proportion of their time spent on general duties. The Welsh Government should consider the merits of issuing guidance to health boards on recommended numbers of diabetes nurses per head of population.	Diabetes Specialist Nurses have a crucial role to play in delivering improved care to people with diabetes, both in the community and hospital, and an important facilitation role in the delivery of structured education. The availability of this resource will need to adequately reflect local needs in the development of LHBs' local diabetes delivery plans. The Welsh Government will conduct an audit of diabetes specialist nurses in line with the recommendation and work with the Diabetes NSAG to consider the merits of issuing guidance to health boards.	Data collection has been undertaken and analysis of this information now needs to take place before a paper is taken to the implementation group.
Recommendation 13 We recommend that the Welsh Government monitors the capacity of the Diabetic Retinopathy Screening Service to provide annual checks for diabetic patients as the growing prevalence of diabetes increases demand for the service.	Since its introduction, the Diabetic Retinopathy Screening Service has provided all-Wales screening to detect sight-threatening diabetic retinopathy at an early stage before visual loss occurs. The continued effectiveness of this service is key to improving treatment and care for people with diabetes. The capacity of the Diabetic Retinopathy Screening Service to provide annual checks will be part of the monitoring of the implementation of the Diabetes Delivery Plan. The Implementation Group will also consider how this resource can optimally deliver screening in the future whilst utilising the service's data to improve research; with a view to delivering additional health outcomes.	The Delivery Plan included a commitment to review and refresh the Diabetic Retinopathy Screening Service Wales (DRSSW) to ensure it achieves the best outcomes for all patients. The annual report showed 93% of diabetes patients in Wales have had a retinopathy examination in the past 15 months. An External Quality Assurance (EQA) review was also carried out in 2014. The EQA review recommendations are currently being implemented by the DRSSW. In addition, the screening interval times are under review by the National Screening Committee (NSC). The outcome of the NSC review will be ready in 2015. It is

Summary of progress against Health and Social Care Committee's recommendations on the Diabetes National Service Framework

		anticipated the screening interval times for some patients will move from 12 to 24 months, which will help to cope with increased demand.

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

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford @wales.gsi.gov.uk

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 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 Care Forum Wales – SNSL(Org) 24 / Tystiolaeth gan Fforwm Gofal Cymru – SNSL(Org) 24

Care Forum Wales would like to thank the Health and Social Care Committee for the opportunity to provide written evidence on the Safe Nurse Staffing (Wales) Bill. In our evidence, we seek to respond to some of the general matters raised in the consultation and more specifically to the question of whether similar provisions should be applied in settings relevant to our members.

Care Forum Wales is the main professional representative organisation for independent providers of health and social care services in Wales. Our 450 plus members include a large percentage of private and third sector nursing homes who provide services that are vital in underpinning the NHS in Wales. Whereas Welsh hospitals provided 11,495 beds in 2013, the independent sector provides over 11,500 beds for people with long term nursing needs who would otherwise have to be cared for in hospital settings at a much greater cost to the tax payer. Welsh Government conservatively estimates the cost of an overnight stay in hospital at £300 per night, or £2,100 per week. Yet the weekly Continuing Health Care payment by local health boards to independent care homes providing long term nursing for people with complex needs is less than £800 per week in most areas. We have long campaigned for the independent sector to be treated as a genuine and equal partner, recognised and valued for its contribution to compassionate care, to employment and to local economies, and resourced at a level that will ensure stability and viability.

In our original response to the bill, Care Forum Wales confirmed its support for the ambition to promote safe nursing levels in NHS acute in-patient settings, but we raised concerns about possible unintended consequences for people using and providing services in the independent sector. Put simply, there is a risk that the requirement to maintain safe nursing levels in acute wards will increase movement of nurses away from the independent sector, exacerbating the existing crisis facing care homes which has seen nursing homes close or de-register to provide personal care only. The net result will be staff shortages and further closures, placing residents at risk; threatening local employment; undermining stability and incoming investment in the sector; and diverting NHS resources from acute care.

In November 2013, BBC Wales reported as a result of a Freedom of Information Request that 800 Welsh nursing home beds had disappeared in the previous four years. Shortly before the original consultation we saw a number of nursing homes closing due to recruitment difficulties, some of which was attributable to recruitment exercises by some Health Boards in response to high profile reports that highlighted the correlation of nursing levels with the ability to provide compassionate care. Care Forum Wales conducted a survey in August 2014, to which 38 members responded, which showed there were 75 nurse vacancies in care homes at that time, 15 of which were attributed to transfer to the NHS. Extrapolating across the 240 settings registered with CSSIW would suggest a national figure of 480 vacancies in that single snapshot in time.

There is no reason to think that this situation has improved since. Indeed, concerns about nurse levels in care homes are now beginning to permeate public consciousness. In her review of residential care for older people, "A Place to Call Home", Sarah Rochira, the Older People's Commissioner (OPC) acknowledged concerns raised by a number of respondents, including Care Forum Wales and the Royal College of Nursing, stating "a shortage of appropriately skilled nursing staff are risk factors to both the quality of care being provided and the ability for a provider to continue provision".

A key factor in nurse shortages is that responsibility for commissioning pre-registration education places falls to the Local Health Boards and Trusts. At the time of the original consultation nurse training was not being commissioned on a partnership basis and with regard for the number of qualified nurses required to safely staff nursing homes. Care Forum Wales has since met with Dr Andrew Goodall, Chief Executive of NHS Wales, and other representatives of Welsh Government and obtained broad support in encouraging Health Boards to recruit for independent sector needs. Options discussed include retraining for former nurses; fast tracking of social care practitioners and uncapped training. However, there is obviously a time lag and these are very much long term solutions that do not address the immediate crisis. Nor has it proved straightforward to identify the numbers of nurses needed and there remain a number of unknown factors, such as the impact of revalidation that has been introduced by the Nursing and Midwifery Council. Further, the OPC has set a requirement that "NHS workforce planning projections identify the current and future levels of nursing required within the residential and nursing care sector". An increased reliance on social care practitioners is also a potential concern at a time when government funding for apprenticeships has been removed for those aged 25 and above, who represent by far the largest part of the workforce.

Nor does this address the wider issue of retention and ability to compete with NHS on an even playing field for high quality nurses. Independent sector providers are simply not able to compete on pay, terms and conditions, with NHS providing sick pay, more annual leave and a better career path. NHS nurses have greater opportunities both to specialise and to experience variety. Our members report that nurses from abroad quickly move on the NHS because hospital working is considered more "exciting". Rural areas in particular seem to be a less popular working destination for nurses, especially for those with families or lacking personal transport. The independent sector is additionally hampered by the perception of care homes as being somehow inferior and less secure. As a result, providers report falling standards in new recruits with most being either newly qualified or having been out of work for some time. Meanwhile, morale and wellbeing within the sector continue to decline as a result of the current shortages, with members reporting that it is common for nurses to work in excess of 60 hours per week. The issues for the independent sector go beyond recruitment and training: we need support to raise the profile of the sector; we need to promote the idea of one workforce; we need genuine partnership and we need fair commissioning.

There is an unfortunate myth that care providers are only interested in profit. This simply is not true, as can be readily seen from the difference between the cost of care provided by NHS and the cost of care commissioned by the NHS. Providers cannot rely on "self-funded" care to remain viable as the vast majority of care is NHS funded and "top ups" are not legal. The sector cannot rely on injections of capital from Welsh Government as can the NHS which, for instance, was recently awarded additional funding to cope with winter pressures. There are also issues with funding for Funded Nursing Care (FNC) which was established in response to section 49 of the Health and Social

Care Act 2001 which stated that “no local authority, after 1 April 2004, may arrange, provide or (by implication) pay for care by a registered nurse for instance in a care home”. It applies to a category of residents where some, but not all of their needs, were nursing: their other needs were deemed social care, which fell within the remit of the local authority, on a means tested basis. For many years care homes have absorbed the loss arising from what is commonly known as the “gap costs” between the funding provided by the Local Authorities and the Local Health Boards, despite government guidance that there should be no gap. The Health Boards appointed Laing and Buisson to review FNC in 2013 but rejected their findings as regards direct nursing costs which the Boards maintain should not include time spent on breaks, supervision and aspects of personal care, for all of which NHS nurses are rightly paid.

Our experience is that Health Boards are likely to interpret guidance as purely discretionary, rather than something that should only be departed from with compelling reason. We fear that the general wording on the face of the bill is therefore not in itself sufficiently proscriptive or transparent to ensure that local Health Boards will recruit or commission services at an adequate level in nursing homes. Whilst we continue to support the aims of the Bill, we remain concerned that the requirement to provide minimum nursing levels only in adult inpatient wards will result in a further drain on staffing levels in nursing homes. We would like the Bill to make clear that there is a duty upon the NHS to commission care in nursing homes at a rate that enables both adequate nursing levels and improved working conditions.

In summary, Care Forum Wales supports the Bill in principle, but we are concerned that if it does not apply to nursing homes it will adversely affect them and their ability to recruit and retain nurses. However, if it were to apply to care homes, funding would not automatically follow and we would want to see some commissioning responsibility clearly included.

Melanie Minty

Policy Adviser

11 February 2015

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 Welsh Independent Healthcare Association – SNSL(Org) 25 /
Tystiolaeth gan Cymdeithas Gofal Iechyd Annibynnol Cymru – SNSL(Org) 25

Safe Nurse Staffing (Wales) Bill

Bill extension to Independent Sector?

Written Submission

Introduction

The Welsh Independent Healthcare Association (WIHA) is a representative association of the vast majority independent acute and mental health hospitals in Wales. WIHA represents the interests of a number of healthcare organisations in order to make a positive contribution to public policy regarding healthcare in Wales.

Nurse Staffing Ratio

WIHA supports the principle of ensuring that there is a scheme via which safe staffing can be assured for all patients regardless of the environment in which they are cared for. However there are some specific issues which WIHA feel need to be considered for the Independent sector in Wales but which may equally affect the NHS.

The Ratio of Registered Nurses to patients and Registered Nurses to Healthcare Support Workers (HCSW) does not take into account the level of training of the HCSW and whilst the rationale may be on the premise that the HCSW has only had minimum training. At two of the 6 acute independent hospitals it has been reported HCSWs are employed or trained to NVQ levels 2 and 3. HCSWs trained to NVQ level 3 have also attained individual competencies on top of this and are therefore very capable of more in-depth patient care than a minimum trained HCSW, and indeed get much job satisfaction from managing their own caseload under the supervision of a Registered Nurse.

The level of training the HCSW has attained is not reflected within the Bill. Whilst WIHA appreciate the existing research does reflect on the percentage of degree qualified nurses, WIHA believe the level of qualification of the HCSW should also be taken into account.

The proposal to ensure the ward sister is supernumerary is within the calculation is not new, the free to care proposals gave this view and it is one which WIHA members have implemented, though the job title may differ within the Independent Sector, using terms such as inpatient manager.

