------------------------Pecyn dogfennau cyhoeddus ------------------------

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Lleoliad:
Ystafell Bwyllgora 1 – Y Senedd

Dyddiad:
Dydd Iau, 29 Ionawr 2015

Amser:
09.00

I gael rhagor o wybodaeth, cysylltwch â:
Llinos Madeley
Clerc y Pwyllgor
0300 200 6565
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Agenda

2 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 2 (09.00 – 09.50) (Tudalennau 1 – 10)

Tina Donnelly, Y Coleg Nyrsio Brenhinol
Lisa Turnbull, Y Coleg Nyrsio Brenhinol

3 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 3 (09.50 – 10.40) (Tudalennau 11 – 23)

Cynrychiolwyr Cyfarwyddwyr Nyrsio Byrddau ac Ymddiriedolaethau Iechyd GIG Cymru:

Rory Farrelly, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Ruth Walker, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Egwyl (10.40 – 10.50)

4 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 4 (10.50 – 11.40) (Tudalennau 24 - 32)

Dr Phil Banfield, BMA Cymru
Dr Victoria Wheatley, BMA Cymru
Dr Rhid Dowdle, Coleg Brenhinol y Ffisigwyr (Cymru)

5 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 5 (11.40 – 12.25) (Tudalennau 33 - 53)

Dr Sally Gosling, Cymdeithas Siartredig y Ffisiotherapyddion
Philippa Ford, Cymdeithas Siartredig y Ffisiotherapyddion
Dr Alison Stroud, Coleg Brenhinol y Therapyddion Lleferydd ac Iaith

6 Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 7 a 8 (12.25)

7 Bil Lefelau Diogel Staff Nyrsio (Cymru): ystyried y dystiolaeth a ddaeth i law (12.25 - 12.40)

8 Bil Rheoleiddio ac Arolygu Gofal (Cymru): paratoi ar gyfer gwaith craffu (12.40 - 12.45) (Tudalennau 54 - 55)

Cinio (12.45 - 13.30)

9 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: sesiwn dystiolaeth 1 (13.30 - 14.15) (Tudalennau 56 - 85)

Dr Charlotte Jones, BMA Cymru
Dr Phil White, BMA Cymru
Dr Peter Horvath-Howard, BMA Cymru

10 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: sesiwn dystiolaeth 2 (14.15 - 15.00) (Tudalennau 86 - 90)

Dr Paul Myres, Coleg Brenhinol yr Ymarferwyr Cyffredinol
Dr Rebecca Payne, Coleg Brenhinol yr Ymarferwyr Cyffredinol

Egwyl (15.00 - 15.15)

11 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: sesiwn dystiolaeth 3 (15.15 - 16.00) (Tudalennau 91 - 96)

Ms Mary Beech, Deoniaeth Cymru
Dr Martin Sullivan, Deoniaeth Cymru

12 Papurau i'w nodi (16.00) (Tudalennau 97 - 100)

Memorandwm Cydsyniad Deddfwriaethol: Y Bil Arloesi Meddygol: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Tudalennau 101 - 102)

Gohebiaeth gan y Pwyllgor Deisebau: P-04-600 Deiseb i Achub y Gwasanaeth Meddygon Teulu (Tudalennau 103 - 110)

13 Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod ac o eitem 1 y cyfarfod ar 4 Chwefror 2015 (16.00)

14 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: ystyried y dystiolaeth a ddaeth i law (16.00 - 16.15)

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 Royal College of Nursing – SNSL(Org) 05 / Tystiolaeth gan Coleg Nursio Brenhinol – SNSL(Org) 05

Inquiry into the Safe Nurse Staffing Levels Bill (Wales)
January 2015

Submission from the Royal College of Nursing, Wales
Presented to the National Assembly for Wales Health & Social Care Committee

ABOUT THE ROYAL COLLEGE OF NURSING (RCN)

The RCN is the world's largest professional union of nurses, representing over 400,000 nurses, midwives, health visitors, nursing students and healthcare support workers, with over 25,000 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing.

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Written Evidence of the Royal College of Nursing in Wales in Response to the National Assembly for Wales Health and Social Care Committee Consultation on Safe Nurse Staffing Levels (Wales) Bill

1. The Royal College of Nursing is the world's largest professional organisation of nurses. It represents over 420,000 nurses, midwives, health visitors, nursing students and healthcare support workers. In Wales the Royal College has over 24,000 members. The majority of our members work in the NHS. The Royal College of Nursing works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession.

The Royal College of Nursing is a UK-wide organisation with its own National Board in Wales. It is a major contributor to nursing practice; standards of care and public policy as it affect health and nursing.

The Royal College of Nursing represents nurses and nursing, promotes excellence in nursing practice and care and shapes health policies.

The Royal College of Nursing welcomes the opportunity to respond to the Health and Social Care Committee's consultation on the Safe Nurse Staffing Levels (Wales) Bill.

Response to General Consultation Questions

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

2. The Royal College of Nursing in Wales believes that there is a need for legislation to make provision about Safe Nurse Staffing Levels.

International research clearly demonstrates that that the number of registered nurses and nursing staff on a ward makes a significant difference to successful patient outcomes including morbidity and mortality. In 2006 Professor Rafferty CBE surveyed nearly four thousand nurses and looked at 118,752 patient episodes of care in 30 hospital trusts in England. Her research found that wards with lower nurse to patient ratios had a 26% higher patient mortality rate. An international meta study in 2007 estimated that each additional full time nurse per patient day saved five lives per 1,000 medical patients, and six per 1,000 surgical patients (Kane et al 2007). Another study found that when

a nurse is charged with more than seven patients per day the risk of the patient dying within 30 days increases by 7 per cent (Aiken et al, 2014).

Poor outcomes also associated with low levels of nursing care include adverse events after surgery; increased accident rates and that patient injuries; increased cross-infection rates; and higher rates of pneumonia.

3. Despite these principles being well known within the nursing profession there has not been a commitment in the NHS to seeing Safe Nursing numbers in practice in wards. Paragraphs 10 to 12 of the Explanatory Memorandum reference the Francis Report (2013), the Keogh review (2013), the Berwick review (2013) and the Andrews Report (2014), all of which have drawn attention to the repeated failure of the NHS to sufficiently prioritise patient safety and the quality of care by safeguarding nursing numbers.

4. In Wales even the All Wales Nurse Staffing Principles Guidance issued by the Chief Nursing Officer (CNO) in 2012 has failed to make a sufficient impact. Trusted To Care (2014) the independent review of the Princess of Wales Hospital and the Neath Port Talbot Hospital specifically refers to *'lack of suitably qualified, educated and motivated staff particularly at night'* and comments: '*The Review Team were also concerned about the way staffing levels in the medical wards were determined as this seemed unconnected to the level of dependency and need on a ward at a specific time.'* The report of the Older People's Commissioner for Wales 'Dignified Care: Two Years On' (2013) states that '*there is a clear link between staffing levels and the safety and quality of care on hospital wards.*' As a result, the Royal College of Nursing believes that legislation is the only way to ensure Safe Nurse Staffing Levels on adult in-patient wards.

5. The figures below are from a Royal College of Nursing Survey carried out in 2013. This was an online survey sent out to a stratified random sample of the Royal College membership. The survey achieved a total of 9,754 usable responses across the UK, with 1,365 usable responses from nurses working in Wales. It shows the patient to nurse ratios reported by members in Wales:

	Patients per registered nurse
All	8.5
Older people	10.9
Mental health	8.2
Children and young people	4.4

Acute and urgent care	8.4

6. The Royal College of Nursing also undertook a Freedom of Information request (table below) which asked the Local Health Boards (LHBs) about the number of patients per registered nurse per day and night and the Ratio of Registered Nurses to Healthcare Support Workers. Their responses show that with the exception of Cwm Taf UHB all the other LHBs are failing to follow this guidance.

Health Board	Number of patients per registered nurse		Ratio of registered nurses to nursing support workers
	day	night	
Abertawe Bro Morgannwg	8 (average)	13 (average)	60:40
Aneurin Bevan	7 (average)	14 (average)	Working to 60:40
Betsi Cadwaladr	2 – 7.5	3 – 15	Varies between 46:54 – 76:24
Cardiff and Vale	Work towards 7 – 8	Work towards 11, but this varies by ward up to 13	47:53 – 74:26 (range of lowest and highest figures by individual wards)
Cwm Taf	Does not exceed 7	Does not exceed 11	Should be no less than 60:40
Hywel Dda	4 – 8	9 – 15	72:28

Source: Local Health Boards (individual responses to Freedom of Information requests)

7. The Royal College of Nursing believes that legislation by the National Assembly is necessary and will ensure that Health Boards place a greater priority on ensuring safe nursing levels on wards.

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

8. The Royal College of Nursing believes the provisions laid out in the Bill are the best way of achieving the Bill's purpose.

9. The duty on Health Boards to have regard to safe nurse staffing levels will ensure a Corporate level of accountability for the first time and increase the significance of the advice of the Nurse Director to the Board. Too often Board and Executive teams have consciously or unconsciously focused on financial and other strategic priorities at the expense of this key indicator of patient safety.

10. The requirement on Health Boards to publish information demonstrating how they have met the guidance will allow effective scrutiny, evidence of impact and also increase accountability.

11. In seeking to achieve the purpose of safe nursing levels the Bill does not set actual numbers but instead refers to the use to evidenced based and validated workforce planning tools, standards and guidelines of professional organisations and the role of professional judgment. The Royal College of Nursing views this as the sensible and sustainable approach

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

12. The Royal College of Nursing does not believe there are potential barriers to implementing the Bill. All LHBs currently undertake workforce planning and have the tools available to them to ensure that this legislation can be implemented without delay. This Bill simply places a duty upon the LHBs to consider Safe Nurse Staffing when planning their workforce.

Are there any unintended consequences arising from the Bill?

