Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfle Cyfartal
The Committee on Equality of Opportunity

Dydd Mawrth, 1 Rhagfyr 2009
Tuesday, 1 December 2009

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Ann Jones	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Jonathan Morgan	Ceidwadwyr Cymreig Welsh Conservatives
Janet Ryder	Plaid Cymru The Party of Wales
Joyce Watson	Llafur Labour

Eraill yn bresennol
Others in attendance

Stuart Bonar	Cynghorwr Polisi, Coleg Brenhinol y Bydwragedd Policy Adviser, Royal College of Midwives
Dr Andrew Freedman	Uwch-ddarlithydd, Yr Ysgol Meddygaeth, Prifysgol Caerdydd Senior Lecturer, School of Medicine, Cardiff University
Edwina Hart	Aelod Cynulliad, Llafur (y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol) Assembly Member, Labour (Minister for Health and Social Services)
Julie Richards	Pennaeth Bydwreigiaeth ac Iechyd Rhywiol, Bwrdd Iechyd Lleol Powys Head of Midwifery & Sexual Health, Powys Local Health Board
Martin Semple	Pennaeth y Sefydliad, Coleg Nyrsio Brenhinol Cymru Head of Institute, Royal College of Nursing Wales
Lisa Turnbull	Cynghorwr Polisi, Coleg Nyrsio Brenhinol Cymru Policy Adviser, Royal College of Nursing Wales
Dr Jane Wilkinson	Dirprwy Brif Swyddog Meddygol Deputy Chief Medical Officer

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

Catherine Hunt	Dirprwy Glerc Deputy Clerk
Helen Roberts	Cynghorydd Cyfreithiol Legal Adviser
Bethan Webber	Clerc Clerk

Dechreuodd y cyfarfod am 9.29 a.m.
The meeting began at 9.29 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Ann Jones:** Good morning, everyone, and welcome to this meeting of the Committee on Equality of Opportunity on Tuesday, 1 December. I will make the usual housekeeping announcements for Members and the public. I ask everyone to switch off their mobile phones,

pagers, BlackBerrys and any other such devices, as they affect the broadcast and simultaneous translation. We are not expecting a fire alarm test this morning, so, should the alarm ring, we will take instructions from the ushers, who will direct us out of the building to the safest point. The assembly point is just outside the building, by the Pierhead building. I always say at this point that you can follow me, because I will be the first out of the building if anything goes wrong.

[2] We have not received any apologies; therefore, the committee has a full complement this morning. I invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none.

[3] We operate bilingually; simultaneous translation of Welsh into English is available on channel 1 on the headsets, while the verbatim language is amplified on channel 0 if you have trouble hearing. The acoustics in this room are not always as they should be, so if you have trouble hearing, please use the headsets.

9.30 a.m.

Ymchwiliad i Wahaniaethu yn Erbyn Pobl sy'n Byw gyda HIV gan Weithwyr Gofal Iechyd Proffesiynol a Darparwyr Gofal Iechyd—Tystiolaeth gan y Coleg Nyrsio Brenhinol a Coleg Brenhinol y Bydwragedd
Inquiry into Discrimination against People Living with HIV by Healthcare Professionals and Providers—Evidence from the Royal College of Nursing and the Royal College of Midwives

[4] **Ann Jones:** Today we have two witnesses from the Royal College of Nursing: Lisa Turnbull and Martin Semple, who are accompanied by Julie Richards and Stuart Bonar. Julie is the head of midwifery and sexual health at Powys Teaching Local Health Board and Stuart is policy adviser for the Royal College of Midwives. You are all welcome. Thank you for your papers and for agreeing to attend the committee. We will go straight to Members' questions.

[5] We found that there was a lack of robust research evidence about the nature and extent of discrimination against people living with HIV in healthcare settings. Witnesses have provided anecdotal evidence that it is a problem, but we often find that that is all. Is discrimination against people living with HIV something that has been brought to the attention of your organisations? If so, can you provide us with some examples?

[6] **Ms Turnbull:** That is a fair point. The research is limited and is not always recent or available on Wales. However, enough research has been brought to the attention of our organisation that, a few years ago, we responded to some of the concerns raised with us by the Terrence Higgins Trust in particular by launching an educational campaign aimed at members of the nursing family. That campaign was designed to raise awareness and educate by restating the significance of treating people with dignity and respect and how that relates to people living with HIV.

[7] **Ann Jones:** Is discrimination more likely to occur in some settings than in others? Do you have any evidence to show that?

[8] **Ms Turnbull:** The concerns brought to our attention were not specifically related to the care of people living with HIV, but to more general areas, for example, emergency care departments, primary care and other healthcare settings, which are not directly related to our membership. So it was related to those more general settings.

[9] **Ann Jones:** Julie, do you have anything to add to that?

[10] **Mr Richards:** For me, the clinical pathway that has come out for residents in Wales who are living with HIV will significantly ensure that there is clear partnership work in the areas that Lisa just referred to, particularly in primary care and dental care services. That will bring those living with HIV in Wales to the forefront.

[11] **Janet Ryder:** In its written evidence to the committee, the Royal College of Nursing states that it

[12] 'strongly believes that whether the stigma and discrimination that is felt is real or perceived to be real makes no difference. Either way, the profession of nursing working in collaboration with other disciplines must do more to make the services they provide more sensitive to these patients' needs.'

[13] We have had evidence from some healthcare professionals in which they have argued that in some cases people have perceived discrimination where there has not been any. For example, a person living with HIV may not be aware that the doctors and nurses caring for them are using a universal cross-contamination prevention measure and not a special measure just because that person is HIV positive. What are your views on that?

[14] **Mr Semple:** We acknowledge that perception rather than intention is what matters; indeed, the campaign that the RCN began in 2007 acknowledged that regardless of whether people perceive your intentions positively or negatively, what matters is their understanding of them. It is an important point that, even in pre-registration, nurses are taught that it is absolutely essential to explain things to every patient, before you do anything. So, there would be an expectation that a nurse would explain universal precautions to everybody, regardless of intent. It is a fairly standard technique. The people that you are caring for are potential recipients of infection and people who might spread infection.

[15] **Janet Ryder:** Might it not be the case that because certain cross-contamination methods are so universally used now, and have become embedded into people's work routines, they do not realise that there is a need to explain them to people? That patient might be coming into a medical setting or a hospital for the first time and may not realise that those precautions are universal, while the practitioner does it every day and does not see anything abnormal in it. Is there a need to revisit the guidelines on this?

[16] **Mr Semple:** Continuing professional development focuses on reminding people of essentials, among which are explanation and communication, and that is critical to making sure that we at least reduce the risk of people perceiving our actions as discriminatory.

[17] **Ann Jones:** Do the midwives want to add anything?

[18] **Mr Bonar:** I would agree with that point. If it can be stated clearly that it is a universal measure, the information about hospital infections is so well known now that that would be understood by service users, and, therefore, I think that an increase in practitioners' explanations to service users would be very welcome.

[19] **Janet Ryder:** We had some interesting evidence last week that would suggest that, in some areas, all pregnant women are offered an HIV test as a matter of course. However, we were told last week that that was not universal practice. I would like your views on whether all pregnant women are offered a test or whether only those known to be HIV positive or believed to be in a high-risk group are offered a test. What might be the relative advantages of offering a universal test to everyone?