It will also need to be recognised that within the Independent Sector some units may have very small inpatient "wards" or departments which may not require an individual Sister/Charge Nurse to be in charge. For instance a 10 bedded day care unit may be overseen by a ward sister who takes care of day care and a small surgical unit of 18 beds. The Bill would need to leave sufficient flexibility to ensure that it will allow the differing structures within the Independent Sector to meet the terms of the Bill. The Independent Sector internal nursing hierarchy does not directly match the NHS and does not necessarily need to replicate this structure to ensure that safe care is given.

Reporting mechanism

Internal Reporting mechanism for safer staffing within the independent sector in individual hospitals would be via their hospitals governance boards. Internal organisational reporting would be via their organisational governance structures that would replicate reporting of other governance events e.g. IPC/never events, untoward incidents etc.

HIW would consider staffing levels on their inspection process as an external validity process.

Sanctions if falling below required level

Sanctions for Independent Sector organisations would need to be considered and could only be linked to HIW regulatory powers. This would include provision of an action plan to ensure falling below the required standard was being addressed.

Conclusion

The WIHA is very pleased to have had the opportunity to comment on a possible amendment for the Safe Nurse Staffing Bill to include the independent healthcare sector and it is important that should the Bill be extended that is will include all of the Independent Sector not just NHS funded care within the Sector.

For further information please contact:

Sally Taber
Secretariat of WIHA
Association of Independent Healthcare Organisations
1 King Street, London
EC2V 8AU
T: [redacted]
E: [redacted]

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 Welsh Independent Healthcare Association - SNSL AI 10 / Tystiolaeth gan Cymdeithas Gofal Iechyd Annibynnol Cymru - SNSL AI 10

Safe Nurse Staffing Levels (Wales) Bill
WIHA's second written submission to the Health and Social Care Committee

Introduction

1. Further to the Welsh Independent Healthcare Association's (WIHA) response to the Call for Evidence on this Bill, WIHA is pleased to submit this further response to two questions posed by the Health and Social Care Committee.

2. WIHA is the representative association of the majority of independent acute and mental health hospitals in Wales. Please find attached the latest WIHA Credentials document which provides an overview of the independent healthcare sector in Wales.

Applying the provisions of the Bill to independent healthcare settings

3. *Question 1 - Why, in your view, the Bill should include provisions that apply to independent healthcare settings - the WIHA's written evidence states: "The WIHA is very pleased to have had the opportunity to comment on a possible amendment for the Safe Nurse Staffing Levels Bill to include the independent healthcare sector and it is important that should the Bill be extended that is will include all of the Independent Sector not just NHS funded care within the Sector."*

4. The independent healthcare sector serves to provide safe quality healthcare to patients who choose to self-pay or use private medical insurance. The sector also provides some additional capacity to the NHS in periods of extreme pressure on NHS services. Safe staffing is a key aspect of independent healthcare quality standards in order to protect **all patients** (**whether NHS or privately-funded)** and to supply safe care in a dignified manner. Therefore inclusion in the Bill allows the independent sector to reflect their support of safe staffing for all the patients they treat.

5. The independent healthcare sector is, of course, already reviewed for safe practise by Healthcare Inspectorate Wales. However the additional provision of standards via this Bill would support this function and provide clear guidance to the regulator and providers.

6. WIHA members treat a mixture of NHS and privately-funded (private medical insurance and self-pay) patients alongside each other; there is no distinction between patients on the basis of their funding source. Indeed nursing staff would not necessarily know the funding means of a particular patient. Were the Bill to only apply to NHS-funded patients it could lead to a discriminatory system between the two groups of patients which may cause confusion and care lapses.

Nurse staffing ratios in the independent healthcare sector

7. *Question 2 - Whether the industry adheres to any staffing ratios at the moment and, if so, what those ratios are, to what extent compliance is monitored and by whom, and what the rates of compliance are.*

8. *Does the sector adhere to any staffing ratios at the moment?*

9. Staffing ratios are assessed using the clinical judgement and expertise of the clinical leaders as a recognised tool. Acuity of patients, skill mix of staff, category of surgery and local factors are all used to establish safe staffing. Staffing ratios are assessed as a minimum 24 hours in advance, and as a continuous measure. The aim is to meet patient need at the time and in order to do so the system requires flexibility. The actual ratios may be slightly different dependant on the WIHA member and indicate minimum safe staffing levels rather than a maximum.

10. WIHA members also take cognisance of relevant guidance in this area, for example:
    - NICE guideline *Safe staffing for nurses on adult inpatient wards in acute hospitals*, which has application in Wales.
    - Royal College of Nursing publications such as *Guidance on Safe Nurse Staffing Levels in the UK*.

11. WIHA values the bi-annual meetings held with Chief Nursing Officer (CNO) for Wales, Dr Jean White, and her inclusive approach to WIHA members. The CNO communicates developments in this area to WIHA members.

12. *If so, what are these ratios?*

13. As per paragraph 9 above, nursing staff ratios vary for a number of reasons. It is essential that professional judgement is used throughout the planning process.

14. Ratios in WIHA member hospitals also reflect the abilities of our Healthcare Assistants (HCAs) who having gained an NVQ Level Three are able to participate more fully in providing care.

15. To what extent is compliance monitored?

16. Any unsafe levels of staffing are escalated via clinical leaders to senior nursing management under the WIHA member's clinical governance structures. Compliance is also monitored via audit at clinical reviews, and is part of the complaints and any adverse incident investigations. Comprehensive Whistleblowing policies are in place to protect the staff member should there be an issue which an individual feels is necessary to escalate.

17. Healthcare Inspectorate Wales have also discussed safe staffing at recent inspection visits of certain WIHA member hospitals.

18. By whom is compliance monitored?

19. Compliance is monitored by clinical leaders and shift coordinators within the organisation. As stated above this is also monitored periodically through the internal clinical audit process and externally by Healthcare Inspectorate Wales.

20. What are the rates of compliance?

21. WIHA members achieve 100% compliance as there is a zero tolerance approach to unsafe staffing. Bank and agency staff are used to fill any staffing shortages.

Particular points to consider in the independent healthcare sector context

22. Should this Bill be enacted, robust workforce planning strategies will be needed to ensure that there are sufficient nursing staff numbers to ensure compliance. WIHA members are beginning to be included in formal workforce planning structures for Wales and this would need to be continued. Nursing staff can and do work across the NHS and independent sector and it is therefore helpful to consider workforce planning in the widest sense to encompass the entire healthcare sector.

23. The proposed Bill makes mention of registered nurse ratios and the ratio of healthcare support workers to registered nurses but makes no specific recommendation on the HCA role nor on minimum numbers for these important members of staff. WIHA members have invested in the training of their HCA staff who consequently play a significant role in the provision of essential nursing care. It would seem prudent that their role is recognised within this Bill.

24. Independent healthcare providers tend to deliver care using a holistic approach based on a multi-disciplinary team. Different professions have more scope to deliver care that might not traditionally be delivered by their profession in a different setting. For example, the boundaries between nurses and occupational therapists may be more blurred in parts - focusing solely on nurse staffing ratios could have adverse effects on such allied health professions.

25. Models of effective healthcare delivery are continually evolving and due to their nature independent healthcare providers are able to respond quickly to such changes. There is a real danger that any inflexible legislation could become outdated as care delivery models change and new evidence bases develop.

26. The independent healthcare sector has a significant provision of the mental health and learning disabilities services in Wales and WIHA would be interested to know whether such settings would also be brought under the auspices of the Bill.

Conclusion

27. Nurse staffing ratios are a highly complex issue. Should the Bill's remit be extended beyond the NHS, sufficient flexibility would need to be built into its provisions to ensure that it allows the differing structures within the independent sector to meet the terms.

28. In order for Committee members to gain a broader understanding of the independent healthcare sector, WIHA would like to formally invite them to visit their local WIHA member hospital. This will enable members to see the hospital in operation and speak directly to the lead nurse on the issue of safe staffing levels.

11 March 2015

Welsh Independent Healthcare Association
Cymdeithas Gofal Iechyd Annibynnol Cymru

High quality patient care
Working in collaboration
Investment in local economy

2013/2014 CREDENTIALS DOCUMENT

Gofalu am Gleifion dros Gymru

Investment in the latest equipment is essential for the care of our patients

The Mental Health sector provided **85,000** patient bed days in 2013-2014

The acute sector provided over **16,500** in-patient/day case episodes in 2013-2014

The Learning Disability Services provided over **21,700** bed days in 2013-2014

WIHA members ensure their staff receive high quality training and development to ensure continuing high levels of care

Introduction

The past year has seen a number of changes in the independent sector, both in terms of acute provision and mental health regulation. Nevertheless, and despite the challenging economic climate, many thousands of patients have used the services and treatments provided by independent hospitals in Wales.

We employ almost 2,000 people and treat tens of thousands of patients every year, either as inpatients or on an outpatient basis, and across a range of general health services but increasingly in particular areas of more specialist care and treatment.

We are working more and more closely in an advisory and collaborative way with both the Welsh Government and Health Boards to improve alignment with our common objectives of the highest standards of patient safety and quality. We believe there is more scope to develop shared learning and ideas in healthcare innovation and improvement by working in a more collaborative manner.

As local employers often in areas with higher than average levels of unemployment, we also provide opportunities for employment across a range of disciplines and areas. We seek to promote good practice in our employment practices and by doing so to demonstrate our commitment to Corporate Social Responsibility.

The Welsh Independent Healthcare Association (WIHA) was formed several years ago and aims to provide a single co-ordinated voice to facilitate consultation and share practice across the sector, helping to streamline communication and avoid repetition and engagement with a multiplicity of individual organisations.

We have compiled this booklet to provide some key facts and figures about the independent healthcare sector in Wales. A detailed summary is available of the result of the audit.

I hope you find this booklet helpful and please do contact me if you would like more information about the WIHA, its members, or the work of the independent health sector in Wales.

Thank you.

Simon Rogers,
Chairman WIHA

Telephone: [redacted]

Email: [redacted]

About the Independent Health Sector

The WIHA is made up of:

- 6 acute hospital organisations
- 6 mental health organisations (comprising 23 units)
- 2 organisations providing learning disability services

All of these hospitals collaborate with a wide range of stakeholders, including patients, consultants and their professional associations, regulatory bodies, intermediaries, Local Health Boards, GPs and community health services.

The six acute independent hospital organisations which took part in this audit:

- Treated more than 16,500 inpatient/day cases in the period 2013-14.
- Managed more than 23,000 bed days in the same period.

The six mental health organisations:

- Managed more than 85,000 bed days, again in the same period
- All of the NHS funded bed days.

The learning disability units:

- Managed over 21,700 bed days, in the same period
- All of them NHS funded beds.

All WIHA members have a commitment to quality assurance as a key part of the delivery of safe and effective services to patients, and they have systems in place to identify the central cause of any issues raised which help to ensure that problems do not recur.

In addition, the sector makes a sizeable contribution to both Welsh employment and the Welsh economy by providing employment for a large number of people, while the vast majority of the goods and services are bought locally.

These include areas such as foodstuffs, supplies, engineering support, grounds maintenance, building and construction.