13. The Royal College of Nursing does not believe there will be any detrimental unintended consequences that can arise from this Bill. The experience of similar legislation in Victoria, Australia and California has been very positive (Serratt, 2013).

14. The Royal College of Nursing has previously been asked whether this Bill might result in a sudden increased demand for nurses might cause instability in another sector. This has not been the experience elsewhere. Indeed there was an increase in the number of nurses wishing to return to practice in Australia. If there was an increased demand this could be dealt with by an increase in the number of student nurses places commissioned.

15. A second fear expressed to us has been that costs could escalate as a result of employing more nurses. More detailed information and analysis is provided to the Committee in the

Explanatory Memorandum but a summary of the Royal College's response to this would be that *expenditure on nursing demonstrates the most effective impact on patient outcomes* (Bray et al, 2014)

16. The regulatory Impact section of the Explanatory Memorandum references findings from the 'perfectly resourced ward' pilot conducted by Aneurin Bevan Health Board at the end of 2012. Over the three month period of the pilot, although nursing establishment costs were 6% higher than the preceding period, the considerable reductions in the costs of agency more than outweighed these increases. At the end of the three month period, the combined staffing costs of the two wards had not increased and in fact was marginally lower than the preceding period.

17. The Welsh Government has not published figures for spending on agency nursing in 2014 but the Royal College of Nursing is aware that agency costs to the NHS have increased 43% compared to 2013 and is at its highest level for four years. The Royal College of Nursing would estimate the cost of non-medical agency payments as between £20 and £30m in 2014.

A 2011 study (Hurst, 2011) found that hospital wards with temporary staff had poorer staffing levels, higher workloads, more sickness absence and lower ward quality scores than wards that were staffed by permanent nurses only.

18. Much research has also shown the financial benefit of safe nurse staffing levels. For example in 2009 US research quantified benefits per additional nurse at $60,000 with an additional $10,300 for reduced patient mortality, and $1800 from faster recovery. In the UK in 2009 Dr Foster Intelligence published research showing shorter hospital stays in acute Trusts that had more nurses per bed.

19. A final concern that has been raised with us is that other healthcare professions may feel disadvantaged by not being explicitly mentioned in this Bill.

20. The Royal College of Nursing has been delighted to receive support from BMA, RCP, the Diabetes National Specialist Advisory Group and UNISON Cymru.

21. Healthcare requires a multidisciplinary team approach to achieve the best outcome for the patient. At different moments in the journey of the patient they may require care from a surgeon, a pharmacist, a speech and language therapist, a physiotherapist etc.

The weight of academic evidence demonstrating the significance of the nursing impact is not a testimony to the superiority of the nursing profession but merely a testimony to that fact that the nature of nursing is a 24/7 caring role by the side of patient encompassing the very fundamentals of care including nutrition, hydration, alleviating pain etc. A core part of the nursing role is continuous assessment of the acuity of the patient, as the patients' needs change or escalate, nurses are responsible for referring onwards to other healthcare professionals.

Nurses make up the largest staff group in the NHS because they are
needed by patient *at all times* – and their absence has a significant negative impact.

Response to Consultation Question on Provisions in the Bill

View on the fact that, in the first instance, the duty applies to adult in-patient wards in acute hospitals only?

22. The vast majority of academic research demonstrating the value of safe nurse staffing levels has been carried out in adult in-patient wards in acute hospitals. Certainly, based on the information that we have provided in Paragraphs 3 to 5, the Royal College of Nursing believe that by starting on adult in-patient wards in acute hospitals this piece of legislation is aiming to focus where there is the most need.

23. The Royal College of Nursing welcomes the provision that Welsh Ministers may make provision for the duty to be extended to additional settings within the NHS in Wales ensuring that Registered Nurses have time to care in such a way that ensures the dignity of the patient as well as clinical effectiveness. The Royal College of Nursing believes the nursing in the community needs legal safeguards relating to Safe Nurse Staffing too. Staffing levels are mandatory in care homes and other settings and the Royal College of Nursing would welcome the opportunity to work with regulatory and inspection agencies and with the Welsh Government to develop effective workforce tools for the community.

Views on the requirement of the Welsh Government to issue guidance in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which sets out the methods

which NHS organisations should use to ensure there is an appropriate level of safe staffing

24. The Royal College of Nursing welcomes the requirement on the Welsh Government to issue guidance which sets out the methods which NHS organisations should use to ensure there is an appropriate level of safe staffing. There needs to be a consistent and professional appropriate approach across Wales. Through this mechanism the Welsh Government would achieve this.

25. The Royal College of Nursing believes that Nurses must be able to meet patients fundamental care needs and efficaciously play their part in the delivery of complex treatments and therapies. The description of the potential guidance in the Bill is extremely helpful as it strikes an appropriate balance between the need of the individual nurse to use, and have respected, her professional judgment on the needs the patients, along with organisational support in the form of professionally recognised workforce planning tools and corporate accountability for patient safety.

Views on Welsh Government guidance including provision to ensure minimum ratios are not applied as upper limit?

26. The Royal College of Nursing strongly prefers to use the term 'safe'. The ratios evidenced by academics and cited by the CNO in Wales are because they are deemed as the 'safe ratio'. That is, if the ratios on the wards fall below this number, the wards themselves become unsafe and mortality and morbidity rates increase. These numbers are evidenced based.

27. However common sense and professional judgment both dictate that if the needs of patients are greater than normal then the safe number of nurses in duty will be higher. Professional standards and the nature of medicine itself can change safe practice. The Royal College of Nursing is pleased that the approach to guidance in this Bill recognises and allows for this.

28. As the committee will be aware, similar legislation has also been enacted in other parts of the world and there is no evidence of minimum becoming a maximum/standard number.

Views on Welsh Government guidance setting out process of providing information to patients on the numbers and roles of the staff on duty?

29. The Royal College of Nursing believes that this legislation will strengthen the accountability of relevant service planners and managers for the safety, quality and efficacy of their workforce planning and workforce management. We believe that Nurse Staffing information should be published at all levels of the healthcare system. This might include: placing information at ward level on notice boards for public consumption, in the LHBs annual report; during quarterly reviews between the Chief Executive of NHS Wales and in annual reports the this committee. The information for Wales/LHBs could also be placed on StatsWales for a LHB/LHB comparison.

Views on Welsh Government guidance including protections for certain activities and particular roles when staffing levels are being determined

30. The Royal College of Nursing believes that when decisions on Safe Nurse Staffing Levels are being made, some roles such as that of Ward Sister/Charge Nurse should be supernumerary. The Nurses in these roles should not be considered when determining Safe Nurse Staffing Levels because their roles provide oversight for the ward and other members of the nursing team on the ward must be able to refer to their clinical judgment when necessary. This was a clear recommendation of the Welsh Government Free to lead Free to Care strategy (2008) to improve patient care by empowering the ward sister and yet is still remains unachieved.

Student Nurses should also be considered to be supernumerary. Student Nurses are still undergoing training and should not be required to take the place of a Registered Nurse until they have completed their training and are then registered with the NMC. Including Student Nurses when workforce planning is unacceptable; puts patients at risk and places the Student Nurses in an unjust position.

Views on the requirement of the Welsh Government to consult before issuing guidance

31. The Royal College of Nursing believes this is a sensible and appropriate requirement allowing for professional organisations and other stakeholders to comment.

Views on the requirement for Welsh Minister's to review the operation and effectiveness of the Act

32. With regards to Section 3 of the Bill the Royal College of Nursing agrees that Welsh Ministers should be required to review

the operation and effectiveness of the Act once it has been enacted. The only way the effectiveness of the Act can be discovered is via a reporting mechanism and as the Welsh Ministers are responsible for the NHS in Wales this appears to be an appropriate mechanism. The first report would allow the Royal College as well as this Committee the opportunity to compare mortality rates and other indicators pre-legislation to those in the first year of the Act.

Views on the effectiveness and impact of the existing guidance

33. As mentioned above, the Royal College of Nursing believes that the All Wales Nurse Staffing Principles Guidance issued by the CNO in 2012 has failed to have the desired impact and will continue to do so. We believe that the guidance lacks the 'teeth' that legislation and statutory instruments provide. This legislation can be compared to the legislation to ban smoking in public and the ensure wearing of seatbelts in cars. In both of these cases knowledge about the benefits of not smoking and of wearing a seatbelt was widespread but the existence of legislation improved both the behaviour of individuals and that of organisations. This legislation will impact positively on public wellbeing and the patient experience.

View on balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance

34. The Royal College of Nursing feels that the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance is appropriate. By excluding specific numbers from the Primary legislation, Welsh Ministers are given the flexibility to increase the scope of the legislation, by making it applicable to more areas and to update the ratios if academic evidence shows the need for them to change. This flexibility will save time and money and ensure that Wales is able to provide the Safe Nurse Staffing that patients in Wales deserve.

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

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

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

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

Introduction.

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

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

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

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

Summary

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

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

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

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

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

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

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

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

Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27. Other unintended consequences arising from the Bill includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

xiv) The monitoring requirements set out in the Bill?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The importance of multidisciplinary teams

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

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

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

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

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

Engaging with the public

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

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

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

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

Integration

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

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

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

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

Conclusion

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

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

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

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

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

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

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

[xviii] Ibid

Eitem 4

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Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from BMA Cymru Wales – SNSL(Org) 04 / Tystiolaeth gan BMA Cymru – SNSL(Org) 04

GENERAL PRINCIPLES OF THE SAFE NURSE STAFFING LEVELS (WALES) BILL

Consultation by the National Assembly for Wales' Health and Social Care Committee

Response from BMA Cymru Wales

14 January 2015

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the consultation by the National Assembly for Wales' Health and Social Care Committee on the general principles of the Safe Nurse Staffing Levels (Wales) Bill.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE

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Y Gymdeithas Feddygol Brydeinig
British Medical Association
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BMA Cymru Wales offers the following responses to the specific questions posed by the Committee upon which we have a view:

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

In line with the comments provided in response to the two previous consultations, BMA Cymru Wales continues to express its support for the need for this legislation. The requirement for adequate staffing levels, particularly in acute hospital wards has been frequently underlined – such as in a recent study published in *The Lancet*[1] which highlighted the link between nurse staffing levels and patient outcomes, and the recent report by Professor June Andrews and Mark Butler[2] which outlined inadequacies in the care of older patients at the Princess of Wales and Neath Port Talbot Hospitals. We consider that until appropriate safeguards are implemented, such as those which would be put in place by this Bill, then local health boards in Wales will continue to deplete ward nursing establishments and run wards with unsafe nurse staffing levels.

