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

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

Consultation on Safe Nurse Staffing Levels (Wales) Bill

Response from: Professor Dame June Clark

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

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

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

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

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

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

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

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

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

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

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

Provisions in the Bill

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

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

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

Duty applies to adult inpatient wards in acute hospitals only

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

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

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

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

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

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

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

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

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

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

Protection for certain activities and roles
These provisions are important

Requirement to consult

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

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

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

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

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

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

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January 2015