Our patients rate the level of care they receive extremely highly


Total staff in sector
1,928
Acute inpatients discharges
16,901
Acute outpatient attendance
143,296

Ensuring the Quality of Clinical Care

Patients in the independent sector receive high standards of clinical care, and are treated in high-quality facilities by leading consultants using some of the latest technology.

WIHA members have stringent measures in place to combat Methicillin Resistant Staphylococcus Aureas (MRSA) and other hospital acquired infections.

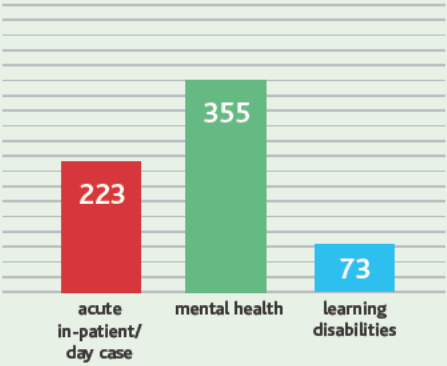
As a result, no incidences of hospital acquired MRSA Bacteraemia and only 1 case of Clostridium Difficile were recorded in the WIHA acute hospitals completing the questionnaire in 2013/2014, and they managed a total of 23,134 bed days.

99%

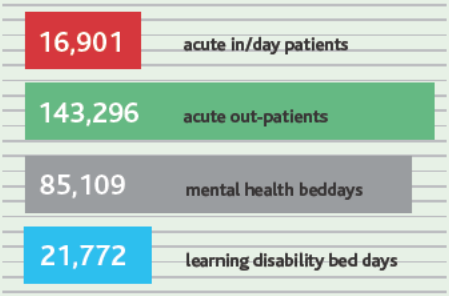
of patients would recommend our hospitals to others

Summary of results of the audit

number of beds



number of patients treated



levels of patient satisfaction and complaints

All the independent sector organisations in the audit have high rates of patient satisfaction. The average results in 2013/14 for the WIHA group were:

- **99%** of patients surveyed would recommend our hospitals to others
- **99%** of patients rated the service as either excellent, very good, or good.
- **99%** of patients rated the cleanliness of the facility as excellent, very good or good.

Quality assurance

The independent health sector receives very few complaints.

- In the mental health hospitals complaints represented just 0.04 per cent of patient days.
- The number of complaints made in the acute hospitals represented less than 0.1 per cent of all attendances.

99% rated the cleanliness of our hospitals as excellent, very good or good

Complaints across the sector represented less that 0.1% of all patient activity

Organisations who are members of WIHA and supplied data for this document:

Acute Surgical:

- BMI Werndale Hospital, Carmarthen
- Nuffield Health Cardiff & Vale Hospitals, Cardiff and Vale of Glamorgan
- Sancta Maria Hospital, Swansea
- Spire Cardiff Hospital, Cardiff
- Spire Yale Hospital, Wrexham
- St Josephs Hospital, Newport

Mental Health:

- The Cambian Group
- Lighthouse Healthcare, Phoenix House
- Ludlow Street Healthcare
- Partnership in Care, Llanarth Court Hospital, Raglan
- Priory Group
- Rushcliffe Independent Hospital

Learning Disabilities:

- Ludlow Street Healthcare
- Priory Group

Organisations not participating are Mental Health UK and Pastoral Healthcare

Produced by Welsh Independent Healthcare Association with grateful thanks to Lene Gurney, Association of Independent Healthcare Organisations (AIHO)
Independent Healthcare Advisory Services (IHAS) Division [redacted].

Further information about the WIHA can be found at
www.independenthealthcare.org.uk/wiha

Document is Restricted

Document is Restricted

Document is Restricted

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

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau

Evidence from The Wallich – ASM(AI) 32 / Tystiolaeth gan Y Wallich – ASM(AI) 32

To	Health and Social Care Committee – Inquiry into Alcohol & Substance Misuse
From	The Wallich
Date	March 2015
Further Information	Antonia Watson [redacted] Sue Goodman [redacted]

1.0 Background

1.1 The Wallich is a pan Wales charity providing prevention, support and accommodation to homeless people and people vulnerably housed. It works with a range of 'client groups' providing generic and more specialist support services for people with drug and alcohol problems.

1.2 The evidence is drawn primarily from data relating to one year 23.02.14 – 23.02.15. This includes accommodation based services, street outreach and floating support.

1.3 People supported above have accessed services that are funded by Supporting People or S180. Needs of people accessing Wrexham's Tier 2 service have not been included.

1.4 The data sample relates to 4,092 individuals, of which 24% identify as having a problem with alcohol and/or drugs (n=980).

1.5 The Wallich was at the forefront of developing specific accommodation and support in the 1990's for 'street drinking gangs' and IV drug users in accommodation based services.[i] These services operate today, and are still expanding. (Refer to appendix 1 for a breakdown of 'specialist services' by local authority). Accommodation based services and street outreach to rough sleepers have a higher number of people with problematic alcohol and/or drug use than floating support.

1.6 The Wallich was commissioned by Cardiff and The Vale Substance Misuse Area Planning Board in 2014 to research the impact of alcohol on older people (A separate submission) and Newport LA in 2014, exploring the needs of street drinkers (of which Data is included in the report

[1] The Shoreline projects/ accommodation and support for 'street drinking gangs' and developing a drug policy which allowed injecting drug use in residential accommodation.

Wallich Data – 1 year 23.02.14 – 23.02 15
(Under reporting likely)

Total number of clients in sample	**4,092**
Total number of clients with substance misuse problem	980
Total number of substances used (poly use)	1,488
Key substances used	
Cannabis	231
Alcohol	270
Heroin	338
Methadone	104
Benzodiazepines	50
Crack Cocaine	29
Specific health issues	
Hep C	77
Liver condition	43

2.0 The impact of alcohol and substance misuse on people in Wales, including young people and university students, older people, homeless people and people in police custody or prisons.

Young people

- Young people often leave home due to family breakdown and become homeless/sofa surfing
- Needs to be increased focus on the needs of children and young people
- Increased focus on prevention through education at school
- Increase in youth centres particularly where excluded from school(Llanelli Centre Project an example)
- Give clear message on impact on health through substance misuse including possible impact on mental health
- Increase early invention, lack of funding for conflict resolution services for families at an early stage to reduce young people becoming homeless
- Lack of sign posting for families in crisis
- Future impact of legal highs is unclear
- Need increase support for young people across Wales
- Difficult to obtain secure accommodation particularly 16-17year olds and limited access to benefits
- Young people can have difficulties keeping to tenancy responsibilities with substance misuse issues

Older people

- Wallich residential accommodation for street drinkers (safer for individual and community safety)
- Street drinking anti-social for community particularly town centres, dynamics of seasonal issues (summer time)
- Many of our older clients who are heavy drinkers would have died on the streets without gaining access to non-abstinence accommodation
- Safer injecting in projects safer than using public areas
- Alcohol and older people research results (awareness raising, help and support etc.). outreach clinics
- Where individuals want treatment, needs to be appropriate and clear aftercare options because high incidence of relapse
- Joined up approach to reduce the impact of street begging (education of the public)
- Need to build recovery which is sustainable rather than short term detox
- Lack of knowledge/training regarding alcohol consumption in older person's residential accommodation. Role of sheltered housing/extra care providers
- Problems getting care for chronic drinkers. Excluded from sheltered, Care not provided in e.g. Shoreline accommodation.
- Lack of age appropriate, accurate information for older drinkers regarding provision of service and harm reduction. Age appropriate staff

Homeless people

- Lack of trust, a fear that LA's will be judgemental or contact the police
- Belief that the LA will not do anything to help them
- Lack of duty particularly towards single males
- Option is to go to 'dry hostel' which isn't an option for most people. Need choice of 'wet/dry' provision to meet needs of individuals, non-abstinence accommodation model is a vital part of reducing homelessness and harm reduction
- Are often chaotic with limited choices of where to go. Discrimination by mainstream providers
- Offered B & B temporary accommodation without support cause problems then back on the streets
- Need rapid access to treatment at the point of request. Waiting lists, appointments may fail thee individual
- Effect of dual diagnosis which comes first mental health or substance misuse. Need to 'treat the whole person'
- Many drink/use substances to cope with the trauma of being homeless living on the streets or to self-medicate
- Most housing providers in Wales will not work with the most chaotic homeless people

People in police custody or prison

- The Wallich houses many prison leavers who are homeless, many of whom had short sentences
- Bardsey project in Ceredigion model for prison leavers in residential accommodation with support
- Ex-prisoners who are heavy drinkers leave prison without a programme of harm reduction in place
- Returning to locality may be detrimental to health
- Housing Act (Wales) needs to look beyond just accommodation for resettlement to be successful
- Prison leavers often state that the structured environment of custody supported their recovery, upon release structure is not available immediately resulting in relapse

- Planned resettlement is not always available as landlords cannot afford voids, this prevents pre-release resettlement work

- The Wallich PREP project provides a resettlement service for men leaving HMP Parc. Success is partly due to the integration of services within BCB, across sectors/funding streams.

3.0 The effectiveness of current Welsh Government policies on tacking alcohol and substance misuse and any further action that maybe required.

- WG Guidance formed in 2010. About having regional partnerships responsible for tacking issues of substance misuse with team to support planning/commissioning/monitoring. Need to ensure that these are effective across Wales
- Focus in North Wales vision 'working together we will seek to make North Wales a safer and healthier place to live, work and visit by preventing and reducing the impact that substance misuse has in our communities by promoting recovery and providing the best service possible to help those in need'.
- Focus is on recovery and reduce harm, There is a problem with this in that not everyone will abstain or want to but this is the focus and need both models (recovery and harm reduction)
- Lack of resources for recovery, concentration of detox (some people have 7 detox programmes) go back to same group of people/lifestyle
- Lack of single pathway to recovery for individuals (detox, recovery)
- The various strategies, codes, and frameworks relating to the wide spectrum of alcohol and drug services is complicated to navigate. The main document considered in this paper is Working Together to Reduce Harm 2008-2018. From The Wallich's experience of working primarily within the S180 and Supporting People funding arena's, frontline provision is concerned with referral to Tier3 and 4 services, harm reduction through generic support work, knowledge of the local recovery community . The nature of many of the clients

accessing The Wallich's services is often complex and alcohol and substance misuse can go hand in hand with mental health, sex work, criminal activity etc. Whilst this works well at the local level, there if limited knowledge of the strategic level.