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

We would support the provisions of the Bill in the manner they have been set out in Section 1 of the Bill as it has been introduced. However, we have some concerns as to how these provisions are then further taken forward within Section 2.

Specifically we have concerns that in securing appropriate staffing levels in adult inpatient wards in acute hospitals, the legislation as currently drafted might lead to nursing levels inadvertently being depleted in other inpatient settings such as in community hospitals.

We feel that additional safeguards may therefore need to be added in to this this legislation to ensure that a minimum nurse staffing level is delivered in all inpatient settings. This might be achieved, for instance, by requiring that there should be at least two qualified nurses present on an inpatient ward at all times – with sufficient cover from a third nurse also being provided in cases where there would otherwise only be two nurses present, in order for them to be able to take breaks.

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

We envisage that health boards might cite potential difficulties in being able to recruit sufficient nurses, including qualified nurses, and may state that they already experience difficulties in many instances in even recruiting agency nurses to fill gaps in rotas. Our members note that many nursing staff may regularly undertake additional shifts to ensure adequate staffing cover can be provided. There may, however, also have to be an acceptance from more senior nurses in managerial roles that they may at times also have to assist with direct patient care to ensure the provisions of this Bill can be fulfilled.

Are there any unintended consequences arising from the Bill?

We would reiterate our concern that requiring minimum ratios in specific defined inpatient settings could inadvertently lead to a depletion of nurse staffing levels in other inpatient settings. Amendments to the Bill may therefore be required to ensure this could not be the case.

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

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[1] L H Aitken et al (2014) *Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study.* The Lancet. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/fulltext

[2] http://wales.gov.uk/topics/health/publications/health/reports/care/?lang=en

We support this duty, subject to the concerns we have raised above being addressed regarding the need to mitigate against the possibility of inadvertent adverse impacts on nurse staffing levels in other inpatient settings. However, we would note that the key to the success of this proposed duty may be derived from any accompanying powers that may be required to ensure that it is in fact fulfilled by health boards. We would hope that a statutory duty would in itself provide greater leverage to ensure that health boards do meet such obligations in relation to providing safe nurse staffing levels, whilst noting that current non-statutory obligations are often ineffective. We would therefore seek assurance that either having a statutory duty in itself will provide sufficient incentive to ensure safe nurse staffing levels are delivered, or else that sufficient additional measures and/or sanctions are also agreed to ensure that this will be the case.

An alternative approach that some of our members have suggested, might be to empower sisters and charge nurses to close wards down in cases where they feel they have a nurse staffing level that is inadequate for them to safely care for the patients in their charge. This might be a more effective approach than simply placing the duty to comply with this legislation on health boards themselves.

The Bill could also give consideration to how individual members of staff, and not specifically just nurses, would be able to raise concerns regarding unsafe nurse staffing levels without any fear of reprisal. In our view, it is vitally important that all staff can be fully protected in raising such concerns – and indeed the system in place should ensure they are actively encouraged to do so when they perceive safe nurse staffing levels are not in place, in order to maximise the effectiveness of this legislation.

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

The view of BMA Cymru Wales is that what would be regarded as 'reasonable' may require clearer definition, as it leaves it open to interpretation what steps might be seen as reasonable and what steps might therefore be seen as unreasonable. We feel it may be preferable for this duty to instead require all 'possible' steps, as we consider this might be more likely to lead to the intentions of the Bill being delivered.

Do you have a view on the fact that, in the first instance, the duty applies to adult inpatient wards in acute hospitals only?

We would again reiterate the concerns we have already expressed that this may lead to inadvertent adverse impacts on nurse staffing levels in other inpatient settings, such as in community hospitals. The Bill may therefore require to be amended to ensure such a concern is mitigated against.

Do you have a view on the requirement for the Welsh Government to issue guidance in respect of the duty set out in section 10A(1)(b) inserted by section 2(1) of the Bill which:

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

We consider that the guidance which will be required to define what particular minimum ratios should be in place in different specific circumstances must clearly define what is meant by a safe staffing level in a way that also takes into account the provision of an appropriate skill mix (e.g. between nurses and healthcare workers) in order for this to be achieved.

This guidance should recognise that the individual needs of patients may have to be taken into account in order to determine what the appropriate minimum ratio might be in a particular situation. For instance, some patients on acute psychiatric wards may require a designated member of staff to sit with them continually. The needs of individual patients within a ward may therefore need to be taken into account

in determining what the appropriate minimum ratio might be at a specific time on a specific ward, and not just the type of ward and the number of patients currently present.

We feel it could be helpful for what is described as 'additional settings' to which the provisions of the Bill could also apply to be defined so that it is clearer what might be intended.

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

Whilst we accept this might happen in circumstances where there is insufficient funding available, or where there are particular challenges in recruiting nursing staff, we also believe that the benefits of such a requirement in preventing wards from being run with unsafe nurse staffing levels would significantly outweigh the disadvantages of this potentially being the case.

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

We consider this is important if we want to ensure that excellent care is delivered to patients by motivated staff.

Do you have a view on the requirement for each health service body to publish an annual report?

This would appear to us to be an appropriate requirement. We would suggest that an appropriate standardised format is developed for these annual reports which also includes explicit requirements to provide detailed information concerning breaches of the provisions of this Bill, as well as of any action plans being implemented to prevent such breaches from reoccurring.

Do you have a view on the requirement for Welsh Ministers to review the operation and effectiveness of the Act as set out in section 3?

We support this requirement. Whilst it would be hoped that this legislation would be effective in achieving its aims from the date of its implementation, it would seem only sensible to include a provision for Welsh Ministers to subsequently review its operation and effectiveness in the way that has been outlined.

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

In the experience of our members, current guidance does not appear to have had a noticeable effect in preventing what they would perceive as unsafe nurse staffing levels. As such, we would reiterate our support for this Bill.

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol
Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Royal College of Physicians - SNSL(Org) 02 / Tystiolaeth gan Coleg Brenhinol y Meddygon - SNSL(Org) 02

Written evidence: Safe Nurse Staffing Levels (Wales) Bill

RCP (Wales) written evidence

Key points

- This Bill must be properly enforced to ensure 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 from this Bill must be published in a transparent and accountable way to inform future service improvement.

For more information, please contact:

Lowri Jackson
Senior policy and public affairs adviser for Wales

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Regus House, Falcon Drive
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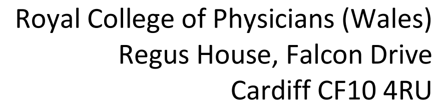

www.rcplondon.ac.uk/wales

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Health and Social Care Committee
National Assembly for Wales
Cardiff CF99 1NA

SeneddHealth@Assembly.Wales

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
Dr Alan Rees MD FRCP

From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP

08 January 2015

Dear colleague,

Thank you for the opportunity to respond to your consultation on the general principles of the Safe Nurse Staffing Levels (Wales) Bill.

About us

The Royal College of Physicians (Wales) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in Wales and across the world with education, training and support throughout their careers. As an independent body representing 30,000 fellows and members worldwide, including 800 in Wales, we advise and work with government, the public, patients and other professions to improve health and healthcare.

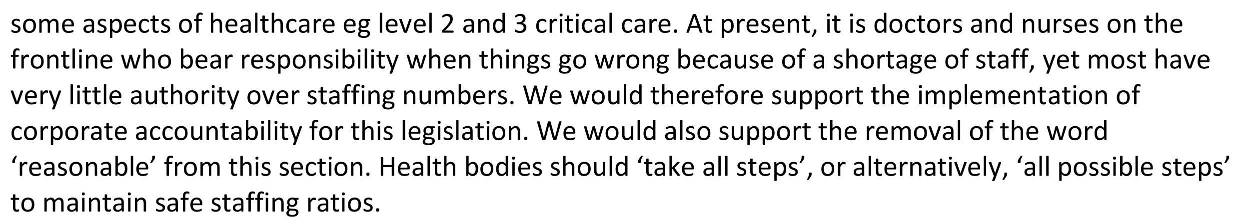
Our response

The Royal College of Physicians (RCP) strongly welcomes this Bill and its multi-disciplinary approach. The Bill and related guidance should consider a range of factors to ensure that staffing levels adapt to meet local need, including staff competencies, staff behaviours, patient load, relative and carer need, and sudden changes in workload. Patients should be fully involved in monitoring and evaluating this work. We welcome the stated purpose of this Bill, that is, that nurses should be deployed in sufficient numbers to enable the provision of safe nursing care to patients at all times; improve working conditions for nursing and other staff; and strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Below we have pulled out a number of specific areas for comment.