[20] **Ms Richards:** In Wales, since early 2001, we have been offering routine HIV testing to all pregnant women. That is in line with national policy. All pregnant women are offered HIV testing as part of their routine antenatal screening in every organisation in Wales and across the UK. Antenatal Screening Wales monitors the uptake of HIV screening and it is as high as 97 per cent in some organisations. So, it is evident that it is more than just a targeted test for those women who services might have believed to be at high risk. There is huge benefit in detecting HIV to both the women and the unborn baby because treatment can be instigated at a very early stage during pregnancy and there could be a chance that a woman's health could deteriorate if there was an unknown HIV status. Obviously, there are equal advantages to ensuring the safe delivery of the baby, as there is a very low chance of transmission if pregnant women know about their HIV status. That testing is routinely offered and dealt with across Wales.

[21] **Janet Ryder:** Is the 97 per cent uptake in Wales?

[22] **Ms Richards:** It is in one of the organisations in Wales. With any screening, you will find that you will have different pockets of uptake according to your population. Generally, across Wales, the uptake of HIV screening is very high in comparison with some other areas across the UK.

[23] **Eleanor Burnham:** If that is the case—I refer to your informative paper, which we all enjoyed reading—on page 2 of your paper, on women with HIV in Wales, you assert that the RCM does not have precise information on the number of women in Wales who are living with AIDS and HIV and who are pregnant or have given birth. If you have a 97 per cent uptake of screening, why is that so?

[24] **Ms Richards:** That would be information that the RCM would be able to gather. Information on the uptake of HIV testing is held by Antenatal Screening Wales.

9.40 a.m.

[25] **Mr Bonar:** Yes, I believe that to be the case. We probably could, with more time, seek to obtain those figures from the various boards, but I do not think that they were figures that we could get hold of at the time.

[26] **Eleanor Burnham:** That would be helpful—is that okay, Chair?

[27] **Ann Jones:** Yes.

[28] **Eleanor Burnham:** As we have discussed it, and these assertions have been made, that was just something that I wanted to pick up.

[29] **Ann Jones:** Okay. We will move on.

[30] **Joyce Watson:** Good morning. The RCM paper identifies liaison between midwives, virologists and other members of the healthcare team as good practice. That could be contrasted with the perception that general practitioners and dentists who refer to HIV specialists are offering a discriminatory service. Can you tell us more about the multi-disciplinary team and how it works to support a pregnant woman with HIV?

[31] **Ms Richards:** Multidisciplinary working is key to the care of any pregnant woman, regardless of HIV status. It is essential, and we work hard with midwives from the first appointment throughout the pregnancy, including in planning for birth, and in the post-natal period. It is important that midwives work closely with primary and secondary care on high-risk obstetric services. Equally, if you had a client with specific complex needs—which

would include a client with HIV—it would be important to take a multi-agency approach to the care of that client and her family.

[32] **Joyce Watson:** In evidence to committee, the British Medical Association and the British Dental Association said that doctors and dentists living with HIV have been discriminated against by employers and colleagues. Have you any evidence to suggest that nurses and midwives living with HIV have been discriminated against?

[33] **Mr Semple:** There was a paper in a nursing journal in September of this year that reported on a survey of 1,800 people with HIV in the UK, about 9 per cent of whom were healthcare workers. A number of them gave demonstrable evidence of what they saw as discrimination, stigma and treatment that was possibly driven by policies that were implemented in inappropriate ways.

[34] **Joyce Watson:** Could you point us in the direction of that paper so that we can look at it?

[35] **Mr Semple:** Yes—I have a copy here and I am happy to leave it with the committee.

[36] **Ann Jones:** Thank you.

[37] **Janet Ryder:** Could I come in here? What do you mean by 'policies that were implemented in inappropriate ways'?

[38] **Mr Semple:** The guidance from the regulatory body for nursing, midwifery and health visiting is quite clear: you must respect the confidence of the member of staff unless you believe that there is a threat to public safety, which would predominantly be infection. The vast majority of organisations perceive that as long as you carry out universal precautions then people are kept safe. There were a number of examples in the paper where the identity of staff with HIV had been disclosed because of a failure to understand the guidance.

[39] **Ann Jones:** Would the midwives like to answer Joyce's question?

[40] **Mr Bonar:** I am not aware of any work on midwives with HIV. I can double-check that, and, if I find anything, I can let the committee know.

[41] **Ann Jones:** Thank you. Joyce, do you want to move on?

[42] **Joyce Watson:** I think that the next question has been covered.

[43] **Ann Jones:** Then Eleanor is next.

[44] **Eleanor Burnham:** I am interested in the clinical care pathway for pregnant women, on page 5 of your interesting paper. Can you explain to me, as a mother who breastfed, why you recommend and educate against breastfeeding for mothers who have HIV?

[45] **Ms Richards:** There is clear evidence of a risk of transmission of HIV from the breast milk to the baby.

[46] **Eleanor Burnham:** But the mother has carried the baby for nine months, so one would assume that the risk has already been present.

[47] **Ms Richards:** The evidence is that there is a risk of transmission in the event of a vaginal birth, which is why a caesarean section is advocated, and in the transmission of breast milk. It is not the case that there is uterine/placental transmission.

[48] **Eleanor Burnham:** I have another brief supplementary question, with your indulgence, Chair. In view of the high rates of Methicillin-resistant Staphylococcus aureus and other infections that we now know lurk everywhere, would it not be wise to follow the British Dental Association's example of taking extremely efficient precautions against all types of infection, rather than protecting just against this? General nursing and hygiene would then, in my humble opinion, improve across the board.

[49] **Mr Bonar:** At the top of page 3 of our evidence, we say that universal infection-control measures provide a good level of defence, including for women whose HIV status is unknown, so I agree with that view.

[50] **Eleanor Burnham:** Yr wyf yn mynd i ofyn y cwestiwn nesaf yn Gymraeg. Allwch chi glywed y cyfieithiad ar sianel 1? Da iawn, gwelaf y gallwch. Mae papur y Coleg Nyrsio Brenhinol yn dweud y dylai byrddau iechyd lleol wneud mwy i asesu, monitro a rhagweld anghenion pobl sydd ag HIV yn eu hardaloedd a dylai'r casgliadau gael eu hadlewyrchu wrth ddarparu adnoddau ar gyfer gwasanaethau. A oes gan fyrddau iechyd lleol unrhyw drefniadau mewn lle, yn enwedig y rhai newydd, i fonitro, asesu a rhagweld anghenion pobl ag HIV? A ydych chi'n ymwybodol o unrhyw arfer da presennol yn y maes hwn, naill ai yng Nghymru neu du hwnt?

Eleanor Burnham: I will ask the next question in Welsh. Can you hear the translation on channel 1? Good, I see that you can. The Royal College of Nursing paper states that local health boards should do more to assess, monitor, and forecast the needs of people living with HIV in their areas, and that those conclusions should be reflected in the provision of resources for services. Do local health boards currently have any arrangements in place, particularly the new boards, to monitor, assess and forecast the needs of people living with HIV? Are you aware of any existing good practice in this area, either in Wales or further afield?

[51] **Ann Jones:** Who wants to take that one?

[52] **Mr Semple:** I will; I just wanted to make sure that I had used the technology correctly.