- Evidence on the ground demonstrates a lack of 'joined up 'approach. E.G multiple residential treatments, person returns to same environment and fails due to lack of appropriate accommodation/support
- The Shoreline model has proven to be cost effective in terms of savings to the public purse (Heirene 2014), improvements in the health of the individuals and a visible improvement in the reduction of street based activity. Similarly allowing injecting drug use in hostel type accommodation has resulted in reduction of overdose, increase in treatment, improved public safety etc. Where Government Policy has not been effective is at a local level where extreme opposition to such approaches is often experienced.
- Research illustrates that alcohol misuse is likely to cause significant impact particularly on older people (Alcohol Concern 2011, The Wallich 2014), labelled a 'hidden epidemic'. The Welsh Government identifies that a 'cultural change' in general is required to tackle the rise in alcohol misuse. There is little, if any high profile media campaign (apart from Christmas drink driving), which may be a useful way of reaching general public.
- Need clear communication between all services involved in harm reduction/recovery
- Role of GP's is crucial. Research into barriers to engagement for rough sleepers in Denbighshire (2015), found 40% of rough sleepers had an alcohol/drug problem and that 80% of rough sleepers accessed GP's (the most prevalent provider of support). GP's in this instance are likely to be the gateway to treatment. Needs to be coordinated with support, outreach and accommodation providers. Consider brief interventions being provided by medical (non GP staff)
- 57% of rough sleepers in Denbighshire research stated that their alcohol use was a barrier to accessing services (in particular, Supporting People strategies need to support national alcohol/drug strategies)

4.0 The capacity and availability of local services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse to increase awareness

- Within the homeless sector, drug and alcohol support, knowledge of local services, diversity of service providers/models of support is good. However, the services largely operate without reference to Government Policy.
- Resources required to get messages across Wales regarding effects of heavy drinking on health particularly later on
- All Supporting People funded services should be able to increase awareness of and provide a support and/or prevention service.
- Needle exchange, safer injecting advice, blood borne virus testing to be promoted in homelessness provision (linking SP to strategy)
- Frontline staff should be trained to administer Naloxone to prevent death
- Treatments such as auricular acupuncture could be offered in hostel/supported housing.

- Supporting People Funding should not be limited to a 'list of eligible housing related tasks', but more holistic/joined up definition to meet the needs of people with alcohol/drug issues.
- Needs mapping of services available across Wales would increase knowledge and improve access to services
- Everyone including homeless people should have access to a GP and GP's to have a greater understanding of substance misuse with this particular client group
- To address the problems associated with NIMBYISM (especially outside of cities) 'education' is required at elected member level.
- Increase access to Tier 2 services on a 7days a week basis when people need the service
- Increase the recovery/after care options for individuals across Wales
- Make clear what services are available in each area and what they offer – especially libraries, jobcentres, one stop shops etc.
- Early diagnosis by Community Mental Health Teams and improved access
- Diversionary activities to be part of all homeless services
- Clear communication regarding discharge plans from hospitals and release information from prisons. Single pathway required.

5.0 Other research/observations

- Homeless Link research illustrates (England) that 26 out of 100 homeless people use drugs compared with 8 out of 100 of the general public. The research also illustrates that 1 in 3 misuse alcohol which is more pronounced in hostel accommodation (37%) and similarly drug use is more prevalent in hostels (39%), compared to 5% of the general public. Alcohol use was more prevalent in men.

- The Wallich data is not as sophisticated as that of Homeless Link, however The Wallich would conclude that residential/hostel accommodation is more effective at supporting chaotic clients than floating support and should be considered when commissioning /re-commissioning services. There is a tendency to commission low level support (as its more cost efficient in terms of individuals supported) can/should replace accommodation based services. With a growing tendency for quick time limited interventions (E.G Cardiff Supporting People) the complexity of homelessness could be overlooked.

- The Wallich research (Eirene 2014) looked at the impact of supporting street drinkers in Newport and concluded 'the cost benefit analysis showed that street drinkers accumulated more per year in public service costs than the cost to support them in a 'wet' house service. Therefore the development of a wet house to support street drinkers could save a significant costs to the public purse'.

Wallich Research Documents

- The Shoreline Project 2015
- Alcohol and Older People April 2014
- Exploring the Accommodation Needs of Street Drinkers in Newport: The Case for a Wet House Service December 2014
- A Report on the barriers to engagement faced by rough sleepers in Denbighshire

6.0 Conclusions

- The Working together to Reduce Harm Strategy 2008 – 2018 is an excellent document. However, greater coordination between services is required for its effective implementation. The strategy should not be considered in isolation. Partnership approach required -shared budgets/strategy with WG lead – including health, substance misuse, supporting people, mental health for effective strategy implementation.
- Right treatment at the right time – reducing 'service failure'. Rapid access, appropriate range of provision, cross authority working required for those in homelessness services.
- Treat the person not a set of needs – more effective with the complex needs faced by homeless people.
- Greater consideration to be given to the 'time bomb' waiting to happen for people not in contact with services. Media campaign to be considered.

Appendix 1 – alcohol/substance misuse specific services

Local Authority	**Name of service/Type of Service**	**Numbers accommodated/supported at any one time**
Blaenau Gwent	Substance misuse floating support	8
Bridgend	Vesta – accommodation based project	5
Cardiff	Shoreline – accommodation projects for 'former street drinkers'	34
Cardiff	Community House Team – dual diagnosis accommodation based project	34
Cardiff	Community House Team – dual diagnosis –floating support service	7
Cardiff	Croes Ffin	9
Carmarthenshire	Ty Croeso – abstinence based accommodation project	5
Ceredigion	Ty Nesaf – Accommodation project for people with complex substance misuse support needs	4
Powys	Symud Ymlaem – floating support	25
Swansea	Shoreline – accommodation project for 'former street drinking gangs'	9
Swansea	Gorwellion – abstinence based accommodation project	10
Swansea	Cross Borders Women's project Accommodation – substance misuse and homelessness	16
The Vale of Glamorgan	Croes Ffin accommodation based	9
	Croes Ffin floating support	15

Wrexham	Ty Croeso – Tier 2 drop in service	c 60 people a day

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

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from National Union of Students – ASM 28 / Tystiolaeth gan Undeb Cenedlaethol y Myfyrwyr – ASM 28

NUS and NUS Wales: Information for the HSC Committee

Existing research on students and drinking behaviours:
There are currently 2.5 million students in British higher education, which incorporates 43% of the entire 18-24 year old population[i]. There are 165 higher education institutions. Evidence suggests that students consistently report higher levels of consumption than the wider young adult group, claiming to drink nearly double the amount in a week of every type of drink[ii].

Students report consuming nearly double the amount for every type of drink, with glasses of wine at nearly three times as many[iii]. It is also more common for students to go out with the intention of getting drunk than it is for the wider young adult audience, with 53%[iv] vs. 48%[v] reporting doing this at least once a week, although students report unintentionally getting drunk less (32%[vi] vs. 37%[vii]).

Starting university presents a significant life change for students, with many moving away from home, establishing new groups of friends and living alone for the first time. This level of life change means that students are particularly susceptible to developing new habits and behaviours while at university[viii]. This appears to be particularly key around alcohol consumption, with the expectations around the university lifestyle, as well as new peer pressures having the potential to make new students vulnerable to adopting harmful drinking patterns.

85% of students report believing that drinking and getting drunk is a fundamental part of the student experience and drinking to excess is expected[ix]. This belief creates a vicious cycle where perceptions that other students are drinking, and that being drunk is an integral part of the university experience push students to drink more than they might otherwise.

Despite the belief that getting drunk is fundamental to the university lifestyle, 40% of students report that drinking alcohol has had a negative experience on their university life in general[x]. Students report experiencing the same alcohol-related harms as the wider population, with a slightly higher tendency to get into trouble with the police (although not statistically significant)[xi].

Young people in Wales are more likely to be referred by their GP for alcohol addiction and/or abuse than for any other substance. The strain that this puts on the Welsh NHS cannot be underestimated. The figures for referrals have been dropping year on year, and that is to be welcomed. We hope that such a trend will continue. Further information on this can be found here.

British universities' response towards binge drinking has been mixed, university staff recognise some of the issues surrounding students' excessive alcohol consumption, but as yet, it is not a priority. While most appear to have alcohol policies, they are different at each university, not enforced, and the level of knowledge about them among staff is very low.

It is important at this point to clarify that students are certainly not a homogenous group and their drinking behaviours reflect this. Student drinking behaviours are influenced by a wide range of different factors. Many students choose not to drink for a variety of social or cultural reasons.

Many of the articles on British university students and binge drinking are limited to single university studies or specific student groups so caution should be taken before extrapolating these findings to the wider population. Students' unions and chaplaincies have traditionally taken a lead in this area, but the efforts have been localised to specific areas of the campus and again are dealing with consequences rather than prevention. To effect change we need an institution wide approach to responsible alcohol consumption.

Previous NUS work on responsible alcohol consumption:
In the past NUS has worked with Drinkaware to deliver the 'Why let good times go bad?' campaign to students' unions across the UK, with most displaying campaign materials and a smaller sample bringing the campaign to life on their campus through sponsored club nights.

Although the campaign achieved some successes over its five year period, Drinkaware's own evaluation identified that it had not achieved a significant shift in young adult's behaviour and suggested a different approach needed to be taken (Independent review of the Drinkaware trust, 2013[xii]).

NUS have also worked with Drinkaware, the Home Office and the Association of Chief Police Officers to produce guidance for both students' unions and license enforcement officers on how to work in partnership and tackle the problems associated with commercial bar crawls. This was in recognition of the high levels of alcohol consumption and anti-social behaviour that took place during these events, as well as the resulting impacts to students' health and wellbeing.

With a growing literature on social norm perceptions as both predictors of drinking behaviour, and the focus of interventions, there have been various pilots of challenging social norms in order to change the drinking patterns of students. This includes work conducted in 2011, by DECIPHer, in partnership with NUS Wales and Drinkaware, to assess first year university students' perceptions of peer drinking behaviour and consequences in four Welsh Universities. Further information can be found here. However drawing any conclusions around the effectiveness of these interventions is difficult, as the evidence for their success is mixed.

While there is lack of evidence of approaches towards behaviour change in the UK involving alcohol, there are examples from other areas, particularly around environmental initiatives in universities. The Green Impact scheme run by NUS is an accreditation and awards scheme for teams or departments throughout an institution whereby staff are encouraged and supported to change their habits and working practices to more environmentally sustainable ones.

First developed in 2006, it has now become a successful behaviour change and staff engagement model that over 155 organisations from different sectors use. Last year, over 40,000 staff made

25,000 changes as a result of the programme across 46 universities and colleges and 105 students' unions. The programme has become so successful that it has now been extended to run in hospitals, small businesses, dentists and a number of schools.

There are a range of factors, unique to the university campus, that influence students to drink more than the wider young adult audience, and these need to be tackled before direct student messaging can be successful. There is also evidence to suggest that once harmful drinking patterns have been established at university, they are more likely to continue into later life.

Introduction to Alcohol Impact

NUS and NUS Wales takes the welfare of students very seriously and our new Alcohol Impact Scheme works with students' unions and institutions to change attitudes towards drinking and building healthier, safer, more productive student communities.

Our pilot runs across England and Wales. We are working with **Swansea University** in Wales, other institutions that we are working with in England can be found on page 3 of this document. Once effective behaviour change can be shown we would hope for the programme to expand rapidly across institutions nationally.

The information we have is still limited and we are not able to fully understand the picture of university students and what works in changing this groups drinking behaviours. We hope with the learnings from our Alcohol Impact pilot to be able to identify and go on to recommend effective policy. A brief summary of our pilot is detailed below.