National Health Service (Wales) Act 2006, Section 10A (1) (a) and (b)
'Each health service body in Wales must in exercising its functions—
(a) have regard to the importance of ensuring that registered nurses are deployed in sufficient numbers to enable the provision of safe nursing care, allowing time to care for patients sensitively, efficiently and effectively; and (b) take all reasonable steps to maintain minimum registered nurse : patient ratios and minimum registered nurse : healthcare support workers ratios in adult inpatient wards in acute hospitals (in accordance with guidance under this section)'

In order to make any kind of impact, this Bill must be enforced. We would welcome more detail on how this is to be achieved. For example, hospitals could be required to shut beds without the required number of nursing staff present. This would be a drastic, but effective move, and it already happens in



some aspects of healthcare eg level 2 and 3 critical care. At present, it is doctors and nurses on the frontline who bear responsibility when things go wrong because of a shortage of staff, yet most have very little authority over staffing numbers. We would therefore support the implementation of corporate accountability for this legislation. We would also support the removal of the word 'reasonable' from this section. Health bodies should 'take all steps', or alternatively, 'all possible steps' to maintain safe staffing ratios.

National Health Service (Wales) Act 2006, Section 10A (3)
'The Welsh Ministers may by regulations make provision for the duty under subsection (1)(b) to extend to additional settings within the National Health Service in Wales.'
We strongly support this provision.

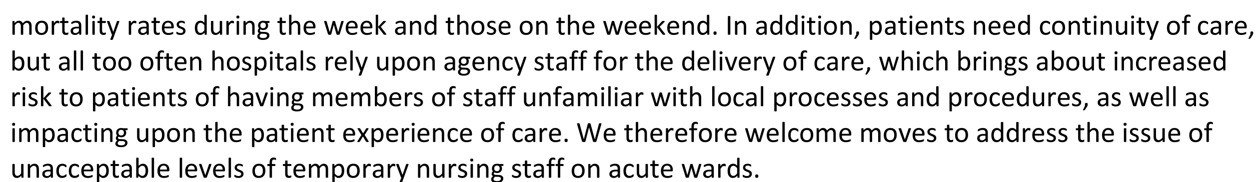
National Health Service (Wales) Act 2006, Section 10A (5) (a)
'The guidance must specify methods by which health service bodies may comply with the duty'
Changes in the acuity of patients can have a major impact on nursing resources. For example, patients in level one care can experience a deterioration in their condition which would require more intensive monitoring until the patient has stabilised. We would support the use of a 'red flag' system when assessing whether available nursing staff meet patients' nursing needs over a 24-hour period. The nurse in charge should be aware of all situations of risk on the ward and they should be able to decide whether additional nursing staff need to be allocated. For example, when nutritional assessments are carried out, there should always be subsequent weighing of the patient or appropriate diet ordered. The RCP would urge those drafting guidance to consider this aspect of nurse staffing levels very carefully. We are keen to be involved in developing these tools as this work progresses.

National Health Service (Wales) Act 2006, Section 10A (5) (f)
'The guidance must be designed to ensure that the requirements of the duty are met on a shift-by-shift basis.'
We strongly support this provision.

National Health Service (Wales) Act 2006, Section 10A (5) (g)
'The guidance must include provision about the publication to patients, to the extent that Welsh Ministers consider it appropriate, of the numbers, roles and responsibilities of nursing staff on duty'
We are not convinced that the current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales are adequate and appropriate, or that this data is always strictly accurate. We strongly support making both medical and nursing staffing data publicly available and easily accessible, and displaying information about staffing numbers in every ward.

National Health Service (Wales) Act 2006, Section 10A (7) (a)
'The protections mentioned in subsection (5)(h) are protections for the supernumerary status of student staff and persons performing supervisory functions (such as Ward Sister or Charge Nurse)'
We support this. However, the guidance must ensure that all protected roles must maintain and develop their clinical skills. We need to ensure that this senior expertise is not lost from the clinical area.

Safe Nurse Staffing Levels (Wales) Act 2014, Section 3 (5)
'The Welsh Ministers must publish a report of the results of each review which gives details of the impact of this Act'
We are very supportive of this provision. We will be especially interested in finding out more about the impact of this legislation on mortality rates and overtime and sickness levels. The RCP is very supportive of the move towards a seven day service, believing that patients deserve the same high quality care in the evening and weekends as they receive during the week. We certainly see it as a priority to introduce a seven day service for acute and emergency care as we recognise that there is a discrepancy between



mortality rates during the week and those on the weekend. In addition, patients need continuity of care, but all too often hospitals rely upon agency staff for the delivery of care, which brings about increased risk to patients of having members of staff unfamiliar with local processes and procedures, as well as impacting upon the patient experience of care. We therefore welcome moves to address the issue of unacceptable levels of temporary nursing staff on acute wards.

The RCP would also like to highlight the following areas of work to the Committee:

Future Hospital Programme
In September 2013, the Royal College of Physicians (RCP) launched the Future Hospital Commission report, *Caring for medical patients*.[1] This 214 page report focuses on the care of acutely ill medical patients, the organisation of medical services, and the role of physicians and trainees across the medical specialties in England and Wales. The model of care proposed is underpinned by the principle that hospitals must be designed around the needs of patients. The Future Hospital Programme (FHP) is now an agreed 2014-2017 organisational priority for the RCP. The purpose of this pan-college project is to develop and implement the RCP's vision for the future of medical care across hospital and community settings. In Wales, this work is being led by our vice president, Dr Alan Rees, a senior consultant physician with an interest in diabetes and endocrinology.

A growing medical workforce crisis
During the Future Hospital Commission, the RCP found increasing evidence to suggest that both trainee doctors and senior hospital doctors are struggling to cope with the increased demands being placed on the health service. A 2013 GMC study[2] found that a reduction in trainee doctors' hours enforced by the New Deal and the European Working Time Directive (EWTD) has increased the tension in an already over-stretched workforce. Later in 2013, the RCP published a short paper about the medical workforce crisis, *Fit for the future*[3], alongside a longer research document, *The medical registrar: empowering the unsung heroes of patient care*.[4] This report found that medical registrars are facing increasing challenges in their delivery of patient care in NHS hospitals.

Teams without walls
The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry[5] (the 'Francis report') makes stark reading, and it shows that if hospital teams are poorly staffed and/or managed, patient care can suffer with tragic results. Other recent reports, including the *Trusted to care* review[6] into standards of care at Abertawe Bro Morgannwg University Health Board, have highlighted issues of excessive mortality, poor care and the levels of nursing staff – these reports are of great concern to the RCP. Effective patient care can only be delivered by effective teams of doctors, nurses and other allied health professionals working together. This is why we firmly believe that these problems need to be seen as part of a bigger picture of failing holistic care.

The current crisis in hospital care is an impetus to rethink how non-medical professionals work to support medically trained staff. Close collaboration between all professional groups will be needed to reduce the problems seen recently. In 2008, the RCP published *Teams without walls*[7], which outlined an integrated model of care, where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local

[1] http://www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf
[2] http://www.gmc-uk.org/news/14414.asp
[3] http://www.rcplondon.ac.uk/projects/hospital-workforce-fit-future
[4] http://www.rcplondon.ac.uk/sites/default/files/future-medical-registrar_1.pdf
[5] http://www.midstaffspublicinquiry.com/
[6] http://wales.gov.uk/docs/dhss/publications/140512trustedtocareen.pdf
[7] https://www.rcplondon.ac.uk/sites/default/files/teams-without-walls-1_0.pdf

clinicians. The RCP believes that an urgent rethink is required about the provision of hospital care for acutely unwell medical patients to allow safe, high-quality care of patients.

Seven day working
The RCP is very supportive of the move towards a seven day service, believing that patients deserve the same high quality care in the evening and weekends as they receive during the week. We certainly see it as a priority to introduce a seven day service for acute and emergency care. However, we have warned that this will probably require extra resources. It is also key that support and diagnostic services operate over seven days to facilitate transfer out of the hospital setting, which will probably mean more investment in integrated health and social care. It is our hope that reconfiguration of the health service in Wales will enable rotas to be established to provide a seven day service (that is, five day working over a seven day week).

The balance between providing specialist and general care
The RCP believes that the entire hospital workforce must be reorganised to better meet the needs of frail elderly patients. The balance between specialist and generalist skills must be considered. This will still be necessary even if there is a considerable shift from hospital care to community care for older people. The Bill should address the need for a continuous presence of a member of the team, although this does not *always* have to be a registered nurse, as this will depend on the condition of the patient. For example, many patients present to acute medical units with cognitive impairment arising from dementia. Healthcare assistants are able to sit with them if their condition is relatively stable, but should their condition fluctuate then a registered nurse should be able to take over.

Other relevant material
National Institute for Health and Care Excellence (NICE) guidelines are available on safe staffing for nursing in adult inpatient wards in acute hospitals[8] as well as a toolkit for safe staffing[9] and an overview pathway[10]. NICE is also development safe staffing guidelines on a number of other areas in the NHS[11]. We would urge the Committee to consider these evidence-based tools as part of their scrutiny.

For more information
If you have any questions, please contact our colleague, Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted] or on [redacted].

With best wishes,

Dr Alan Rees
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

8 http://www.nice.org.uk/guidance/SG1
9 http://www.nice.org.uk/news/press-and-media/first-toolkit-endorsed-by-nice-for-safe-staffing
10 http://pathways.nice.org.uk/pathways/safe-staffing-for-nursing-in-adult-inpatient-wards-in-acute-hospitals
11 http://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/nice-safe-staffing-guidelines

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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 Chartered Society of Physiotherapy – SNSL(Org) 01 / Tystiolaeth gan Cymdeithas Siartredig Ffisiotherapi – SNSL(Org) 01

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Health and Social Care Committee
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Dear Committee Members

Re: Safe Nurse Staffing Levels (Wales) Bill – Briefing from the CSP to inform scrutiny of the member in charge of the Bill

Introduction

The Chartered Society of Physiotherapy (CSP) welcomes the opportunity to provide a briefing to inform the scrutiny of the member in charge of the Bill. The profession will also be providing a further written contribution in response to the committee's terms of reference.