[53] On assessment and monitoring functions, the first point that we have made in our paper is that we are aware that a number of people who are potentially affected have failed to come forward because of their fear of discrimination. That goes for both the general public and healthcare workers. On assessment and monitoring functions, the first action that LHBs have to take is to ensure that they manage people in a way that they clearly see as non-discriminatory, so, we must have a mechanism by which people are encouraged to come forward.

[54] Secondly, there is growing evidence that a number of people with HIV are presenting late, and there is a specific definition of presenting late in relation to a blood test. So, there is a concern, particularly in primary care, that opportunities are being missed, in that when people present with other infections, they are not being given the opportunity to have a test. We feel that the assessment starts at the point of giving people the opportunity to have a test, whereas, at the moment, many people are presenting late. That is something that could be strengthened in primary care, and it must be backed up by good education systems and possibly supported by HIV specialist nurses who will be responsible for education.

[55] I looked at the National Public Health Service's most recent entry on HIV, and there has been a spike in the past year, particularly among the heterosexual community—

[56] **Eleanor Burnham:** Can you clarify what you mean by a 'spike'?

[57] **Mr Semple:** It is an increase in numbers in the last year.

[58] **Eleanor Burnham:** I ask in case anyone is watching or listening.

[59] **Mr Semple:** We are concerned that there is a stereotypical view, among the public and, potentially, the healthcare professions, that HIV still only happens to homosexual men and so on. To assess and monitor, we need an educational system that makes people aware of where we are now. In some way, we still seem to be exposed to knowledge that was given and shared in the 1980s.

[60] **Eleanor Burnham:** That means—with your indulgence, Chair—that the training is not keeping pace with current medical opinion on the matter, which has moved forward.

[61] **Mr Semple:** If you look at pre-registration nurse training, for example, you will see that the whole curriculum is very compressed, which means that the points at which HIV is discussed are partly in pathophysiology, partly in infection, and partly in communication and self-awareness, and so on. So, I am sure that the students are made aware of the current situation and current trends.

9.50 a.m.

[62] In practice, which is where most people learn their skill, some of the anecdotes in the papers tell us that people are still stereotyping individuals with this condition as having to come from a particular part of the community. Current evidence suggests that that is not the case, particularly the evidence relating to heterosexual infection.

[63] **Ms Turnbull:** A point of view is being made here about the difference between pre-registration training and the continuing professional development that all healthcare professions rely heavily upon. It is significant and relevant to the committee that continuing professional development opportunities for nurses are significantly lower in Wales than in other countries of the UK. There were 12 days of training, on average, in 2005, which has now fallen to six. For non-medical professions, this is often training to which they have no statutory right, therefore it is obviously training that they sometimes have to access in their own time and at their own cost. Obviously, there is a cost to the organisation of backfilling the places when you send people on training courses, so there is perhaps a wider problem not only in secondary care in the NHS, but in primary care, with the uptake of training courses generally when they are provided.

[64] **Ms Richards:** It might be useful to answer the second part of your question, which was about examples of good practice, and take forward some of the points that Martin first made about the importance of improving the testing. A significant amount of work is now taking place across Wales with primary care services, so that they feel comfortable and enabled to offer HIV testing to other populations. Some of the organisations have worked very closely with the Terrence Higgins Trust and have been doing some pilot work in setting up the testing scheme where you can drop in and have a HIV test very quickly and drop back out of the service. That has been particularly fruitful in some of our city areas where there is a transient population.

[65] **Eleanor Burnham:** Fel y trafodwyd yn gynharach, mae'r Coleg Nyrsio Brenhinol wedi galw am gynnydd yn nifer y nyrsys arbenigol sydd yn gweithio yn y gwasanaeth iechyd, ac am fwy o gysondeb o ran cael mynediad at ofal HIV arbenigol ar draws

Eleanor Burnham: As was mentioned earlier, the Royal College of Nursing has called for an increase in the number of specialist nurses working in the health service, and improved consistency of access to specialist HIV care across Wales. How

Cymru. Sut y gall hyn arwain at lai o wahaniaethu mewn lleoliadau gofal iechyd nad ydynt yn arbenigol, megis gofal sylfaenol?

might this lead to less discrimination in non-specialist healthcare settings, such as primary care?

[66] **Mr Semple:** We believe that all discrimination is borne of ignorance and lack of knowledge, skills and understanding. One of the functions of a specialist nurse is to educate people who are generalist to understand both the perspectives of the patient and the clinical implications, the treatments, management pathways and so forth. Therefore, we do feel that there is a role for specialist nurses in disseminating good practice, but this is obviously borne on the back of the point that Lisa made about the availability of continuing professional development post-registration.

[67] **Eleanor Burnham:** So, really, it is possibly a matter of funding and raising awareness. At what level would this be done? Are you talking about the highest possible level and then percolating down?

[68] **Ms Turnbull:** All levels would be appropriate. The figures that I am talking about, of access to continuing professional development, are for nurses across all sectors; therefore, this would include practice nurses, nurses working in hospitals, nurses working in the community, and at all different levels. At all levels, we can see that nurses have less access to continuing professional development than they used to have, and also less access than colleagues across the border have. So, there is clearly a problem with access to CPD.

[69] **Jonathan Morgan:** The Royal College of Nursing recommends in its paper that nurses in primary care settings should be trained and educated to offer HIV testing in the local community. Why do you think that that might be needed?

[70] **Mr Semple:** I will respond first, but I am sure that Julie will have examples to give. There have been a number of attempts to change public and professional attitudes to people with HIV, one of which is that, as treatments for HIV have progressed, people's life expectation is considerably improved, which means that living with HIV becomes a chronic condition. If you look at where chronic conditions are managed in NHS Wales, you will see that it is in primary care settings. So, while the management of people with existing conditions is important, it is also important to note that most of our public health work happens at a primary care level, so let us equip those staff with the skills to be able to have these conversations in a way that does not make people feel discriminated against, and avoid those people being diagnosed very late, for the sorts of reasons that we discussed earlier.

[71] **Jonathan Morgan:** So it is to help avoid a level of discrimination that could otherwise occur if a patient were treated in a primary healthcare setting.

[72] **Mr Semple:** It is to avoid discrimination, but also to help early identification and diagnosis, so there are a number of reasons for that. There is an excellent publication on HIV in primary care, which I think was produced by the National AIDS Trust. It could produce another document, called 'HIV in non-specialist settings', as an attempt to raise awareness among the non-specialist community. It does appear from anecdotes that where stigma is perceived, it tends to happen in non-specialist settings rather than specialist settings. We believe that that is an indication of a lack of education and a lack of understanding.

[73] **Jonathan Morgan:** The RCN also recommends that education materials should be provided to healthcare professionals who work outside HIV and sexual health care settings, to reinforce key messages around clinical good practice, particularly tackling stigma and promoting dignity and respect, which you mentioned earlier. In written submissions that the committee has received, it has been highlighted that a number of existing guidance and policy

documents and training programmes already cover these areas. So, I wonder why, in your view, these current resources may be somewhat inadequate.

[74] **Ms Turnbull:** It may well not be the case that you need to develop new resources; it may be that people need time to access them, to read them, to discuss them and, certainly in a peer-group setting, discuss how they would take forward the principles and implement them in their work. Over the last two years, we have been running a nutrition campaign, which has brought together a range of educational materials, not necessarily new ones, but ones that already exist. With our workshops and educational programme, we have been giving people the time to reflect on their practice and incorporate the changes in the way that they practice. It may not be a case of needing to develop new materials; it may be that people are either not aware of them or do not have the time to properly take them on board.