Summary of Alcohol Impact pilot

We have submitted this paper in conjunction with our first Baseline survey data report. As the baseline survey data report is not yet published, we would ask the committee to not share this data externally. We will look to publish our data, once we have completed our extensive research programme.

1. Background

In April 2013, we begun to explore how we might change student behaviours by creating a social norm of responsible alcohol consumption at a key moment of change in student lives. This built on NUS' established and successful pro-environmental behaviours change work that received catalyst funding from Defra in 2010/11.

The result is that NUS will seek to reduce alcohol-related crime and disorder associated with higher education through the piloting of an innovative, institution-wide behaviour change programme called Alcohol Impact. We will achieve this through the creation of an accreditation mark that universities will see as a 'badge of honour', that will provide a framework for institutions and students' unions to undertake important, impactful interventions through policy, procedure, retailing and accommodation that ultimately lead to an institution-wide social norm of responsible consumption with excellent potential legacy through behaviour change and habit formation.

As well as demonstrating impact attributable to the interventions, we will create a robust evidence base from our work, identifying the links between students, alcohol and crime and disorder, which will future support the development and evolution of the programme.

2. How the universities were chosen

Our model is based on a creating a strong partnership between students' unions and their parent institutions. A range of institutions were selected for the pilot to ensure it was representative of the diversity of the sector. These variances included institutional mission groups (e.g. Russell Group, Million+, etc.), their geographical location (campus *vs*. urban; northern *vs*. southern); demographic trends (ethnicity and age of the student profiles), as well as attempting to cluster them to create local exchange and dialogue, and help us with ease of delivery. Some institutions were also identified by the Home Office as being in their local action areas.

During the pilot year we will be working with the following eight institutions:

Name of Partnership	Number of students
Liverpool John Moores University and Students' Union	22,585
Loughborough University and Students' Union	15,460
Manchester Metropolitan University and Students' Union	32,465
Royal Holloway University of London and Students' Union	9,565
Swansea University and Students' Union	14,360
University of Brighton and Students' Union	21,310
University of Central Lancashire and Students' Union (control)	28,720
University of Nottingham and Students' Union	35,540
	180,005

3. Accreditation criteria and scores

In March 2014 a collaborative workshop was held to give all seven pilot partnerships the opportunity to meet us, the Home Office and each other, to find out more about current trends in research around alcohol and students, and share interventions that have previously been delivered. It also served to collect ideas from them for the criteria that formed the backbone of Alcohol Impact.

Subsequently the accreditation criteria were developed collaboratively with the Partnerships and the Home Office through a series of open discussions, the process helping to instil an important sense of ownerships with the partner institutions.

We have 46 criteria [A1-01 – A1-46], which includes 17 Mandatory and 29 optional criteria. This gives a total overall score of 181 and we have set the threshold score for accreditation at 60% of the marks, a score of 109 or more including points from the mandatory criteria (70 points). In addition to this there is the option to form three site specific criteria [A1-47–A1-49] this allows pilot partnerships to craft the workbook, making it bespoke to suit their own local needs. Each criterion is scored between 1 and 10 in terms of difficulty (with 1 being the least impactful and easiest to implement and 10 being the most impactful and difficult to implement).

4. Workbook and microsite

The workbook includes further information on why we are asking for each criterion to be met, the research behind this, how we will audit each criterion and linking to examples of good practice. We have also launched our microsite, this will continue to be updated over the coming months, with examples of interventions being delivered and sharing of good practice, so please do refer back to it!

5. Steering groups

Pilot partnerships are now working through the criterion to see how they might attain and what they want to do as a result of them.

One of the mandatory criteria asks for pilot partnerships to form a steering group - a group of key individuals that can support and implement Alcohol Impact through the life of the pilot. All pilot partnerships have now formed their steering groups. Due to the nature of the programme, the variety of members of the group varies locally. Steering groups should be student led and are likely to include commercial services, student services, teaching staff, policy makers, senior university management, students' union staff and officers.

Alongside a diverse blend of internal roles and remits, some steering groups include some non-financial involvement from external stakeholders such as the NHS, Police, city council and fire services.

6. Interventions

Through carefully planned interventions, formulated through the use of the Individual, Social and Material model (ISM), and with the support of ISM author Andrew Darnton, have worked with the pilot institutions and their students' unions to develop interventions that form the criteria. As part of the mandatory criteria [A1-35], each partnership needs to pilot one or more innovative interventions on responsible alcohol consumption.

Partnerships have focused on a variety of different local issues, which have included:

- Pre-drinking in groups in halls
- Damage in halls
- Peer-pressure to drink more than students want
- House party safety
- Student safety after a night out
- Drink-driving
- Binge drinking

Interventions have included:

- Use of breathalyser's as an educational feedback tool
- Communication campaigns, video clips
- Alcohol/quiet spaces at large events
- Safer taxi schemes
- Working with fresher's helpers to develop pledges to shift the culture of welcome weeks to focus on non-alcohol related events such as 'raveminton' and other events.
- Working with external companies to deliver alcohol free events such as giving out free food and non-alcoholic drinks.

7. The pilot

The initial pilot will run from April 2014 to April 2015. Subject to the results of this pilot, The Home Office will consider recurrent funding for a second year to allow the NUS to take the project to scale, with the aim of no grant being required in year three, at which point NUS would plan for the scheme to be expanding rapidly on a self-funded basis, with institutions paying to be audited and accredited.

8. Monitoring and evaluating impact

Three surveys, alongside diary studies and focus groups will be deployed to monitor changes in attitudes, behaviours, and experiences of crime & disorder over the period of the pilot.

9. Auditing

A team of volunteer student auditors will be recruited from nearby universities and colleges and trained (alongside staff from the organisation where appropriate) to audit the programme in March/April 2015. Each Partnership is audited to verify the results of the programme, provide teams with support, and identify good practice examples. NUS will oversee the audit process to ensure credibility, consistency and fairness.

Once results have been verified, a national Alcohol Impact awards event will take place in June 2015 to celebrate the individual and collective achievements of our seven pilot partnerships. The plan is that Partnerships will be reassessed every three years for the accreditation.

Colum McGuire, NUS VP Welfare
Beth Button, NUS Wales President
07 January 2015

Endnotes

[i] Geall, J. Youth Marking Strategy 2013 conference, held 16th April 2013

[ii] NUS Services Limited (2013), 'Why let good times go bad?' campaign evaluation, commissioned by Drinkaware

[iii] Ibid

[iv] NUS Services Limited (2013), op. cit.

[v] Millward Brown (2012), op. cit.

[vi] NUS Services Limited (2013), op. cit.

[vii] Millward Brown (2012), op. cit.

[viii] Thompson, S. et al (2011),"Moments of change" as opportunities for influencing behaviour: A report to the Department for Environment, Food and Rural Affairs', The New Economics Foundation, Defra, London

[ix] NUS Services Limited (2013), *op. cit.*

[x] NUS Services Limited (2013), op. cit.

[xi] Drinkaware KPI research, prepared by Ipsos MORI, 2013

[xii] Independent review of The Drinkaware Trust (2006–2012), prepared by 23red, 2013

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

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Gwent Police – ASM 13 / Tystiolaeth gan Heddlu Gwent – ASM 13

National Assembly for Wales' Health and Social Care Committee -

Inquiry into alcohol and substance misuse.

The effects of alcohol and substance misuse on people in police custody.

Gwent Police Response-

1.1 Whilst police custody figures can provide a useful perspective on the prevalence of drug or alcohol misuse in the population, they are subject to a significant number of biasing influences. These influences can range from simple logistics - the number of officers available to patrol and make arrests – to the effect of such debates as whether hospital or custody is the right place for someone suffering from the ill-effects of alcohol misuse. This means that the figures must be approached with caution and any conclusions drawn should be tentative.

1.2 Gwent Police made approximately 16,000 arrests in 2013, this contrasts with approximately 14,000 in 2014. Broadly, the figures show the same trends in alcohol and substance misuse across the period. There were 800 arrests for being drunk and disorderly in a public place in 2013 (about 5% of the total), which is approximately equivalent to the anticipated 550 (about 4% of the total) for 2014, taking into account the decrease in overall detainee numbers.

1.3 This is reflected in the returns for the number of people arrested for driving whilst above the legal limit for alcohol, some 700 in 2013 against 500 in 2014. Again, these are not significantly different when overall numbers are considered.

1.4 When considering trends in drug misuse, the arrest numbers for possession of controlled substances are very low. Cannabis remains the drug most commonly possessed and is about 3 times more prevalent than any other drug when considering the number of people arrested. In 2013 arrests for possession of Amphetamine and Cathinone derived substances were approximately equivalent and about double that for possession of either Heroin or Cocaine.

1.5 2014 has seen arrests for Amphetamine, Cathinone derived substances and Cocaine all drop significantly. Arrests for Heroin possession have remained about the same. That said, the dataset is too limited to allow any conclusions to be drawn from these apparent variations and they are more likely to result from differences in officer numbers or behaviour than from any actual variation in behaviour on the part of the drug-using population in Wales. Significantly more data would be needed to support any conclusions.

1.6 The final area where custody figures can reflect on the questions at hand is in the risk assessments made by custody staff when considering detainees brought before them. Custody sergeants are required to assess the demeanour of detainees on their arrival at the custody facilities and this assessment includes whether the detainee is apparently intoxicated or not. In 2013 some 17% of detainees, for all offences, were recorded as displaying intoxication, whether from drink or drugs. In 2014, this increased to about 27% of all detainees arrested. Again, it would be inappropriate to draw firm conclusions from such a limited dataset – which is as likely to derive from changes in local recording practices as any other factor - but it would be interesting to see whether this was reflected in results from the other three Welsh forces.

Collated by Insp Nick McLain, 07/01/15.

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

Inquiry into alcohol and substance misuse / Ymchwiliad i gamddefnyddio alcohol a sylweddau
Evidence from Her Majesty's Chief Inspector of Prisons – ASM 22 / Tystiolaeth gan Prif Arolygydd Carchardai Ei Mawrhydi – ASM 22

Response to the National Assembly for Wales' Health and Social Care Committee: Inquiry into alcohol and substance misuse

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the National Assembly for Wales' Health and Social Care Committee's inquiry into alcohol and substance misuse.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMI Prisons also inspects court custody, police custody and customs custody (jointly with HM Inspectorate of Constabulary), and secure training centres (with Ofsted).

3. HMI Prisons coordinates, and is a member of, the UK's National Preventive Mechanism (NPM), the body established in compliance with the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT). The NPM's primary focus is the prevention of torture and ill treatment in all places of detention. Article 19 (c) of the Protocol sets out the NPM's powers to submit proposals concerning existing or draft legislation.

4. The following response is based on inspection evidence. All inspections are carried out against our *Expectations* - independent criteria based on relevant international human rights standards and norms.