As highlighted in our response to the member in charge of the Bill, the CSP and our members are wholly committed to supporting the drive to improve the quality of care and outcomes for patients, and understand the spirit of the proposed Bill. However, we cannot support an approach to legislation that does not address staffing in a multidisciplinary way, does not focus on quality outcomes for patients, and risks a focus on numbers of nurses in isolation from the plethora of other factors that impact on patient outcomes and benefit.

Comments from the CSP

1. The CSP notes that the Bill seeks to address the issue of 'minimum' staffing levels and has been renamed the 'Safe' Nurse Staffing Levels (Wales) Bill. Also, that the Bill includes specific provision that any ratio is upwardly

adjustable and must not be used as an upper limit by the health service body to which such a ratio applies. However, the profession considers that ambiguity still remains around the intended meaning of 'safe', with this exacerbating the risk that the legislation will be misinterpreted and misapplied.

This is heightened by the interchangeable use of both words within the Bill. 'Safe' and 'minimum' are used without clarity of intention. Safe is used as the heading for Section 2 and is used at Section 2- insert Section 10a sub-section (1) paragraph (a). Minimum is used at Section 2 – insert Section 10A sub-section (1) paragraph (b), while Section 2 - insert Section 10A sub-section (5) paragraphs (b), (c) and (e) all refer to 'minimum ratios'. This latter term also leads to concern that a specific patient : nurse staff ratio will be defined, or be presumed to exist that can be applied to different patient care/service delivery contexts, regardless of variables relating to patient acuity, environment and wider staffing issues (including those relating to skill mix and the multi-disciplinary team).

2. The Society remains concerned that a 'minimum' staffing level does not necessarily mean a 'safe' staffing level. As there is no guarantee that implementing a set level of staffing achieves the delivery of safe care, there is a risk of the Bill misleading the public and failing to support a cohesive approach to staffing levels across services in ways that will contribute to safe and effective patient care. The CSP considers that any guidance from the Welsh Ministers should be fully transparent about the evidence-base for the positive correlation between staffing levels and quality of patient care.

3. The Society notes in the explanatory memorandum the assertion that the ratios should be maintained in adult in-patient wards in acute hospitals as this is where the majority of evidence exists. The profession wishes to reference very recent work undertaken by National Institute for Health and Care Excellence whose extensive review of the literature highlighted an explicit lack of evidence relating to nurse staffing levels linked to patient outcomes. (Detail in sections 2 and 3, document accessible via; http://www.nice.org.uk/Guidance/SG1)

   The Society is also concerned about the transferability of the limited observational studies that exist from outside of the UK to requirements for Wales.

   The CSP continues to question how it can be possible to provide an over-arching minimum staffing level when the level of care required by individuals or groups of patients (e.g. within a particular patient group, stage of a care pathway, or a care environment) may vary from hour to hour, day to day or from week to week. The intended longer-term of the legislation in terms of the patient care settings to which it should apply is also unclear, with it only being indicated in Section 2 – insert Section 10A sub-section (1) paragraph (b) that it is intended to relate specifically to staffing levels in adult inpatient wards in acute hospitals.

   Recognising the absence of robust evidence, the profession is further concerned about the suggestion of wider application of the minimum ratios to

other settings and circumstances. It is essential that consideration of staffing levels in any area of service delivery takes account of the multiple variables that impact on quality of patient care and outcomes. These variables relate to the three broad areas of patient acuity, service environment, and staffing factors (including those pertaining to skill mix and the integrated contributions of the multi-disciplinary team).

In addition, there is no reference to staffing levels that can help to ensure effective quality of care for patients. Wrapped up in the term 'effective', the profession would see care that is delivered with compassion, in partnership with patients to ensure that it is delivered in line with their individual needs and preferences, based on the best available evidence, and with due consideration to optimising outcomes for patients and optimising use of resources. This will include consideration of how staffing levels and configurations across the multi-disciplinary team can reduce individuals' need for hospital admission, their length of stay, and re-admission.

4. The CSP notes from the explanatory memorandum that the Bill seeks to address the risk that the legislation will have the consequence of service providers diverting resources from other areas and staffing groups in order to comply with mandated nurse staffing levels. However, given that section 2 – insert Section 10A sub-section (1) paragraph (a) relates only to nursing, the CSP considers there is still the risk that reductions will be made to staffing in other groups (such as Allied Health Professions (AHPs)), or that some services to patients will be terminated to meet the new, legally enforced nurse staffing levels requirements. The profession therefore remain strongly concerned that the legislation would have a perverse impact. The negative implications of the legislation could well be to reduce the safety, quality and effectiveness of care; lessen patient access to services that will have long-term benefits for their health and well-being; and compromise the delivery of cost-effective, affordable services in response to changing population and patient needs.

   The CSP is convinced that the need for patients to have services that are 'safe' and 'effective' requires 'appropriate' levels of staffing across the whole workforce including medical, nursing, AHPs such as physiotherapy and others. Staffing levels of the other staff groups do impact on high quality patient care. Addressing staffing needs within one profession is therefore insufficient for safeguarding and optimising the effectiveness of care for patients in totality.

5. The CSP notes in Section 2 – insert Section 10A sub-section (6) paragraph (a) a reference to the use of validated workforce planning tools, which are capable of being applied to calculations by reference to individual nursing shifts. We would urge that a focus on nurse input and tasks risks compromising the required focus on patient outcomes and benefit. Furthermore, we are aware that the recent NICE work on safe staffing in acute wards in acute hospitals failed to identify robust evidence on the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix. The value of this requirement within the Bill is therefore questionable.

6. We would also urge that an appropriate distinction in terminology is achieved between use of staffing level ratios and workforce planning activities, when these obviously reflect different aspects of services in terms of resourcing, design and delivery. The use of terms interchangeably is likely to cause confusion.

7. The CSP notes in section 2 – insert Section 10A sub section (6) paragraph (c) a reference to provision for the required nursing skill mix needed to reflect patient care needs and local circumstances. Greater clarity and definition is needed on what constitutes 'local circumstances' and a greater emphasis on ensuring that expectations reflect the significance of local factors relating to patient acuity, service environment and wider staffing issues.

8. The CSP welcomes, in section 2 – insert Section 10A sub-section (7) paragraph (c) the reference to time to undertake or participate in continuing professional development, including mentorship and supervision roles. However, once again, the CSP highlights that it is essential that these needs are recognised across the whole workforce, including for AHPs and support workers, with the risks of a focus on nurse staffing requirements mitigated.

9. The "range of matters" in section 3 sub-section (5) paragraphs (a) to (i) are noted to primarily relate to failures of care rather than positive aspects of quality of care and patient outcomes and as previously highlighted the evidence base for monitoring and reporting such elements requires further consideration.

Concluding comments

In conclusion, whilst supporting attention to enhance the quality of care and outcomes for patients, the CSP considers a more rounded and multi-factorial method is necessary to achieve safe and effective care delivered by appropriate staffing. The Society continues to hold the view that a number or ratio is not an indicator of good quality care delivered with compassion.

The profession is content for this evidence to be made available publicly.

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 52,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self-management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

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 Chartered Society of Physiotherapy – SNSL(Org) 07 / Tystiolaeth gan Cymdeithas Siartredig Ffisiotherapi – SNSL(Org) 07

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Health and Social Care Committee
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9th of January 2015

Dear Committee Members

Re: Safe Nurse Staffing Levels (Wales) Bill – Written Evidence from the Chartered Society of Physiotherapy

Introduction

The Chartered Society of Physiotherapy (CSP) welcomes the opportunity to provide written evidence to the committee. As far as possible we have attempted to answer the questions the committee has posed.

As highlighted in our response to the member in charge of the Bill, the CSP and our members are wholly committed to supporting the drive to improve the quality of care and outcomes for patients, and understand the spirit of the proposed Bill. However, we cannot support an approach to legislation that does not address staffing in a multidisciplinary way, does not focus on quality outcomes for patients, and risks a focus on numbers of nurses in isolation from the plethora of other factors that impact on patient outcomes and benefit.

Response to the consultation questions

1. General

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

The Chartered Society of Physiotherapy (CSP) is highly committed to ensuring the delivery of high-quality patient care and supporting, leading and contributing to initiatives focused on improving service delivery and ensuring patients receive safe, compassionate, person-centred care that is accessible, timely and effective. Delivery of care has to respond to the needs of an ageing population and increasing numbers of patients with long-term and multiple conditions, while achieving a stronger shift to health promotion, illness prevention and patient self-management. This commitment underpins our feedback to this consultation. All our points should therefore be seen and taken within this context.

In terms of proposed legislation on nurse staffing levels, we are concerned that this is not a solution to ensuring the delivery of high-quality, compassionate care and that it will not achieve its intended aims. We have concerns for a number of reasons (which we expand on in our response to subsequent questions). These are broadly as follows:

- The legislation risks diverting attention away from achieving quality of outcomes for patients (including long-term benefits, the fulfilment of personal treatment goals, and the promotion of self-management) and focusing narrowly on specific service input and delivery issues (rather than on initiatives designed to achieve service improvements within a context of financial constraint)
- It risks nurse staffing numbers becoming a focus that is addressed in isolation from the many other factors that affect quality outcomes and experience for patients (relating to broader factors to do with staffing – including skill mix and the contribution of the whole multi-disciplinary team; patient need, including in relation to acuity and dependency; and service delivery models, context and improvements)
- It risks creating unintended consequences that will impact negatively on the quality of patient care, thereby having the opposite effect from its intended purpose (please see our response to 1.4).