[75] **Jonathan Morgan:** Who should take the lead on ensuring that those educational materials are provided to members of staff? Presumably, the hospital authorities or the primary care general manager should be leading on that and making sure that the staff have all the relevant materials.

[76] **Ms Turnbull:** This comes back to the point that I made earlier about continuing professional development in general. In an ideal world, what you would be seeing is a programme for that healthcare community covering all sorts of necessary issues, and there would be a budget for that. As we know, from the figures, it is clear that very often the budget is not available, time is not made available and, therefore, it may be that the type of education and training that is provided is a bit more ad hoc or is perhaps not as strategically put together as an actual programme for that community. So, the answer to your question is that there should be a programme, led certainly in our profession by the nurse director, and led in other professions by whomever is most appropriate.

[77] **Jonathan Morgan:** Some time ago, when we were talking about training that can be offered to members of the nursing profession, I remember that there was huge concern around, for example, the fact that a substantial number of nurses in Wales were not getting their mandatory infection-control training. Are there certain types of training that are mandatory and other types of training that you need to access at some point, but are not time restricted in the sense that you need to have it done fairly quickly? One would anticipate and hope that infection-control training would be done as quickly as possible, although I know from our conversations that that does not always happen. On respect and dignity and treating people with care and caution, if training around HIV and AIDS and how you deal with someone in that situation falls within the ambit of dignity, where does that training sit as compared with training for infection control? Is it as high a priority?

10.00 a.m.

[78] **Mr Semple:** If we take dignity as an example, the RCN has been running a dignity campaign for the last 18 months. In Wales, we have run some dignity pilots. All the old NHS trusts had their own dignity programmes in place. Indeed, many people asked why on earth we needed them, as surely dignity is a fundamental part of essential care. It is the bread and butter of every healthcare professional. However, it has been done in this way because of concerns expressed in some publications about the failure to meet fundamentals. Some of those issues have been addressed in the ‘Free to Lead, Free to Care’ report on the empowering ward sisters programme, which is a new framework for the development of ward managers.

[79] The challenge is that all these things are important. For example, the RCN completed a survey last November on needlestick injuries, and we had nearly 5,000 responses from our members. Of those, 49 per cent said that they had themselves suffered a needlestick injury and yet few had received training on how to manage such injuries, although there had been

some training on dealing with sharps injuries and so on. Managing a needlestick injury following the event and, more importantly, preventing it happening in the first place by ensuring that people understand the basics are absolutely essential. When there is a compressed working day, and someone somewhere is making a decision on what is most important, the physical, life-threatening things generally take precedence—but then that is about resources.

[80] **Jonathan Morgan:** I am still a little unclear on this. If I were a nurse and I had just started working on day one, would I be required to have a certain level of training in certain areas, but then in other areas be allowed to say, 'Well, I will do that this year but I may get on to that next year'? Where does the training on dignity and respect required to deal with a patient who has HIV or AIDS sit in comparison with training that is a mandatory requirement of the job—or is it all mandatory?

[81] **Mr Semple:** I understand the question that you are asking. I will let Julie answer the question on mandatory training, including cardiopulmonary resuscitation, fire awareness, and so on. All nurses, midwives and health visitors are required by their regulatory body to undertake a certain number of hours of updating every three years. That is not a lot. It is 35 hours, which is not a huge ask by any stretch of the imagination. An awful lot has to be fitted into those 35 hours, and they are the responsibility of the individual, not the employer, although it is considered good practice for employers to support employees. The nurses are then caught, as they have to do everything that is not mandatory in 35 hours, which includes fire awareness, CPR, anaphylaxis—

[82] **Jonathan Morgan:** I want to identify which things are mandatory. Where does dignity and respect training fall? Is it mandatory or non-mandatory?

[83] **Ms Richards:** Our Nursing and Midwifery Council's code of conduct and practice clearly outlines what is required of a professional, regarding the standards of practice relating to dignity, confidentiality and communication, all of which are basic requirements. I feel that the fundamentals of that philosophy are threaded through any training, standards and guidance that we have, as well as any discussions that would occur as part of any professional updating.

[84] **Jonathan Morgan:** I am still not clear on this issue. With respect, it is a bit like trying to push water uphill. There is training that is a mandatory legal requirement for a nurse to undertake, is there not?

[85] **Mr Semple:** Dignity is not it.

[86] **Jonathan Morgan:** Okay, dignity is not it. Dignity falls within non-mandatory training. I accept that it is in the professional code of practice that there is an expectation that nurses do this, but it is not a part of the mandatory framework as set out in—

[87] **Mr Semple:** It would be described as 'regulatory'.

[88] **Jonathan Morgan:** It is regulatory, as opposed to non-mandatory. Okay, that is fine. Sorry, I was being slightly awkward there, but that is terrific. Thank you.

[89] **Eleanor Burnham:** Could I have a follow-up question, please?

[90] **Ann Jones:** Could you be brief, please? We are out of time for this item.

[91] **Eleanor Burnham:** I believe that this should be the point at which we hear anecdotal and other evidence of the fact that many nurses in many areas now believe that they are not

there to care, but to be technicians, almost. I am being quite careful in what I say here, but if that is the case—and I had not realised that dignity was only an expected part of the code of practice—I would have thought that dignity training should be mandatory, particularly in view of what you said earlier, namely that you are now into training and raising awareness about dignity.

[92] **Ms Turnbull:** The Royal College of Nursing has been campaigning for a while about the fact that continuing professional development in Wales is not being provided in a strategic way, and we would welcome the committee's views on that. Money is not being ring-fenced for it, and we in Wales are behind other countries. That is true even in the mandatory areas, of which dignity is not one, where our figures are very low. Clearly, that is not acceptable. So, we concur absolutely with that view, and that is one reason why we have been running our own educational campaigns with our members in various areas, such as on dignity, nutrition and HIV care, in the example that we put to the committee.

[93] **Ann Jones:** That concludes our session with you. Thank you all for answering the questions. You will get a copy of the transcript of this session to check it for accuracy. If you could send the relevant pieces of information that you offered to provide us with, that would really help us with our inquiry. This is our last oral evidence session. We then hope to move towards looking at what we hope to put in our recommendations. So, thank you for your valuable information.

10.05 a.m.

Ymchwiliad i Wahaniaethu yn Erbyn Pobl sy'n Byw ag HIV gan Weithwyr Gofal Iechyd Proffesiynol a Darparwyr Gofal Iechyd—Tystiolaeth gan Ysgol Feddygaeth Prifysgol Caerdydd
Inquiry into Discrimination Against People Living with HIV by Healthcare Professionals and Providers—Evidence from Cardiff University School of Medicine

[94] **Ann Jones:** It is now a pleasure to welcome and thank Dr Andrew Freedman, a senior lecturer at Cardiff University School of Medicine. Thank you for sparing the time to come here to answer questions today. You have now seen the format of the meeting. Thank you also for your paper, which will form a part of our evidence. I will start with the first question.

[95] Has discrimination against people living with HIV been brought to your attention as an issue that needs to be addressed through training? If so, can you give us some examples?