5. This submission covers all three areas of interest to the inquiry, and evidence is limited to those areas specifically with our statutory remit relating to prisons, namely:
   - the impacts of alcohol and substance misuse on people in Wales, specifically young people and adults in the five prisons in Wales: HMP Cardiff, HMP Parc, HMP Swansea, HMP Usk and HMP Prescoed;
   - the effectiveness of current prison service policies in Wales in tackling alcohol and substance misuse and any further action that may be required; and
   - the capacity and availability of prison-based services across Wales to raise awareness and deal with the impact of the harms associated with alcohol and substance misuse in Welsh prisons.

6. HMI Prisons has inspected all five Welsh prisons within the last two years, as follows:
   - HMP Cardiff: Inspected 18-22 March 2013[1]
   - HMP/YOI Parc: Inspected 9-19 July 2013[2]
   - HMP Swansea: Inspected 1-10 October 2014[3]
   - HMP Usk and HMP/YOI Prescoed: Inspected jointly 22 April-3 May 2013[4]

   Full details of our prisoner survey results from the five Welsh prisons can be found in the appendix.

HMI Prisons' submission

7. In its inspections, HMI Prisons evaluates specific outcomes for prisoners relating to alcohol and substance misuse. Our overarching expectation is that prisoners with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody. Specifically, we also look at whether:
   - Prisoners dependent on drugs and/or alcohol receive clinical treatment which is safe, effective and meets individual needs
   - Prisoners have prompt access to a range of psychosocial interventions and services, which are consistent with the assessed needs of the population.[5]

8. Alcohol and drugs, often of unknown composition, may be a direct threat to the health of the prisoners who consumes them immediately or, after repeated use, in the longer term. We are also aware that most of misused substances in prisons cause trouble that has the potential to de-stabilise prison regimes and safety. Alcohol and drugs affect behaviour, usually negatively, and lead to debt with associated bullying and assaults.

I. Alcohol in prisons

The availability of alcohol in Welsh prisons

9. The bringing of alcohol into prisons, its brewing or distilling in prisons and its consumption on prison premises are all prohibited by law.

10. During our inspections we have noted that the illicit supply and use of alcohol is a much smaller problem than is the case with drugs, but illicitly brewed alcohol (IBA), known in prisons as 'Hooch', is not uncommon in some prisons. Category C establishments and open prisons (Category D) have the greatest problems in this regard. We have also seen a small increase in the discovery of distilled alcohol in some prisons in England.

11. In open prisons, commercially produced alcohol is often purchased and brought back by prisoners who have been released on temporary licence (ROTL), either for home visits or regular work in the community as part of their open prison conditions.

12. Christmas, New Year and events like the World Cup are recognised as times when illicit alcohol use will be more likely to become available in prisons. IBA and distilled alcohol are

[1] Report available at: *http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/cardiff-2013.pdf*
[2] Report available at: *http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Parc-2013.pdf*
[3] Report forthcoming.
[4] Report available at: *http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/usk-prescoed-2013.pdf*
[5] HMIP Expectations: Criteria for assessing the treatment of prisoners and conditions in prisons. Available at: http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/adult-expectations-2012.pdf

usually very strong forms of alcohol and have been known to cause significant harm to prisoners' health. As a disinhibitor, alcohol has well-documented links to violent behaviour.

13. At HMP Usk, significantly fewer prisoners than the comparator[6] (3% v 30%) said it was easy to get alcohol. At HMP/YOI Prescoed (Wales' only open prison) slightly fewer than the comparator (22% v 25%) said that it was easy to get alcohol.

Alcohol problems among prisoners arriving at Welsh prisons

14. Our survey results showed that in the three local[7] Welsh prisons, more people arrived at these prisons with what they described as an alcohol problem than at comparator prisons (HMP Cardiff: 35% v 27%; HMP/YOI Parc 21% v 16%; HMP Swansea 39% v 22%).

15. Local prisons will see the most acute alcohol related problems, as prisoners frequently come into the prison either under the influence or in an acute state of withdrawal.[8]

Clinical and psychosocial treatment for prisoners with alcohol problems in Welsh prisons

16. In two out of the three Welsh prisons with a 'local' function, significantly fewer prisoners than the comparators said they had received help for their alcohol problems (HMP Cardiff: 33% v 60%; HMP/YOI Parc: 54% v 63%). At HMP Swansea the figure was similar to the comparator at 62% v 58%.

17. Whilst clinical alcohol detoxification (i.e. the removal of the physical dependency and withdrawal effects on the body) is generally found to be satisfactorily delivered in prisons that we inspect, we have noted that psychosocial support can be varied. At HMP Cardiff, fewer prisoners than at comparator establishments (33% v 60%) said that they had received help for their alcohol problems. The range of available interventions addressing such problems encompassed one-to-one sessions and group work, including the Building Skills for Recovery programme. Alcoholics Anonymous groups were held fortnightly, but were not available to remand prisoners, which may have contributed to the poor survey results.

18. Moreover, HMP Cardiff was the only one of the three Welsh local prisons where the answer to our survey question 'Was the support [with their drug or alcohol problem] helpful?' scored significantly worse than the comparator: 33% v 66%.

19. At HMP/YOI Parc, fewer prisoners said they had received help or support with their alcohol problem than at comparator prisons (54% v 63%). However, Alcoholic Anonymous meetings, Building Skills for Recovery and COVAID (Control of violence for angry impulsive drinkers) courses were available. One-to-one sessions and access to a recovery unit were also available.

20. Despite HMP Swansea scoring higher than comparator prisons regarding access to help or support, we found that the only help available to prisoners with alcohol problems was clinical detoxification and no supporting psychosocial interventions were being delivered at the time of our inspection. This was due to discipline-staff shortages and an insufficiently resourced psychosocial team.

---

[6] The comparator is all similar prisons in Wales and England

[7] Local prisons are those that receive prisoners directly from the courts, either on remand or sentenced, prior to their allocation to other establishments. Local prisons also receive prisoners recalled for breaching their release or parole licence conditions.

[8] N.B. the comparators for local prisons change as more data from inspections is gathered and added to the database.

II. Substance misuse in prisons

The availability of drugs in Welsh prisons

21. In 2008, David Blakey produced a report for NOMS entitled 'Disrupting the supply of illicit drugs into prisons' which cited five routes that are still widely used to get drugs into prisons:
    - with visitors
    - over the prison wall
    - in post and parcels
    - brought in by prisoners
    - brought in by corrupt staff[9]

22. HMI Prisons inspections show that in recent years, the use of street drugs in prisons has been largely overtaken by prescription medication, which is often diverted from the patient to whom it was prescribed. Medication is either willingly sold or taken by bullying. Prisoners may also fake symptoms in order to get medication, either for their own misuse or to sell on.

23. The most commonly abused types of drugs in prisons are those substances that have a depressant effect on the central nervous system. Depressants commonly abused include:
    - opioids (painkillers) e.g. buprenorphine (Subutex), tramadol, codeine, dihydrocodeine and (less commonly) street heroin
    - tranquillisers e.g. benzodiazepines like diazepam (formerly Valium) and mirtazepine
    - anti-epileptics e.g. gabapentin and pregabalin
    - anti-psychotics e.g. thienobenzodiazepines like olanzepine and quetiapine
    - cannabinoids e.g. herbal cannabis and synthetic cannabinoids found in new psychoactive substances (NPS) such as Spice or Black Mamba.

24. As we reported to the National Assembly for Wales Health and Social Care Committee in October 2014, as the use of new psychoactive substances (NPS) gains momentum in Welsh communities, it can be predicted with some confidence that Welsh prisons should expect a rise in the incidence of NPS misuse, as is certainly the case in England. Prisoners find NPS an attractive alternative to more traditional drugs for a number of reasons related to the lack of detectability and reduced risks of penalties.[10]

25. Our survey results across the five Welsh prisons showed that in three of the prisons the availability of drugs was higher than the comparator: HMP Cardiff (34% v 29%), HMP Swansea (44% v 33%) and HMP/YOI Prescoed (47% v 32%). In the other two prisons, survey results indicated that the availability of drugs at HMP/YOI Parc was similar to comparator prisons (32% v 30%) and was much lower than comparators at HMP Usk (9% v 32%).

26. Mandatory drug testing (MDT) is conducted on a random sample of either 5% or 10% of a prison's population each month. The 5% rate is for populations of more than 400 prisoners and the 10% rate for populations of less than 400 prisoners.

27. The populations and random positive MDT rates of the five Welsh prisons when last inspected were not any higher than comparator prisons elsewhere. The specific results were as follows:
    - HMP Cardiff (Category B, public sector prison) population: 763; random positive MDT rate: 9.7%

[9] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/blakeyreport.pdf
[10] See HMI Prisons' submission to the National Assembly for Wales Health and Social Care Committee for a full response on new psychoactive substances:
http://www.senedd.assembly.wales/documents/s33106/LH%2018%20HM%20Inspectorate%20of%20Prisons.pdf

- HMP/YOI Parc (Category B, private sector prison) population: 1326; random positive MDT rate: 5.5%
- HMP Swansea (Category B, public sector prison) population: 436; random positive MDT rate: 9.2%
- HMP Usk (Category C, public sector prison) population: 270; random positive MDT rate (combined with the rate from HMP/YOI Prescoed): 3.4%
- HMP/YOI Prescoed (Category D, public sector prison) population: 230

30. In general, HMI Prisons has noted a general decline in the positive rates resulting from the mandatory drug testing of prisoners – both in random testing and that carried out under 'reasonable suspicion'. However, this trend does not mean that prisoners' illicit drug use has reduced. While MDT rates provide an indicator, they do not reliably measure drug availability in establishments – nor does testing necessarily deter prisoners' use of illicit drugs. In our survey, 31% said that illegal drugs were easy or very easy to obtain in their prison, and 7% told us they had developed a problem with illegal drugs and 7% with diverted medications since coming to prison.[11]

31. The main reason for this is that the current MDT does not detect new psychoactive substances and most diverted prescribed medications.[12] The list of drugs detectable under MDT rules had remained unchanged since the addition of buprenorphine (Subutex) in 2009. Two widely diverted and misused drugs – tramadol (a painkiller) and Gabapentin (an anti-epileptic) – were not on the MDT panel, although tramadol was reclassified as a controlled drug in June 2014 and will be added.[13]

32. The apparent differences then, between prisoners' views on the availability of drugs in HMP Cardiff, HMP Swansea and HMP/YOI Prescoed and the contrastingly relatively average or low MDT figures, can probably be explained by prisoners' use of diverted medication and, to a lesser extent, of NPS.

33. Significantly more prisoners in HMP/YOI Parc and HMP Swansea than in comparator prisons said they had developed drug problems whilst in prison (11% v 7% and 18% v 8% respectively). However, only in HMP Swansea was the figure higher than the comparator for developing a problem with diverted medication in the prison (17% v 9%).

34. HMI Prisons has reported its concerns that reduced staffing to conduct drug testing in prisons in England and Wales has made some suspicion testing programmes virtually inoperable.[14] In one recent inspection, frequent shortages of discipline staff led to inconsistencies in the administration of opiate substitution medication, and where this was supervised by inexperienced officers, these were not alert to potential trading in medication.[15] These can all be factors in making it easier for prisoners to obtain and use drugs in prisons and would be applicable in Welsh and English prisons.