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

As indicated above, we have concerns about whether the proposed legislation and the proposed provisions within the Bill can form an effective way of achieving their

intended purpose. In line with our response to 1.1, our concerns centre on the following:

- The lack of the provisions' focus on the quality of patient experience and outcomes
- Confusion in the definition and use of terminology within the draft legislation, which creates ambiguity in its intended meaning and raises questions about how it is likely to be interpreted and implemented (for example, 'safe', 'sufficient' and 'minimum' are all used as descriptors in relation to staffing levels, apparently inter-changeably and without clarity on their intended distinctions)
- The practicalities of Government Ministers producing guidance on the detail of the legislation's implementation (including in ways that are sensitive to factors relating to patient need, staffing and service delivery context and that can be sufficiently premised on available evidence and established tools and resources; (see http://www.nice.org.uk/guidance/sg1/chapter/3-gaps-in-the-evidence)
- The risks and likely unintended consequences of the legislation, including through its focus on one type of setting for the delivery of care to one (if broad) group of patients and the planned formulation and potential uniform application of a minimum recommended nurse: patient ratio that would apply regardless of patient dependency and need.

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

In line with our response above, we see the following as potential barriers to the effective implementation of the legislation and its achieving its intended aims and purpose:

- Lack of clarity about the intended focus of the provisions; in particular, this relates to our points about ambiguities in the terminology used and an apparent conflation of issues and approaches to staffing levels as being the same as those to do with workforce planning

- Significant questions about the practicalities of implementing the provisions, including due to the conflation of issues and the assumptions that underpin them; for example, it is misplaced to assume that recommended minimum staffing levels would necessarily reduce a reliance on temporary and agency nursing staff

- The unintended consequences of the provisions that could detract from achieving their intended purpose, including through undermining the overall quality and outcomes of patient care; in particular, this could arise through the legislation leading to a depletion of staffing resource and capacity among the professions,

staff groups, patient groups and care delivery settings that are not covered by the proposed legislation - aside from undermining quality of care and service improvements, this could have a negative impact on the working conditions of other staff groups, when one of the express purposes of the proposed legislation is to improve working conditions for nurses.

1.4 Are there any unintended consequences arising from the Bill?

As indicated elsewhere, we see a range of unintended consequences arising from the Bill. These include the legislation producing the following risks and issues:

- Its creating a narrow focus on numbers of staff within nursing (registered and non-registered) to the detriment of looking at all the factors that contribute to ensuring patient safety through the delivery of timely, high-quality care
- Its leading to a diversion of resources to ensure the fulfilment of minimum patient: nursing staff ratios at the expense of sufficient, safe and effective staff resourcing within other service delivery areas and within other staff groups (and not necessarily in ways that would ensure sustainable service delivery models or adherence to good employment practice)
- Related to the above, its conferring a pre-eminence to ensuring time and support are factored into nursing capacity and resources for clinical leadership, continuing professional development (CPD) and student supervision when these elements are equally important for sustainable, high-quality care across all staff groups
- Its creating a distracting, bureaucratic focus on fulfilling and demonstrating fulfilment of minimum requirements at the expense of ensuring a focus on achieving and maintaining high-quality care, experience and outcomes for all patients (across all population and patient groups and all service delivery settings)
- Its leading to a focus on and adherence to a minimum nurse:patient ratio, regardless of assertions that this is not the intention.

2 <u>Provisions in the Bill</u>

What is the CSP's view on:

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

The CSP believes that health service bodies should be accountable to the Welsh Government for ensuring safe and effective staffing across all staff groups. How this accountability is implemented needs careful consideration. We question the value and appropriateness of a prescriptive, legislative approach to one staff group that encourages a focus on nurse:patient ratios in isolation from all the other factors affecting the quality of patient care. This risks forming a distraction from enacting a meaningful approach to strengthened accountability. We believe that there are other ways of achieving this that take a genuinely holistic approach, are appropriately inclusive of all factors and variables, and encourage a focus on outcomes for patients.

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

There would need to be detail and definition as to what is considered to be 'all reasonable steps'. A process would be needed to develop guidance on what those reasonable steps should be, with detailed consideration given to the development of appropriate mechanisms for organisations to use to demonstrate compliance with the legislation. Protocols and clear arrangements would also need to be in place to track, monitor and deal with failures to meet the duties under the legislation (as highlighted in our answer to 2.6).

In line with our broader concerns, we have reservations about the value of processes that would need to be in place and the risks that these would detract from broader initiatives to improve services and optimise the quality of patient care (including face-to-face contacts with patients).

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

As indicated above, we have concerns about the proposal that the legislation will only apply to adult in-patient wards in acute hospitals. While we have fundamental concerns about legislating for safe staffing levels as an approach, we have specific concerns that this limitation will have unintended consequences in terms of impacting negatively on staffing levels for other patient groups, in other care settings and for other staff groups through resources being diverted to meet legislative requirements for this specific care environment and this specific staff group.
The ultimate result of the legislation could therefore be that the overall quality of patient care, experience and outcomes will be reduced as a result, in direct opposition to its intended purpose.

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

- **Sets out methods which NHS organisations should use to ensure there is an appropriate levels of nursing staffing (including methods set out in section !0A(6) inserted by section 2(1) of the Bill?**
- **Includes provision to ensure that the minimum ratios are not applied as an upper limit?**
- **Sets out a process for the publication to patients of information on the numbers and roles of nursing staff on duty?**
- **Includes protections for certain activities and particular roles when staffing levels are being determined?**

We have concerns about the planned requirement for the Welsh Government to issue guidance. This is for a range of reasons, in line with the points we raise above, centred on the following:

- We question the appropriateness and feasibility of the Welsh Government mandating specific methods and implementation of the legislation to the level of detail implied

- We question the extent of the resources, tools and evidence on which the Welsh Government could draw to produce such detailed guidance (see http://www.nice.org.uk/guidance/sg1/chapter/3-gaps-in-the-evidence)

- We are concerned that the current ambiguities in the draft legislation create risks for how detailed guidance could be produced in a meaningful way

- We are concerned about the appropriateness and feasibility of producing guidance that risks increasing prescription on issues that require a sensitivity to a wide range of local variables and factors (to do with patient need, staffing and service environment)

- We are concerned about the unintended consequences of producing detailed guidance in this way; for example, a particular focus on protecting 'certain activities and particular roles' would risk other activities and roles that sit outside the planned legislation being unprotected, with depletion in resourcing occurring as a result – in turn, this would be likely to impact negatively on patients' quality of care, experience and outcomes.

2.5 The requirement for Welsh Ministers to consult before issuing guidance?

For all the reasons outlined, we would see it as imperative that Welsh Ministers would consult before issuing guidance. This consultation process should be wide-ranging and inclusive, ensuring a full and robust scrutiny of the potential implications, risks and unintended consequences of the guidance and its potential interpretation and implementation.

2.6 The monitoring requirements set out in the Bill?

We would see the development of a process for comprehensive monitoring as an important component. Clear guidance would be required from the Welsh Government and monitoring may well require gaining data that is not collected currently. This would need to be considered and identified within costing for implementing the Bill.

We would want to be assured that the monitoring process was wide enough in its focus to consider and evaluate issues impacting on the quality of patients' experience and outcomes, as well as effective and efficient service delivery (including in relation to hospital admissions, readmissions and discharge; increased attendance at A&E departments; delays in the formulation of care packages for patients at home; and impact on social service costs). As part of this, the process should also capture information on issues affecting other professions and staff groups, not just nursing. This would be essential for ensuring that due account is taken of the kinds of unintended consequences identified elsewhere in our response.

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

We would see the production of regular reviews of the adherence and impact of the planned legislation as an important component. However, we would be concerned that annual reporting requirements achieved a balance in the following areas:

- Were sufficiently streamlined to avoid creating an unnecessary and counter-productive administrative burden on service providers
- Were sufficiently inclusive and wide-ranging to ensure a focus on the quality of patient care, experience and outcomes, including the potential for the legislation to have unintended consequences (for example, a negative impact on patient care, a diversion of staffing resource, and a depletion of capacity from other areas of care and service delivery in order to ensure legislative requirements can be met)
- Were sufficiently searching in terms of evaluative feedback on the challenges of implementing the legislation and its real value and impact in fulfilling its intended purpose.

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

We would see the requirement for review by Welsh Ministers of the operation and effectiveness of the Act as an important component. However, we would want to ensure that the Welsh Government also addresses the potential for the legislation to have unintended consequences. It would be important that full consideration was given to the relevance of factors and variables across different services, and the significance of these for the effectiveness of the Act. Indicators of success should also include a focus on the positive aspects of quality care and patient outcomes, and not just the prevalence of the negative measures identified in the legislation that point to failures in care.

3 Impact of existing guidance

Guidance exists in England and Wales that aims to ensure safe staffing levels. This includes the 'All Wales Nurse Staffing Principles Guidance' issued by the Chief Nursing Officer in 2012 and the 2014 NICE safe staffing guidelines for 'Adult in-patient wards in acute hospitals in England.

3.1 Does the CSP have a view on the effectiveness and impact of the existing guidance?

The CSP considers that the 'All Wales Nurse Staffing Principles Guidance' issued by the Chief Nursing Officer in 2012 has been an important tool within the NHS in Wales, but notes that adherence to its recommendation has not appeared within tier 1 of the NHS performance management framework. Rather than resorting to the use of legislation, work is required to determine the reasons why the guidance has not been adhered to in the ways intended. It would also be helpful for NHS Wales to consider safe, effective and appropriate staffing across the whole workforce to ensure quality outcomes for patients.

4 Powers to make subordinate legislation and guidance

The Bill contains one provision which enables subordinate legislation to be made (section 10A(3) inserted by section 2(1)). This provision would confer powers on Welsh Ministers to amend the settings to which minimum staffing ratios will apply to extend it to settings other than adult inpatients wards in acute hospitals.

4.1 Does the CSP have a view on the balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

We have concerns about the proposed legislation being premised on one health care setting, with the prospect of detail and the future coverage of other areas being progressed through subordinate legislation and guidance. These are linked strongly

to our concerns about how the legislation is framed, including its narrow focus and current ambiguities in terminology.

5 Financial implications

5.1 Does the CSP have a view on the financial implications of the Bill as set out in part 2 of the Explanatory Memorandum?