[96] **Dr Freedman:** Yes, it has, but I think that it has improved over the years. I have been a consultant physician working in the field since the earliest days in the 1980s—although I was not a consultant at that time. There was a big problem then, mainly borne out of ignorance. The situation has improved but I am aware that there are still examples of discrimination, although I hope that they are more isolated. We are increasingly emphasising professionalism as part of medical student training, and this clearly comes under that category.

[97] **Ann Jones:** Do students have an opportunity to raise and reflect on issues during training?

[98] **Dr Freedman:** Yes. The training is not just didactic lectures. There are seminars and opportunities for discussion. For instance, later this week, I will be giving a seminar to students on ethics and HIV infection, and the students will be discussing just these sorts of

issues.

[99] **Janet Ryder:** Practitioners in the medical and dental professions are sometimes carriers of HIV/AIDS. We have heard evidence from the British Medical Association and the British Dental Association to suggest that doctors and dentists living with HIV and AIDS have experienced discrimination from employers and colleagues. To what extent is that aspect of discrimination reflected in the programmes that you run? Will that be reflected in the programme that you just said was coming up? What experience do you have of students themselves presenting as HIV positive?

[100] **Dr Freedman:** The seminar that I was talking about is admittedly only to a small fraction of the whole student intake, but we do discuss HIV-infected healthcare workers. It is a fairly specialist field. Students have to learn a crowded medical curriculum, so it would not be a core topic as such. However, there is postgraduate training in relation to that for doctors who are dealing with patients who have HIV, and that may include other healthcare workers who have HIV.

[101] **Janet Ryder:** Would you expect or encourage a student to disclose that in interview?

[102] **Dr Freedman:** To disclose their HIV status, do you mean?

[103] **Janet Ryder:** Yes.

[104] **Dr Freedman:** All new entrants to the NHS are now tested for blood-borne viruses and tuberculosis, so it would be detected.

[105] **Janet Ryder:** If that test detected the virus in someone who did not know that they were carrying it, what support would be offered to them?

[106] **Dr Freedman:** The occupational health service would take the lead on that. Clearly, there are implications and limits on what it is allowed to do. The individual could not perform exposure-prone procedures but would receive continuing support, and would be allowed to continue to train and work in appropriate areas.

10.10 a.m.

[107] **Janet Ryder:** So, it would have a direct impact on their training.

[108] **Dr Freedman:** It would affect their training. It is more common for us to see students who have hepatitis B, which results in the same restrictions on the areas in which they can work. I have not seen a student with HIV, but I am sure that it will arise, and it must have arisen in other medical schools.

[109] **Jonathan Morgan:** Good morning. The committee has taken evidence that suggests that cross-contamination prevention measures are not always applied universally. In some cases, there are examples of excessive precautions being taken by medical and nursing staff in a hospital setting when dealing with a patient who has HIV. In which circumstances, if any, would medical students be taught to employ specific cross-contamination prevention measures when working with patients known to have HIV as opposed to with patients whose HIV status is unknown?

[110] **Dr Freedman:** Medical students and all medical staff are taught to use universal precautions, and the emphasis is on the universal. The point being that there will be patients who have undiagnosed blood-borne virus infections. So, when taking blood and putting in cannulae, they are taught to use universal, rather than exceptional, precautions. There will be

instances in which a patient who has HIV also has something such as tuberculosis, and then it would be necessary to use other protective measures to prevent the spread of infection. Students are taught about infection control as part of their infectious disease training.

[111] **Jonathan Morgan:** Is the training on infection control that students go through a part of their assessment, of whether they are competent to be a practitioner in the NHS? Does it form a part of the assessment, or is it a part of the training?

[112] **Dr Freedman:** They may be assessed on it, and there may be questions in their exams that cover that. They would certainly be expected to be able to answer questions on it.

[113] **Jonathan Morgan:** In its written evidence to the committee, the Royal College of Nursing recommended that nurses in primary care be educated and trained to offer HIV testing in local communities, as it could lead to a decrease in the stigma surrounding HIV and AIDS, as well as offer more help people to manage what is, in essence, a chronic condition. How are medical students and particularly those interested in becoming GPs trained to offer HIV tests?

[114] **Dr Freedman:** For medical students, that would not be done in great depth, although they are taught about the importance of early diagnosis and testing in appropriate settings. Most of it would come at postgraduate level. So, training on testing in primary care and so on would take place during general practice training.

[115] **Eleanor Burnham:** Yn eich barn chi, a allai meddygon teulu a gweithwyr meddygol proffesiynol eraill mewn lleoliadau cymunedol gymryd rôl mwy rhagweithiol o ran cynnig profion HIV? Pa effaith allai hynny ei chael ar sut y mae pobl sydd ag HIV yn cael eu trin mewn lleoliadau gofal iechyd?

Eleanor Burnham: In your opinion, could general practitioners and other professional medical workers in community settings take a more proactive role in offering HIV testing? What impact could that have on how people who have HIV are treated in healthcare settings?

[116] **Dr Freedman:** I agree with that idea, and GPs should be encouraged to take a much more proactive role. Wearing one of my other hats, I am the secretary of the British HIV Association, and that is one thing that we at BHIVA are trying to push. We have just published a paper that emphasises what we hope will be an increasing role for primary care in respect of testing and looking after patients who have HIV. Clearly, that will help to reduce any stigma and normalise HIV as another chronic medical condition.

[117] **Ann Jones:** Could you share that paper with the committee?

[118] **Dr Freedman:** Yes, I would be happy to.

[119] **Ann Jones:** Thank you.

[120] **Eleanor Burnham:** Faint o bwyslais sy'n cael ei roi ar y Ddeddf Gwahaniaethu ar Sail Anabledd 1995 fel y'i diwygiwyd, sy'n amddiffyn rhag gwahaniaethu yn erbyn pobl sydd ag HIV yn ystod hyfforddiant meddygol?

Eleanor Burnham: How much emphasis is placed on the Disability Discrimination Act 1995 as amended, which makes provision to prevent the discrimination of those who have HIV during medical training?

[121] **Dr Freedman:** As I mentioned earlier, there is now a course on professionalism, which includes GMC guidance, good medical practice, duties of a doctor, and these various Acts will be covered, not in great detail, but just so that students are made aware of their obligations under the law, and under GMC guidance not to discriminate.

[122] **Eleanor Burnham:** So, in respect of some of the evidence we heard earlier from the RCN, in response to my questions about issues of dignity and so on, this is an integral part of your training and code of conduct.

[123] **Dr Freedman:** Very much so. It is a relatively recent development in being made a core part of the medical undergraduate course.

[124] **Joyce Watson:** You talked about the emphasis on training practitioners in how they deal with patients and their medical care. Equally, do you think that enough emphasis is placed on the social issues, such as the stigma and discrimination, facing people who happen to be HIV positive? Are we training the future medical profession to deal with both sides?

[125] **Dr Freedman:** I think that we are. We have training days for undergraduates on professionalism, which includes stigma—not just in relation to HIV, but more broadly in relation to patients' race, disability, sexuality and so on. There is only so much lecturing that you can do. These are concepts that students and practitioners develop over time. From the first year, students are given information regarding this, and are reminded of their duty not to discriminate.

[126] **Joyce Watson:** In your paper you say that the amount of further training in relation to HIV that qualified doctors have will depend on the speciality that they then follow. Given that people living with HIV are likely to have a range of health needs that will be addressed in non-specialist settings, do you think that post-qualification training places adequate emphasis on the issues affecting people with HIV?