Drug problems among prisoners arriving at Welsh prisons

35. HMI Prisons surveys of the three local prisons in Wales showed that significantly more prisoners arrived with existing drug problems than at comparator prisons (HMP Cardiff: 44%

[11] *Annual Report 2013-2014*, http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf
[12] See HMI Prisons' submission to the National Assembly for Wales Health and Social Care Committee: http://www.senedd.assembly.wales/documents/s33106/LH%2018%20HM%20Inspectorate%20of%20Prisons.pdf.
[13] *Annual Report 2013-2014*, http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf
[14] *Annual Report 2013-2014*, http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/10/HMIP-AR_2013-141.pdf p.30
[15] *HMP Elmley Report* http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/11/Elmley-web-2014.pdf (para 1.85)

v 36%; HMP/YOI Parc: 29% v 22%; HMP Swansea: 51% v 33%). At HMP Usk the figure was significantly lower than to comparator (10% v 23%) and at HMP/YOI Prescoed it was similar to the comparator (9% v 10%).

Clinical drug treatment in Welsh prisons

35. One of the striking differences between English and Welsh prisons is that the integrated drug treatment system (IDTS) has been introduced in England but not in Wales.

36. IDTS aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:
    - close support and care for opiate dependent prisoners during early custody;
    - improving the integration between clinical and psychosocial services (known as CARAT - counselling, assessment, referral, advice and through-care services); and
    - reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

37. The absence of the funding that accompanied the development of IDTS in English prisons has left drug services the two public sector local prisons in Wales (HMP Cardiff and HMP Swansea) lagging behind and, in our view, providing a less safe service in comparison to their English counterparts.

38. Whilst drug treatment therapies are provided in Welsh prisons, first night initiation onto opiate substitutes is not available in HMP Cardiff or HMP Swansea. Instead, men who arrive at these prisons with no previous history of community-based opiate substitution treatment will be rapidly detoxified.

39. Furthermore, no distinction is made between remanded or sentenced prisoners. So it is not uncommon for an opiate dependent prisoner to be remanded for 2-3 weeks, detoxified (regardless of their own wishes or intent to stop using drugs), and then be returned to court and subsequently released. The implications of this are that the prisoner, having been rapidly detoxified from opiates, will lose all physical tolerance to the drug in an average of 14 days. If that prisoner then uses opiates on release, their risk of overdose is extremely high, especially for those who had been previously using high doses over a long period of time.

40. In HMP/YOI Parc prison, prescribing is more flexible. First night prescribing of opiate substitutes is available, and remand prisoners are routinely given maintenance doses that keep their opiate tolerance high, so reducing the risk of overdose should they be released from court.

Psychosocial drug treatment in Welsh prisons

41. The introduction of IDTS in England also allocated funding for the development of integrated psychosocial support. Over the last few years, this has developed into a comprehensive package of one-to-one sessions with key workers, group-work and self-help fellowships, like AA, NA and SMART Recovery[16], in many English prisons.

42. The integration of clinical and psychosocial services means that prisoners should receive a more holistically focused drug treatment service that combines any necessary clinical treatment (either at maintenance levels or as a reducing dose) with psychosocial support that should ultimately encourage them to into recovery and a life free from drugs. HMI Prisons

[16] SMART: self management and recovery training

Expectations and National Guidelines on the treatment of drug dependence both encourage the delivery of integrated services.[17]

43. Whilst we found some good psychosocial work being conducted in HMP Cardiff, it was poorly integrated with clinical treatment. In HMP Swansea, there was also poor integration of clinical interventions with psychosocial interventions. The psychosocial team was understaffed and so could do little more than conduct initial assessments and brief interventions. Officers on the drug recovery wing who had been trained to deliver group work programmes were so frequently re-deployed to other duties that they had ceased all programme delivery. In HMP/YOI Parc the picture was better, with the psychosocial service providing a similar package of options to those found in English prisons.

44. Drug services in HMP Usk and HMP/YOI Prescoed did not accept men requiring opiate substitution. There were no group programmes at either prison, which can be a limiting factor in the effectiveness of a drug and alcohol service. However, at HMP/YOI Prescoed where evening one-to-one sessions were available, an impressive 100% of respondents who said they had a drug or alcohol problem said they had received support against 65% in comparator prisons.

Resettlement from Welsh prisons for prisoners with alcohol and drug problems

45. The introduction of the Wales Integrated Offender Intervention Service (IOIS), which has a remit to reduce re-offending, has improved post release support for prisoners with substance misuse problems.

46. At HMP/YOI Parc we found strong links with IOIS providers at a strategic and operational level (the head of community engagement led the drug strategy and was responsible for community IOISs), and prisoners could access designated prison link workers from South, West and North Wales who regularly attended the prison and were able to meet those due for release at the gate.

47. At HPM Cardiff, support for prisoners with drug and alcohol problems nearing release was also very good. A dedicated 'continuity of care' post was provided by the psychosocial team each week, ensuring that community drug and alcohol agency appointments were arranged for prisoners on release. The transitional support scheme, co-ordinated by G4S (in partnership with the prison and the Wales Probation Trust), provided reintegration planning help for prisoners with a history of substance misuse, including alcohol. Mentors worked with newly released prisoners for up to three months to help with practical and motivational issues.

48. At HMP Swansea, improvements in joint working between CARATs and the offender management unit had contributed to better reintegration planning outcomes for prisoners with substance misuse problems. Release planning started with initial CARAT assessments and the CARAT team had effective links with the provider's own network of community support (the Welsh Centre for Action on Dependency and Addiction) and other regional agencies.

49. In our inspections of HMP Usk and HMP/YOI Prescoed, psychosocial case files demonstrated good quality relapse prevention work with drug as well as alcohol users, and men were given appropriate harm reduction advice and information during their sentence and before release. CARAT staff on both sites had developed good links with local drug intervention

[17] http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/adult-expectations-2012.pdf (Expectation 29.5); UK National Clinical Guidelines for drug misuse treatment: http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

programmes and community drug services, including residential rehabilitation providers.

Conclusion

50. Based on evidence from our inspections, we can draw the following broad conclusions concerning the ways in which Welsh prisons tackle alcohol and substance misuse problems and the outcomes for prisoners in Welsh prisons:
    - Prisoners requiring clinical alcohol detoxification in the three local prisons generally receive a good service.
    - Prisoners requiring psychosocial support for alcohol problems received a better service at HMP/YOI Parc than at either HMP Cardiff or HMP Swansea. At HMP Usk and HMP/YOI Prescoed there was a lack of group-based support.
    - Prisoners requiring clinical treatment for opiate dependency get a reasonably good service at HMP/YOI Parc but at both HMP Cardiff and HMP Swansea outcomes for prisoners are much poorer.
    - As with psychosocial support for alcohol, outcomes for prisoners requiring psychosocial support for drug problems could expect a better service at HMP/YOI Parc than at either HMP Cardiff or HMP Swansea. At HMP Usk and HMP/YOI Prescoed there was a lack of group-based support.
    - Resettlement outcomes for prisoners with both alcohol and drug problems returning to addresses in South Wales can expect a very good service that links well with community providers.

We hope that you find this information useful and should you require anything further, please do not hesitate to contact us.

Paul Roberts
Specialist Substance Use Inspector

on behalf of

Nick Hardwick
HM Chief Inspector of Prisons

9th January 2015

Appendix

HMIP Survey results from prisons in Wales 2013 -2014

Notes

All figures are in percentages. Comparators are similar prisons across England and Wales	
	Any percentage highlighted in green is significantly better than the comparator
	Any percentage highlighted in blue is significantly worse than the comparator

	Most recent inspection	Comparator		Most recent inspection	Previous inspection
Did you have a drug problem on arrival at this prison?					
Cardiff 2013	44	36		44	29
Parc 2013	29	22		29	43
Swansea 2014	51	33		51	66
Usk 2013	10	23		10	12
Prescoed 2013	9	10		9	16

Did you have an alcohol problem on arrival at this prison?					
Cardiff	35	27		35	17
Parc	21	16		21	30
Swansea	39	22		39	43
Usk	12	17		12	13
Prescoed	12	8		12	12

Is it easy/very easy to get alcohol in this prison?					
Cardiff	13	13		13	
Parc	20	18		20	
Swansea	17	14		17	
Usk	3	18		3	
Prescoed	22	25		22	

Is it easy/very easy to get illegal drugs in this prison?					
Cardiff	34	29		34	25
Parc	32	30		32	30
Swansea	44	33		44	21
Usk	9	30		9	6
Prescoed	47	32		47	43

	Most recent inspection	Comparator		Most recent inspection	Previous inspection
Have you developed a problem with drugs since you have been in this prison?					
Cardiff	8	8		8	
Parc	11	7		11	13
Swansea	18	8		18	7
Usk	2	7		2	2
Prescoed	1	3		1	2

Have you developed a problem with diverted medication since you have been in this prison?					
Cardiff	10	8		8	
Parc	7	6		7	
Swansea	17	9		17	
Usk	5	6		5	
Prescoed	2	2		2	

Have you received any help or support with your drug problem while in this prison?					
Cardiff	48	65		48	
Parc	49	65		49	
Swansea	46	61		46	
Usk	72	65		72	
Prescoed	100	65		100	

Have you received any help or support with your alcohol problem while in this prison?					
Cardiff	33	60		33	
Parc	54	63		54	
Swansea	62	58		62	
Usk	85	64		85	
Prescoed	91	74		91	

For those who have received help or support with their drug or alcohol problem: Was the support helpful?					
Cardiff	66	79		66	
Parc	78	80		78	76
Swansea	76	76		76	87
Usk	83	80		83	81
Prescoed	89	86		89	83

Agenda Item 11.1

Health and Social Care Committee

Meeting Venue:	**Committee Room 3 – Senedd**
Meeting date:	**Thursday, 5 March 2015**
Meeting time:	**09.01 – 15.36**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

This meeting can be viewed on Senedd TV at:
http://senedd.tv/en/2671

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Alun Davies AM** **John Griffiths AM** **Elin Jones AM** **Darren Millar AM** **Lynne Neagle AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Peter Black AM (In place of Kirsty Williams AM for items 1 to 5)**
Witnesses:	**Dr Jean White, Chief Nursing Officer** **Fiona Davies, Welsh Government** **Helen Whyley, Welsh Government** **Mark Drakeford AM, the Minister for Health and Social Services** **Stephen Harrhy, Chief Ambulance Services Commissioner** **Professor Siobhan McClelland, Emergency Ambulance Services Committee** **Mick Giannasi, Welsh Ambulance Services NHS Trust** **Tracy Myhill, Welsh Ambulance Services NHS Trust**

	Adam Cairns, Cardiff and Vale University Health Board Allison Williams, Cwm Taf University Health Board
Committee Staff:	Llinos Madeley (Clerk) Helen Finlayson (Second Clerk) Sian Giddins (Deputy Clerk) Rhys Morgan (Deputy Clerk) Enrico Carpanini (Legal Adviser) Stephen Boyce (Researcher) Amy Clifton (Researcher) Philippa Watkins (Researcher) Gwyn Griffiths (Legal Adviser) Sian Thomas (Researcher)

Transcript
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 Apologies were received from Janet Finch-Saunders.
1.2 Apologies were received from Kirsty Williams. For items relating to the Safe Nurse Staffing Levels (Wales) Bill, Peter Black substituted for Kirsty Williams.
1.3 The Chair noted the Committee's best wishes to Kirsty Williams, who was unable to attend the meeting due to illness. The Committee agreed to identify an alternative date for Kirsty Williams to give evidence as Member in charge of the Safe Nurse Staffing Levels (Wales) Bill.