We have concerns that the consideration of the financial implications of the Bill does not take sufficient account of the unintended consequences of its implementation. In particular, we have concerns that a focus on nurse staffing levels for one health care setting/patient group will lead to resources being diverted away from other staff groups and patient needs/service delivery areas in order that compliance with legislative requirements is affordable.

Aside from compromising the quality of patient care and working conditions, this risks a false impression being gained of the Bill's financial implications. It also risks decisions being made about how resources are deployed that are not necessarily in line with patients' best interests, optimising the scope for innovations in service design and delivery, or managing the development and provision of affordable services within a context of financial constraint.

6 Other comments

6.1 Does the CSP have any other comments to make about the Bill or specific sections within it?

We are currently undertaking project work, funded by the CSP Charitable Trust, to develop a robust approach to formulating safe and effective staffing levels (SESL) for UK physiotherapy. The profession is fully committed to being part of the solution to assure the safety, experience and quality outcomes for service users across the health and social care landscape.

The approach in development will have applicability across the UK, taking account of each country's health and social care structures and policies, and aims to reflect the breadth of specialisms/patient pathways, settings, sectors and service delivery models in and through which physiotherapy is provided.

The project outputs will be an online tool with supporting guidance. The approach will be founded on the available evidence base and will be focused on achieving and upholding high-quality compassionate care for patients within affordable service delivery models.

Through our SESL project, we are seeking to achieve the following outcomes:

- Strengthened support to our members in identifying and articulating the physiotherapy staffing resources required to deliver a particular service to uphold and enhance the quality of patient care, while demonstrating cost-effectiveness
- An evidence-based approach to formulating and articulating SESL, grounded in available research literature and current and projected policy (across the UK)
- An approach that upholds and enhances quality in patient care, both in terms of patient experience and outcomes and achieving short- and long-term benefits
- A strengthened CSP contribution to national policy-making and implementation on a key issue relating to the quality of patient care and service design and delivery within increasingly constrained resources and rising expectation.

Concluding comments

In conclusion, whilst supporting attention to enhance the quality of care and outcomes for patients, the CSP considers a more rounded and multi-factorial method is necessary to achieve safe and effective care delivered by appropriate staffing. The Society continues to hold the view that a number or ratio is not an indicator of good quality care delivered with compassion.

The CSP is content for this evidence to be made available publicly.

Submitted by:

Dr Sally Gosling – Assistant Director of Practice and Development at the Chartered Society of Physiotherapy

Philippa Ford MBE MCSP – Public Affairs and Policy Manager for the Chartered Society of Physiotherapy in Wales

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 52,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self-management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving

scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Royal College of Speech and Language Therapists – SNSL(Org) 13 / Tystiolaeth gan Coleg Brenhinol y Therapyddion Iaith a Lleferydd – SNSL(Org) 13

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Health and Social Care Committee,
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21st January, 2015

Dear Committee Member

Safe Nurse Staffing Levels (Wales) Bill – Written Evidence from the Royal College of Speech and Language Therapists

The Royal College of Speech and Language Therapists (RCSLT) welcomes the opportunity to provide written evidence to the Health and Social Care Committee on the above Bill. In providing evidence, we wish to reiterate our commitment to provide the highest standards of patient care and to the best outcomes for patients. However, we are firmly of the view that this can only be achieved through a holistic, multi-disciplinary approach based on the individual needs of the patient. We are also concerned that if resources are diverted to increase nurse staffing levels following legislation then this may have a detrimental impact on other essential services.

We also question whether legislation for minimum nurse staffing levels will hinder or enhance the Welsh Government's Prudent Healthcare Policy for Wales. Prudent Healthcare has not yet had sufficient time to become properly embedded in the delivery of healthcare in Wales and is likely to have an impact, not only on staffing levels, but also on the development of a more diverse workforce and mix of skills required in the future. We are of the view that the proposed legislation

will fetter the ability of NHS Health Boards and Trusts to respond to the Prudent Healthcare principles – particularly in terms of workforce planning, promoting equity and co-production.

For these reasons we do not support a legislative approach that is entirely focused on nurse staffing levels.

<u>Response to consultation questions</u>

1. **<u>General</u>**

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

We are committed to ensuring the highest quality patient care based on a person-centred approach that is safe, compassionate and effective. We are firmly of the view that delivering the best outcomes for patients can best be achieved through a multi-disciplinary approach based on the needs of the patient. Legislation for mandatory staffing levels will not guarantee patient care.

We are concerned that a focus on nurse staffing levels in isolation risks overlooking other important factors that affect outcomes and experience for patients.

1.2 Are the provisions in the Bill the best way to achieve the Bill's overall purpose (as set out in section 1 of the Bill?)

We have concerns over clarity in terms of terminology used. For example, the Bill states that nurses should be deployed in '*sufficient numbers*', to enable '*safe nursing care'*. However, it is unclear as to what '*sufficient numbers'* or what *'safe nursing care'* should be in relation to staffing levels.

We support the view of the NHS Nurse Director in Wales that there needs to be clear professional judgement to ensure that flexibility in staffing remains a critical part of meeting patient needs. In the wake of the Francis Report, there is already an assessment process to determine staffing levels on wards based on the severity of patients' conditions rather than on patient numbers.

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

The focus of the Bill is on nurse staffing levels but does not address wider workforce planning issues. We believe that nurse staffing levels should be planned as part of wider workforce planning for a healthcare system that is designed to meet the needs of its service users and is responsive to the major demographic changes and challenges it faces over the coming years - particularly the challenge of an ageing population and high rates of chronic conditions. We do not believe that minimum nurse staffing levels will be sufficient to meet those challenges if planned in isolation.

1.4 Are there any unintended consequences arising from the Bill?

Yes. We believe there are a number of unintended consequences.

- There are many factors contributing to patient safety and high quality care which may be overlooked if the focus is solely on nurse staffing levels;
- Diverting resources to meet minimum nurse staffing levels could mean the diversion of resources away from other essential services which would impact on patient outcomes;
- There is likely to be increased bureaucracy as hospitals and services will have to demonstrate that they are compliant with minimum nurse staffing levels;
- Legislation may limit the ability of NHS hospitals and services to plan care in a way that best meets the needs and demands of patients in the areas they serve and also stifle innovation;
- Minimum standards may be set too low to achieve the standards of care we are striving for.

2. Provisions in the Bill

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

Health Boards and Trusts are responsible for the quality and safety of care provided to patients and should be accountable to the Welsh Government for safe and effective staffing across all disciplines. We believe that a prescriptive legislative approach to nursing in isolation from other factors could impact adversely on accountability. We support a holistic approach which encompasses all factors contributing to the best outcomes for patients.

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

There would need to be a clear definition of what 'all reasonable steps' are considered to be. It is assumed that there will be clarification on the processes that would be put in place to ensure compliance with minimum nurse staffing levels and the consequences of non compliance.

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

While we do not support legislation on nurse staffing levels, we are concerned that the proposed legislation applies only to adult in-patient wards in acute hospitals. An unintended consequence may be that resources are diverted to these settings which would create imbalances in provision and have an adverse impact on other staff groups and healthcare settings. This would be to the detriment of patients in other healthcare settings in terms of patient care, experience and outcomes. This is also contrary to policy direction to strengthen community services in order to reduce demand on acute services. Within community

hospital settings, the recent benchmarking UK audit showed that better patient outcomes correlated to diversity of professions around the patient.

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

We believe that each hospital and service should exercise their professional judgement in determining how services should be organised to meet demands. We are concerned that guidance specifying minimum nurse to patient ratios would restrict the ability of hospitals and services to respond flexibly to changing demands and patient needs.

2.5 The requirement for the Welsh Government to consult before issuing guidance.

It would be essential for the Welsh Government to conduct an extensive and wide-ranging consultation to ensure that the intentions of the legislation are fully understood and that the implications, risks and unintended consequences are thoroughly scrutinised and evaluated.

2.6 The monitoring requirements set out in the Bill?

The monitoring process should encompass all issues that impact on patient experience and outcomes and collect information relating to other professions and staffing as well as nursing.

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

- While we support the need for clear transparency and accountability, we are concerned that production of annual reports may place additional bureaucratic burdens on service providers;
- Reviews of the impact of the planned legislation should cover quality of patient care, experience and outcomes including impact on other service areas.

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

We recognise that review of the operation and effectiveness of the Act is an integral part of implementing the legislation. We would want to ensure that measures included in the review process are meaningful and cover factors across the range of services where impact of the legislation may have unintended consequences. Also, that indicators should encompass quality of care and patient outcomes.

3. Impact of existing guidance

Does the RCSLT have a view on the effectiveness of the existing guidance?

We believe that the existing All Wales Nurse Staffing Principles Guidance should be properly implemented to ensure adherence to its recommendations and form part of the Tier 1 indicators. We would wish to see staffing principles guidance introduced across the whole NHS workforce.

4. **Powers to make subordinate legislation**

We believe that legislation premised on only one health care setting would be flawed. We are concerned that powers for Welsh Ministers to amend settings to which minimum staffing levels would be conferred through subordinate legislation and not on the face of the Bill. We are concerned about the narrow focus of the Bill as currently proposed.

5. Financial implications

We reiterate our concerns that focus on nurse staffing levels could divert resources away from other essential services that play a vital role in patient care. Similarly, we are concerned that the proposed legislation could divert resources from community services and that financial implications of the Bill will not include consideration of the unintended consequences of its implementation.

The Royal College of Speech and Language Therapists

The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists (SLTs), SLT students and support workers working in the UK. The RCSLT has 15,000 members in the UK (600 in Wales) representing approximately 95% of SLTs working in the UK (who are registered with the Health & Care Professions Council. We promote excellence in practice and influence health, education, care and justice policies.

Submitted by Dr Alison Stroud
Wales Country Policy Officer,
Royal College of Speech and Language Therapists.