[127] **Dr Freedman:** In short, I cannot be certain that that is the case in all different branches of medical settings. I am an HIV specialist and I am certainly keen on educating people in other branches of medicine. I often give lectures to other departments in the hospital, and I think that that is important and that more needs to be done.

[128] **Ann Jones:** Thank you. Janet, you look as though you are about to pose a question.

[129] **Janet Ryder:** I have a couple of questions based on the last question in fact.

[130] **Ann Jones:** Well, ask your question about the last question, and then we will move on.

[131] **Janet Ryder:** The last question was about identifying areas within the current arrangements for the training and education of doctors, in relation to both clinical and equality issues related to HIV, that might be improved. Do you have any thoughts on that? I will let you answer that question first, and I might have some further questions to follow.

[132] **Dr Freedman:** Primary care would be an example. Ten years ago, I think that there was more interest from primary care in inviting physicians such as myself to talk to practices' GP meetings about HIV. I think that continuing professional development time has changed somewhat and it is becoming more compressed, and perhaps there is less call for that. Work is still ongoing, and we encourage it wherever possible.

[133] **Janet Ryder:** You mentioned that CPD time is being compressed A lot of the development training seems to be delivered online, and yet we have a bulk of practicing GPs from a generation that did not have the advantages of the kind of materials that you are writing into current medical training. They came into the profession when diagnosis was relatively new, and perhaps still need to undergo further training. Could you suggest anything that we might consider as a recommendation regarding ways to overcome that or improve that

situation?

10.20 a.m.

[134] **Dr Freedman:** I agree with you that online learning is becoming increasingly important and is making it easier. I cannot speak for other groups of professionals, or postgraduate doctors.

[135] **Janet Ryder:** As you are someone who has qualified in training, would you suggest that, perhaps in certain aspects of medical training such as this, face-to-face training is more advantageous than online training?

[136] **Dr Freedman:** Not necessarily. Face-to-face training is time-consuming for trainers, particularly as there are not many HIV specialists in Wales. Online training can be a very good substitute.

[137] **Janet Ryder:** I would like to ask you one last little question. I would like to take you back to what I asked you at the beginning, about students who have been identified as having something—not necessarily HIV—that would prevent them, perhaps, from being able to practise in every field of medicine. You said that that would have an implication for their training. Does it have an implication for their training in that they would be unable to participate in invasive surgery?

[138] **Dr Freedman:** They would not be able to do that, but it is not a—

[139] **Janet Ryder:** In that case, how can they complete their training?

[140] **Dr Freedman:** The number of invasive procedures that undergraduate students perform is minimal. It would not significantly affect their training. They can go to theatre and observe operations, but they cannot be hands-on when it comes to procedures. However, students really do not do that anyway; that is for postgraduates. They are observing more than participating.

[141] **Janet Ryder:** Is that true even when they do their stints in accident and emergency departments, especially during night shifts when things can be very hard pressed?

[142] **Dr Freedman:** They can see patients and take blood—those things are perfectly acceptable.

[143] **Jonathan Morgan:** I have a question on continuing professional development, given that you said that time for this has become compressed. What are the legal requirements or the regulatory requirements from the professional bodies relating to continuing professional development, either for doctors working in a secondary care setting, or those working in primary care? The legal status of both is fundamentally different in that doctors working in secondary care are principally employed through the NHS body, whereas GPs are technically private practitioners. What are the regulatory requirements?

[144] **Dr Freedman:** The General Medical Council does not stipulate exactly how much CPD doctors should undertake; it merely states that it is their duty to keep abreast of developments.

[145] **Jonathan Morgan:** So, is there a requirement for a doctor either in primary or secondary care to have to demonstrate every 12 months what CPD—

[146] **Dr Freedman:** That is done mostly through the royal colleges, but general

practitioners and, in my case, physicians, are required to undertake a minimum amount of CPD and different types of CPD—meetings, reading journals, and so on—within the field in which they specialise. That is true both of postgraduate trainees and fully qualified consultants and GPs.

[147] **Eleanor Burnham:** In view of the fact that we have such an increase in infections in many of our health settings, would it not be wise to effect a transfer and to expect a general increase in the number of precautions and procedures that you undertake as an HIV expert in general medicine?

[148] **Dr Freedman:** Yes. There is great emphasis on infection control—if that is what you are getting at—within all departments of the hospital.

[149] **Eleanor Burnham:** I believe, then, that you would not have such a level of discrimination because this would be the general way of doing things. The British Dental Association informed us that its high level of infection control is, in its view, second to none, whoever the client may be.

[150] **Dr Freedman:** The risks of HIV transmission, which are very small within hospitals, are well recognised. I do not think that it is people's greatest fear. There are other problems: we have swine flu at the moment, which is much more infectious; and tuberculosis. I think that people are happy that blood-borne viruses are easy to control with appropriate measures.

[151] **Ann Jones:** You answered the question that I was going to ask very well in your answer to Janet, so I think that I can get away with that one. I see that Members have no more questions. Thank you very much for coming in. As I said to the other panel of witnesses, you will receive a copy of the transcript to read through. We look forward to receiving the paper that you mentioned.

[152] **Dr Freedman:** I will send it to you.

[153] **Ann Jones:** Thank you very much.

10.26 a.m.

Ymchwiliad i Wahaniaethu yn erbyn Pobl sy'n Byw ag HIV gan weithwyr Gofal Iechyd Proffesiynol a Darparwyr Gofal Iechyd—Tystiolaeth gan y Gweinidog dros Iechyd a Gwasanaethau Cymdeithasol
Inquiry into Discrimination against People Living with HIV by Healthcare Professionals and Providers—Evidence from the Minister for Health and Social Services

[154] **Ann Jones:** Good morning, Edwina. Thank you for coming, and for your paper. I do not know whether you have been following our inquiry, but we hope that this will be our last evidence session before we move on to try to draw some conclusions from the written and oral evidence.

[155] I will start with the first question. The NHS Confederation told this committee that it is not aware of any healthcare organisation in Wales that has a specific system in place to gather information about the experiences of people who are living with HIV and who feel that they have been discriminated against in some way in healthcare settings. Do you think that the NHS Wales organisations should be able to identify and analyse complaints made about discrimination by healthcare professionals on the grounds of HIV status?

[156] **The Minister for Health and Social Services (Edwina Hart):** I do not demur at the information that was given to you by the confederation. There is no systematic approach to issues regarding discrimination against people with HIV/AIDS within the NHS. I have indicated in my 'Sexual Health and Wellbeing Draft Working Paper for Wales 2009-2014' that we want to deal with discrimination and stigma issues, and we have identified that there is a gap between the anecdotal evidence and the reality of the situation.

[157] We will undertake, with Public Health Wales and the Wales HIV network, a needs assessment of people living with HIV in relation to stigma and discrimination, as part of the work programme from April 2010, to deal with some of the issues. I have had the opportunity, Chair, as Minister for health, to be out and about and meet people who live with HIV, and some of the issues that they have raised with me have been on NHS staff attitudes—general practitioners and others—who do not necessarily have the expertise to deal with them, or feel that they do not, and then refer them to a specialist when they do not need referring because it is a general health issue. I indicated to them that it is important for us to get hard evidence on this, so that we can ensure that we deal with services much better. We are talking about a group of patients who are getting older and will be accessing other services, for example stroke services and dementia services, and we need to be sure that these services are at the level that they require, and that there is an understanding of their needs.