2 Safe Nurse Staffing Levels (Wales) Bill: evidence session 12

2.1 The witnesses responded to questions from Members.

3 Safe Nurse Staffing Levels (Wales) Bill: evidence session 13

3.1 The witnesses responded to questions from Members.
3.2 The Minister agreed to provide the Committee with a note on his powers of direction under Section 12 of the National Health Service (Wales) Act 2006.

4 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from items 5, 6 and 11 of the meeting

4.1 The motion was agreed.

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

5.1 The Committee considered the evidence received.

6 The Committee's forward work programme

6.1 The Members discussed the forward work programme.

6.2 The Committee agreed to schedule further evidence sessions on the Safe Nurse Staffing (Wales) Bill, including a session with Kirsty Williams the Member in charge of the Bill, on 19 March 2015.

6.3 The Committee agreed its approach to gathering oral evidence in relation to Stage 1 scrutiny of the Regulation and Inspection of Social Care (Wales) Bill.

6.4 The Committee noted the outline forward work programme from April to July 2015, subject to further discussion of a request from the Minister for Health and Social Services to defer the summer general and financial scrutiny session to later in the year.

6.5 Members noted the outline work programme for the remainder of the Fourth Assembly, and agreed to defer a decision on their previously identified priorities.

7 Inquiry into the performance of Ambulance Services in Wales: evidence session 1

7.1 The witnesses responded to questions from Members.

7.2 The witnesses agreed to provide the Committee with the following:

- a copy of the interim agreement with the Welsh Ambulance Services NHS Trust for 2014-15;
- an indication of the timescales for the Commissioning Quality and Delivery Framework and, once finalised, a copy of the Framework.

8 Inquiry into the performance of Ambulance Services in Wales: evidence session 2

8.1 The witnesses responded to questions from Members.

8.2 The witnesses agreed to provide the Committee with:

- details of the pilot schemes underway across Wales to improve ambulance services;
- the number of Category A emergency calls made in 2012, 2013 and 2014, the number of incidents to which those calls relate, the number which resulted in an emergency response arriving at the scene, and the number which resulted in an emergency response arriving at the scene within eight minutes;
- the dates on which the Welsh Ambulance Services NHS Trust was consulted or involved in the decision to suspend consultant-led maternity care at Glan Clwyd Hospital; and

- a copy of the Welsh Ambulance Services NHS Trust improvement action plan for the next year.

9 Inquiry into the performance of Ambulance Services in Wales: evidence session 3

9.1 The witnesses responded to questions from Members.

9.2 The witnesses agreed to provide the Committee with:

- details for the last month (February 2015) of the number of ambulances that arrived at each Accident and Emergency department in the Cardiff and Vale University Health Board and Cwm Taf University Health Board areas, and, if possible, the ambulance station at which each of those ambulances is based;
- details of the numbers of patients experiencing handover delays in the Cardiff and Vale University Health Board area;
- details of the actions that Cardiff and Vale University Health Board and Cwm Taf University Health Board are taking to reduce patient handover delays, the improvements that are expected to be achieved, and the associated timescales; and
- a copy of the report of the investigation into unscheduled care experiences at each local health board, anticipated to be published in April 2015.

10 Papers to note

10.1 Correspondence from the Petitions Committee: P-04-625 Support for Safe Nursing Staffing Levels (Wales) Bill

10.1a The Committee noted the correspondence.

10.2 Safe Nurse Staffing Levels (Wales) Bill: Summary of evidence received from the Royal College of Nursing campaign

10.2a The Committee noted the summary of evidence.

11 Inquiry into the performance of Ambulance Services in Wales: consideration of evidence received

11.1 The Committee considered the evidence received and agreed to write to the Deputy Minister for Health.

Y Fonesig Rosemary Butler AC
Dame Rosemary Butler AM

Llywydd
Presiding Officer

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

11 March 2015

Dear David

At its meeting this week, the Business Committee considered a paper from the Government regarding a supplementary Legislative Consent Memorandum (Memorandum No. 4) in relation to the UK Government's Small Business, Enterprise and Employment Bill.

The LCM relates to amendments to provide that the Secretary of State may make regulations which prohibit an NHS employer from discriminating against a prospective employee because he/she has previously made a protected disclosure (a whistle-blowing declaration).

As the Bill is at a very late stage in its progress through Parliament and due to the time constraints, the Business Committee agreed not to refer the LCM to a Committee for scrutiny and noted that the Government would schedule the LCM for debate in Plenary on Tuesday 17 March 2015. However, as the subject matter of the LCM falls within the remit of Health and Social Care Committee, I am writing to draw your attention to the LCM, in case the committee should wish to pursue the matters covered by the LCM in any way.

I am also sending a copy of this letter to the Chair of the Constitutional and Legislative Affairs Committee to note the decision of the Business Committee.

Rosemary

Dame Rosemary Butler AM
Presiding Officer
Chair, Business Committee

Cynulliad Cenedlaethol Cymru
Bae Caerdydd, Caerdydd CF99 1NA
Swyddfa.Breifat@cymru.gov.uk
www.cynulliadcymru.org
T +44 (0)29 2089 8230

National Assembly for Wales
Cardiff Bay, Cardiff CF99 1NA
Private.Office@wales.gov.uk
www.assemblywales.org
T +44 (0)29 2089 8230

Correspondence from the Petitions Committee: P-04-625 Support for Safe Nursing Staffing Levels (Received 12 March 2015)

Dear Llinos

You mentioned that the Health and Social Care Committee will be considering the Safe Nursing Staffing Levels (Wales) Bill next week. As you are aware, the Chair of the Petitions Committee, William Powell, wrote to the Minister for Health and Social Services on 26 February asking for his views on a Petition that called for support for the Bill. The petition has since gathered 1,579 signatures and will be formally considered by the Petitions Committee on 24 March.

The Minister for Health and Social Services has now replied to William Powell and I attach a copy of his letter in case it is of assistance in your Committee's consideration of the Bill next week. Also attached for completeness is William Powell's original letter, which sets out the terms of the Petition and the supporting information submitted with it.

Regards

Steve George
Clerc y Pwyllgor Deisebau
Petitions Committee Clerk

Gwasanaeth y Siambr a Phwyllgorau
Chamber and Committee Service

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

www.cynulliad.cymru
www.assembly.wales

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

Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref P-04-625
Ein cyf/Our ref MD/00797/15

William Powell AM
Chair - Petitions Committee
Ty Hywel
Cardiff Bay
Cardiff
CF99 1NA

committeebusiness@Wales.gsi.gov.uk

11 March 2015

Dear William,

Thank you for your letter of 26 February on behalf of the Petitions Committee and Richard Jones MBE regarding petition P-04-625, Support for the Safe Nursing Staffing Levels (Wales) Bill.

I support wholeheartedly the principle behind Kirsty Williams' suggested legislation, which is to ensure the appropriate numbers of nurses are available on our hospital wards to deliver safe and high-quality nursing care. For this reason, I would like to engage constructively with the legislative process, to see whether the proposed legislation can contribute positively to the range of tools and levers we already have available to achieve that ambition.

However, I also believe it is entirely possible to achieve the policy aims set out in the member's bill under existing powers. We are investing £10m recurrent funding for hospital nurse staffing as part of our response to the Francis enquiry and a new calculation system known as an acuity tool was introduced into the Welsh NHS in April 2014. Used in conjunction with nurse-sensitive data and professional judgement, this nuanced approach provides staffing levels based on patient needs, not a rigid formula.

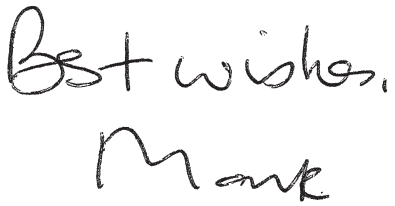
Providing the right number of staff in any given situation is a complex matter. Current practice is to use a triangulated approach to determine nurse staffing levels, using professional judgement; the acuity tool, and nurse-sensitive indicators. Such an approach does not lend itself to incorporating a fixed minimum ratio, and I am concerned that the bill focuses solely on nursing staffing, ignoring the vital role of the other health professions. It also misunderstands the role of health boards, whose responsibility it is to ensure safe services.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford @wales.gsi.gov.uk

In conclusion, I am concerned that the bill in its current format would propose an onerous monitoring and reporting regime, and would require amendment to add value to the current policy direction.

I hope you have found my reply helpful and that it has helped to clarify my position on these issues.



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

Y Pwyllgor Deisebau
Petitions Committee

Mark Drakeford AM
Minister for Health and Social Services
Welsh Government
Tŷ Hywel
Cardiff Bay
CF99 1NA

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

Our ref: P-04-**625**

26 February 2015

Petition title: P-04-625 Support for Safe Nursing Staffing Levels (Wales) Bill

Dear Mark

The Petitions Committee has received the following petition from Richard Jones MBE, which is currently collecting signatures:

Petition wording
We the undersigned call upon Members of the National Assembly for Wales Health and Social Care Committee to vote in favour of the Safe Nursing Staffing Levels (Wales) Bill once it is introduced into the Assembly.

Additional Information
Kirsty Williams AM is soon going to be introducing the Safe Nurse Staffing Levels (Wales) Bill into the National Assembly for Wales. This bill would enshrine in law Chief Nursing Officer in Wales' core principles regarding staffing levels on all medical and surgical wards. The Royal College of Nursing believes that this piece of legislation is necessary to improve patient safety and will help to restore patients faith in the Welsh NHS as well as ensuring that patients in hospitals in Wales receive the nursing care and attention they need and deserve and allows Nurses to be able to deliver care to the standard that they are trained and want to deliver.

Bae Caerdydd / Cardiff Bay
Caerdydd / Cardiff
CF99 1NA

Ffôn / Tel: 0300 200 6375
E-bost / Email: SeneddDeisebau@Cynulliad.Cymru / SeneddPetitions@Assembly.Wales

In advance of our first consideration of this petition the Committee would like to seek your views on the issues raised.

Please forward your response to the Clerking Team at

SeneddPetitions@assembly.wales

A copy of this letter has been sent to the Health and Social Services Committee for information as they are currently undertaking Stage 1 scrutiny of the Safe Nurse Staffing Levels (Wales) Bill.

Yours sincerely

William Powell AC / AM
Cadeirydd / Chair