[158] **Jonathan Morgan:** On the reorganisation of the NHS and the new capacities that might now exist in seven larger organisations, do you think that there is the opportunity for those organisations to gather, analyse and act on information about discrimination against people on the grounds of their HIV status by healthcare staff?

[159] **Edwina Hart:** Yes, there is an opportunity. If you look at some of the training agendas that existed in the NHS on issues of equality and diversity, you will see that they have, in the main, been allowed to follow their own direction of travel and done what training they considered appropriate within areas, rather than having the central guidance that is required. I am minded, given that we now have the seven health organisations, to look at what else we can do on training. We have restructured the NHS, and at the heart of that has been the issue of equality and human rights, but we must look at the strands that underpin that and at what specific work might be required in that area. If you look at disability discrimination, which impacts on this discussion, you will see that we have done quite a lot of work with people with hearing loss and other such issues, but you are quite correct to highlight the fact that there is probably insufficient work being done on HIV.

10.30 a.m.

[160] **Jonathan Morgan:** Minister, you mentioned training. In an earlier session with the Royal College of Nursing, I tried to tease out where issues around dealing with patients with HIV sit within training. The college talked about issues of dignity and respect, and that type of agenda. I then tried to tease out something else, namely where that sits in the mandatory and non-mandatory training. The college said that training staff on dealing with patients with dignity and respect was not part of their mandatory training, but that it falls within their code of professional practice, which is part of non-mandatory training. Do you think that the Government should be looking at moving dignity and respect into mandatory training?

[161] **Edwina Hart:** It is something that we will look at if the report highlights some issues for us. The RCN gave you an honest and accurate response to your question on how it saw issues arising. We tend to look at issues with professions in the context of what they do professionally, such as how they regard issues about infection and all those key elements, rather than looking at the wider aspects. This would involve a greater understanding of the needs of individuals, rather than just their clinical needs. It is something on which we will have to focus in the future in the NHS if we are to deliver properly for all our citizens.

[162] **Joyce Watson:** Good morning, Minister. The Equality and Human Rights Commission has argued that the Welsh Government could use powers contained in the Equality Bill to require public authorities to collect, analyse and act on evidence about discrimination against people living with HIV in a healthcare setting. Have you had any discussions with the Minister for Social Justice and Local Government on taking that forward?

[163] **Edwina Hart:** I have had no discussions with the Minister concerned, and I have had no approach from the commission either.

[164] **Joyce Watson:** Thank you very much for that answer, which will be useful to us. Your paper also identifies current clinical guidance on the prevention of HIV in healthcare settings. Are you confident that the successful implementation of this guidance should ensure that patients with HIV are not discriminated against?

[165] **Edwina Hart:** I will hand over to Dr Wilkinson.

[166] **Dr Wilkinson:** We have standard healthcare practices and codes of conduct in Wales which are laid out on the basis that everyone should be treated the same. We do not know all the people who have HIV or other blood-borne infections, so the standards that we have in hospitals and in the community are based on universal standards for infection control. So, the standards do not discriminate against a particular disease such as HIV, but they protect everyone.

[167] **Joyce Watson:** That leads me nicely to the next question. We have received evidence that some patients who are known to have HIV have been subjected to precautionary measures that they think were not used with other patients while in hospital. Are you confident that your guidelines on universal contamination prevention measures are being properly implemented across the NHS? Are they also being explained to patients, because it is about the perception of this application by patients?

[168] **Dr Wilkinson:** It goes back to what the Minister said about the importance of training, ethos and values in the system. Those people that are most involved in exposure-prone procedures are more likely to have that training, and should have a heightened awareness of these issues. However, we recognise the general importance of raising awareness and standard infection control procedures across the NHS.

[169] **Eleanor Burnham:** Mae gennyf gwestiwn am wneud cwynion yn erbyn staff y gwasanaeth iechyd. Mae'r pwyllgor wedi derbyn tystiolaeth bod llawer o bobl â HIV yn teimlo'n amharod i gwyno oherwydd y pryder na fydd staff yn delio gyda'r gŵyn yn ddigon da. Beth allwch chi a sefydliadau gwasanaeth iechyd cenedlaethol ar draws Cymru ei wneud i wella hyder pobl sydd â HIV i gwyno os ydynt yn teimlo eu bod yn cael eu trin yn wael gan staff gofal iechyd?

Eleanor Burnham: I have a question on making a complaint against NHS staff. The committee has received evidence that many people with HIV are unwilling to complain because of the fear that staff will not deal with the complaint adequately. What can you and NHS bodies across Wales do to improve the confidence of people with HIV to complain if they feel that they have been treated badly by healthcare staff?

[170] **Edwina Hart:** That raises a wider issue about whether people have confidence in the NHS complaints procedure. You will find a reluctance to complain among other individuals as well as those with HIV. They often think that if they complain, someone might get at them the next time they go to hospital. By working with patients' organisations and community health councils, looking at their range of work, we are trying to give people the confidence

and assure them that that is not the case because complaints will improve the service in the long term. I like to think that if complaints go up, we can make a difference to the service because we are seeing the natural trends.

[171] I would be concerned if certain groups said that they were being more adversely affected than the general population. However, I have no specific evidence of that. This is an area where we would need further evidence if we thought that that were the case. I think that there is still a general misunderstanding about HIV/AIDS even within the health community that administers the service for us. There is an unnecessary fear about issues and a lack of understanding because this agenda has moved on substantially from when HIV/AIDS first became an issue in the public's mind. We only have to look at how things are regarded by dentists and how they treat their patients. It is all about basic infection control measures and treating people with dignity and understanding. However, an element of stigma about the disease still lurks in some people's brains. What also concerns me is that people make assumptions when they look at people and they might regard a person as someone who might have HIV/AIDS because of their lifestyle and so on. That is wrong because you should not base anything in the health service on your perception, but on your knowledge of the clinical needs and requirements of the individual.

[172] **Eleanor Burnham:** Honnwyd yn gynt gan y Coleg Nyrsio Brenhinol nad oes digon o hyfforddiant proffesiynol parhaol. Yr ydych wedi trafod hyn gyda Jonathan, ond pa rôl sydd gennych chi i sicrhau bod trefniadau hyfforddi, cyn ac ar ôl cymhwyso, ar gyfer gweithwyr gofal iechyd proffesiynol nad ydynt yn arbenigwyr ar HIV yn ddigonol mewn perthynas ag HIV?

Eleanor Burnham: The Royal College of Nursing claimed earlier that there was not enough permanent professional training. You have discussed this with Jonathan, but what role do you have to ensure that training arrangements, before and after qualifying, for healthcare professionals who are not HIV specialists are sufficient in relation with HIV?

[173] **Edwina Hart:** I would dispute that there is sufficient training on a wide range of issues—we are not just talking about HIV, but about other blood-borne viruses. However, I would say that there is sufficient training in the system—I do not doubt that. If people think that they need training of a different nature to deal with their own perceptions of HIV/AIDS, that is rather different from the professional training that they receive as professionals currently working in the health service. We are now going into an area that is not only about training to deal with health issues, but to deal with people's mindsets. We have never had any requests for such training and this takes us back to the original question asked by Jonathan Morgan, namely do we need to do something, now that we have the local health boards, about how we train on equality and diversity issues? Do we need to pick this up in that arena?

[174] **Eleanor Burnham:** A all gweithwyr gofal iechyd proffesiynol nad ydynt yn arbenigo mewn iechyd rhywiol gael hyfforddiant ar HIV a materion cydraddoldeb cysylltiedig, ac a ydynt yn cael eu hannog i gael hyfforddiant o'r fath? Fel y dywedais, honnwyd yn gynharach nad oedd digon o hyfforddiant proffesiynol parhaus er eich bod wedi dweud rhywbeth cwbl addas ar hyn, sy'n edrych ar y mater mewn ffordd ychydig bach yn wahanol.

Eleanor Burnham: Could healthcare professionals who are not sexual health specialists receive training on HIV and related equality issues and they are encouraged to receive such training? As I said, it was claimed earlier that there was not enough continuing professional training, although you have said something entirely appropriate about this, which looks at the issue in a slightly different way..

[175] **Edwina Hart:** I think that there is sufficient professional development and training in the service. However, I am happy to look at this in the context of equality and diversity and whether we need to provide different types of training on this wider agenda. As I have

indicated, I will ask the head of NHS personnel to see whether she could get model programmes out into the NHS in light of what will be raised in the committee's report. This area has not been explored in great depth by the health department or by me as the Minister, but I have not had a great deal of representations or communications on this. This is only something that I have picked up myself in my visits. So, I welcome anything that emerges from the committee for recommendations on the wider training agenda for NHS staff.

[176] **Eleanor Burnham:** Sut y mae effeithiolrwydd hyfforddiant ac addysg o ran codi ymwybyddiaeth am HIV a hawliau pobl sydd â HIV yn cael ei werthuso gan sefydliadau'r gwasanaeth iechyd gwladol yn eich barn chi?

Eleanor Burnham: How is the effectiveness of education and training to raise awareness about HIV and the rights of people with HIV evaluated by the national health service bodies in your opinion?

10.40 a.m.

[177] **Edwina Hart:** I doubt very much whether there is sufficient information out there to undertake the necessary evaluations, to be absolutely honest. The fact that we will be looking specifically at some issues from April 2010, working with people in the sector to see whether we can get some evidence about what is going on indicates that there is probably a shortfall.

[178] **Eleanor Burnham:** The last matter that I want to raise is that the BDA reckons that it has the best infection control, because it is universal infection control. Do you think that that is best practice that should be rolled out everywhere?

[179] **Dr Wilkinson:** The basis of standard infection control is that you assume that anyone whom you are treating could have HIV, hepatitis B, or anything else for that matter because you do not know. It could be one patient or another. It could be a patient who knows that they have HIV, or it might not. You have to presume that anyone that you treat has the potential for cross infection and act on that basis.

[180] **Ann Jones:** May I pick up a point? The RCN said that it felt that mandatory training in Wales is significantly behind mandatory training in England. Do you have a view on that?

[181] **Edwina Hart:** I would like to see the evidence from the RCN. It is interesting that the RCN has never raised the issue in any of its regular discussions with me.

[182] **Ann Jones:** Thank you for that answer.

[183] **Joyce Watson:** Your paper points to the fact that the NHS CEHR is aware of two training sessions based in the Cwm Taf sexual health service and the Betsi Cadwaladr University Local Health Board that covered HIV and discrimination. What scope might there be to increase the availability of training sessions such as those for healthcare professionals across Wales?

[184] **Edwina Hart:** There is excellent scope to look at the best examples of what has happened in some of the LHBs and extend that. With only seven organisations now, they can learn from each other about what they do in training. There has to be a more central direction regarding the training agenda and some of these key issues. In addition, I refer to it as just 'Betsi' now—it is easier. [*Laughter.*]

[185] **Ann Jones:** We call it BCU up north.

[186] **Jonathan Morgan:** Some of the witnesses have argued that focusing on the awareness and practices of healthcare professionals alone is not enough to tackle

discrimination against people living with HIV in healthcare settings, but that a wider public health campaign is needed. What are your views on that? Do you think that there needs to be a more concerted public awareness campaign?

[187] **Edwina Hart:** I agree with them. It is too narrowly focused, but we have to think across the Government about the issues to do with the discrimination of people with HIV and AIDS. I would welcome a much wider general campaign, because they do not just face discrimination in the health agenda, but in a wider range of areas that we need to consider. If people think that other people have HIV/AIDS, those other people experience discrimination, whether they have HIV/AIDS or not.

[188] **Jonathan Morgan:** To move on to another issue that was raised in the evidence that we took from the BMA and the BDA, we were discussing the issue of discrimination against healthcare workers who have HIV, particularly doctors and dentists. In its written evidence, the BDA states that dentists living with HIV face losing their careers permanently, because the Department of Health protocol is around exposure-prone procedures and that most dental interventions are EPPs. So, its argument is how on earth can a dentist with HIV carry on practising as a dentist because they will not be able to undertake the work of a dentist. In your paper, you say that

[189] 'The rationale for the recommendations is not to prevent those infected with blood-borne viruses from working in the NHS, but to stop them working in clinical areas where their infection may pose a risk to patients in their care.'

[190] Do you think that the policy of preventing HIV-positive healthcare workers from undertaking certain procedures is proportionate and necessary, given the risk of infection to the patient? I ask that because the BMA, in its evidence, said that only

[191] 'three reports exist of transmission from HIV positive doctors to patients. These three reports were made before the introduction of universal precautions or the changes to professional practice'.

[192] Is the protocol for dental services and other healthcare workers proportionate?

[193] **Edwina Hart:** To deal with the first point, the NHS employment policy is clear. I have to put that on the record. Employees with HIV should not be discriminated against in any way. However, you will probably find that people feel that they have been discriminated against in particular ways, and that is an issue. We are currently reviewing the policy areas that you identified, and the review will, hopefully, report in the second half of 2010. Do you want to say anything from a clinical perspective, Jane?

[194] **Dr Wilkinson:** No. I will just reiterate that the review is ongoing, with the tripartite working group looking at that. The world moves on, and we have to keep coming back to these issues as we learn more about the epidemiology of these conditions. Times change.

[195] **Edwina Hart:** I think that the BMA made a fair point in its evidence to the committee.

[196] **Ann Jones:** I see that no-one has any further questions. Thank you for coming to committee, Minister and Dr Wilkinson. We will send you a transcript to check for accuracy. We will now turn to writing the report, and we welcome your positive contribution and the fact that you have said that you are willing to look at our recommendations despite not knowing what they will be. That is a good commitment; it is all that we can ask for as a committee.

[197] **Edwina Hart:** Thank you, Chair.

[198] **Ann Jones:** Before we close the meeting, I remind Members that there is more evidence among the papers to note, including a huge document from the Minister for Social Justice and Local Government on equality of opportunity funding.

[199] This is the last meeting of this term. It is also Bethan's last meeting, so on behalf of you all, I thank her for her work as clerk. She is going off on maternity leave, so we wish her well. The baby is due on new year's eve, so we will wait to hear about that. We will continue to meet on Tuesday mornings when we come back next term, and our first meeting is on 12 January 2010. The new clerk is Claire Morris—I think that most of us know Claire from other committees. Thank you all for your attendance; I will see you in January.

Daeth y cyfarfod i ben am 10.48 a.m.
The meeting ended at 10.48 a.m.