Eitem 8

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

Eitem 9

Yn rhinwedd paragraff(au) vi o Reol Sefydlog 17.42

Mae cyfyngiadau ar y ddogfen hon

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BMA

Cymru Wales

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

Inquiry into the GP workforce in Wales / Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru
Evidence from BMA Wales – GP 01 / Tystiolaeth gan BMA Cymru – GP 01

INQUIRY INTO THE GP WORKFORCE

National Assembly for Wales, Health and Social Care Committee

Response from BMA Cymru Wales

16 January 2015

INTRODUCTION

BMA Cymru Wales welcomes the opportunity to contribute to the Health and Social Care Committee's inquiry into the GP workforce in Wales.

The British Medical Association represents doctors from all branches of medicine all over the UK; and has a total membership of over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, which speaks for doctors at home and abroad. It is also an independent trade union.

BMA Cymru Wales represents over 7,000 members in Wales from every branch of the medical profession.

OVERVIEW

In an ever-evolving healthcare environment the independent contractor model has been at the heart of general practice's flexibility and innovation, which has been vital for affordable NHS care. It is well

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Rhestrwyd yn Undeb Llafur o dan Ddeddf Undebau Llafur a Chysylltiadau Llafur 1974.
Registered as a Company limited by Guarantee. Registered No. 8848 England.
Registered office: BMA House, Tavistock Square, London, WC1H 9JP.
Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.

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Y Gymdeithas Feddygol Brydeinig
British Medical Association
Bma.org.uk/wales

documented that high-quality primary care provides excellent value for money,[1,2,3,4,5] at around £23 per consultation.

Accessible and well-resourced general practices are essential if NHS Wales is to deliver good health outcomes to patients in all parts of Wales. Yet, general practice is facing unprecedented challenges; we recognise that there needs to be fundamental change to make the provision of general practice in Wales sustainable.

Last year, the BMA's General Practice Committee Wales published a strategy[6] intended to chart a way forward to a more certain future. Many of the recommendations in that document are replicated here.

MODERN GENERAL PRACTICE

There is a clear and increasing requirement for the GP workforce to be able to respond effectively to the growing demand for primary care services. This demand has been driven by a range of factors,[7] including:

- population growth, higher birth rates and an ageing population;
- increased prevalence of chronic conditions (e.g. diabetes, obesity, dementia) and multi-morbidity;
- patients with higher expectations;
- increasing non-clinical duties (for example, multiple inspections from QOF, CHC, HIW visits, post payment verification visits; adapting funding changes; engaging in GP clusters and with health board initiatives e.g. prescribing leads); and
- policy initiatives for better-quality care, delivered closer to home.

GPs have increasingly reported they have never known a time when the workload was so intense; many say that services are under immense strain. We regularly hear from members that stress related illnesses are becoming increasingly common. Burnout is a very serious threat to the sustainability of general practice, not to mention to individual doctor health.

In attempting to respond to rising demand, the role of the GP has evolved and individual GPs are more accustomed than ever to innovating in order to improve practice operations and be more effective – for example: reviewing skill-mix; reducing the number of missed appointments; taking a prudent approach to prescribing; increasing the use of new technology; and engaging in cluster networks.

Working pattern preferences have also changed. The younger generation of GPs have different expectations and lifestyle desires than their predecessors. Partnerships are no longer seen as the end point of a career for some in general practice, as they increasingly resemble an overburdened path due to increased workload, bureaucracy and financial responsibility. This needs to be urgently addressed; and the impossible pressures of GP partnership need to be removed to make it an attractive option – for new and existing GPs alike. The partnership model needs to be maintained, supported by flexible career

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[1] A Survey of Primary Care Physicians in 11 Countries, 2009. Perspectives on Care, Cost and Experiences. Schoen, Obsorn, Doty, Squires, Peugh, Applebaum: Commonwealth Fund 2009. Available at: http://www.commonwealthfund.org/Surveys/2009/Nov/2009-Commonwealth-Fund-International-Health-Policy-Survey.aspx

[2] Barbara Starfield, Leiyu Shi, and James Macinko, 2005. Contribution of Primary Care to Health Systems and Health.

[3] Pierard E. 2009. The effect of physician supply on health status as measured in the National Population Health Survey. Waterloo [Canada]: University of Waterloo. Available at: http://economics.uwaterloo.ca/documents/TheEffectPaperPierard_000.pdf

[4] Oldham, et al. 2012. Primary Care – the central function and main focus: Report of the Primary care Working Group. The Global Health Policy Summit.

[5] Kringos et al. 2013. Europe's strong primary care systems are linked to better population health but also higher health spending. Health Affairs:32(4),686-694 Available at: http://nvl002.nivel.nl/postprint/PPpp5128.pdf

[6] BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales

[7] CFWI GP in-depth review: Preliminary findings 2013. Available at: http://www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings/@@publication-detail

options for both men and women. We feel this is essential for being able to attract and retain new doctors to the profession, but note that few such flexible opportunities exist.

In terms of the size of the existing workforce, Wales has 2,617 GPs. This represents 85 GPs per 100,000 patients – the lowest ratio of GPs to patients in the UK.[8] The number of GPs in Wales has risen in absolute terms by 11.2% over the last ten years, but this figure may be misleading because an increasing number of GPs are working less than full-time. When the number of GPs is expressed in terms of whole time equivalents, it has in fact has remained broadly static over this time period, whilst the overall number of health board staff has increased by 19.7% (with some staff groups up by 120%).[9]

A report by the Kings Fund[10] highlighted that the looming shortage of GPs, and the oversupply of hospital specialists, will undermine the drive to safeguard the NHS in the future. The think-tank said the workforce needs to be rebalanced to drive down future costs and prepare for the future needs of the NHS. The projected imbalances between different specialties will have serious implications for patient care and come on top of reports showing wider staff shortages in key areas such as emergency care.

Between 2003 and 2013, the proportion of GPs aged over 55 in Wales increased by 42.1%. While the number of practitioners below 45-years-old also increased, the rate of increase was significantly slower at just 1.2% throughout the same period[11,12]. At the same time, the number of GPs under 50 planning to leave the profession has reached an all-time high.[13] In 2014, 23.4% of all GPs were aged 55 and over – the figures are likely to be much higher in rural and more deprived areas.

The retirement bulge will occur over the next few years; but in combination with both poor recruitment, and concerns over a 'brain drain' with doctors choosing to leave the profession in the UK, the result will be a significant shortfall of GPs. This is a scenario that the BMA has previously warned about as a 'perfect storm'.

Vitally, the GP workforce in Wales needs to increase to more sustainable levels. We estimate that, in addition to other measures, Wales needs at least 200 GP specialty trainee places each year, a rise from the current number of 136. Welsh Government will need to take action to attract trainees to these posts. Since it will take a minimum of three years to train these individuals, it will not significantly mitigate any supply shortfall that exists currently, or could emerge in the next few years.

Other measures, alongside trainee expansion, are therefore required; these are discussed in the sections that follow. These other measures also recognise the fact that an increase in capacity alone may not provide a long term solution – i.e. more GPs working equally as hard while demand continues to rise.

The Welsh Government is planning for more work to be done in primary care and for care planning to be managed through GP cluster networks. Primary care needs the workforce, infrastructure and resources to do the job. Despite strong evidence to support further investment, the share of total NHS expenditure allocated to Welsh GMS has fallen from 10.3% in 2007 to 7.9 %.[14]

The Shape of Training Review,[15] and the implementation of its recommendations, are likely to have a considerable impact on the GP training curriculum – the review correctly identifies the huge challenges faced by the NHS in delivering a high-quality health service to a changing patient population in the decades ahead. These challenges are real and serious but the remedies suggested by Shape of Training

8 GMC State of Medical Education and Practice in the UK 2014
9 BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales
10 King's Fund report on NHS workforce development, 24 July 2013
11 http://www.walesonline.co.uk/news/wales-news/fresh-concerns-raised-gp-recruitment-6882121
12 https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/General-Medical-Services
13 Centre for Health Economics, University of Manchester Seventh National GP Worklife Survey
14 Figures supplied to GPC Wales by Welsh Government
15 http://www.shapeoftraining.co.uk/home.asp

do not offer the right solutions for patients and could risk all that currently works well in high quality medical education; for that reason the BMA has called for a pause in the review.

As health and social care needs grow in both volume and complexity, and health budgets remain constrained, pressure on the current fragmented system will continue to build. The downward pressure on GP income and working conditions has reached a nadir where the very infrastructure of practices is under threat. When practices fail to recruit, they are often forced into reducing the services that they offer to their patients. This is in no one's best interests.

There needs to be a recognition that with improved resources, enhanced GP training, and a significant expansion of the workforce, general practice can help to address the pressures posed by changing demographics and rising co-morbidity.

In the sections that follow, we provide commentary and offer recommendations on each of the three terms of reference areas of the inquiry, namely:

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

Cutting across all of this is the need for a comprehensive workforce strategy for primary care in Wales; one which includes the whole practice team.

RESPONSE (TO TERMS OF REFERENCE)

1 - BARRIERS TO GP RECRUITMENT AND RETENTION

As noted in the preceding section there are a multitude of factors that are combining to negatively affect both the retention of existing GPs in Wales and the attractiveness of entering a career in general practice. These factors include:

Workload

Almost half of the GPs who responded to the recent General Practitioners' Committee UK (GPC UK) survey revealed that increasing workloads and rising pressures were becoming unmanageable or unsustainable all of the time,[16] with 89.4% of GPs indicating 'very high/high levels' of pressure at work.[17] This is the single biggest issue reported to us by general practitioners.

Stress and burnout

Many GPs report that they feel an unsustainable level of pressure in their work, and many are choosing to leave the profession altogether [18] or to move abroad.[19] The Lack of occupational health provision for primary care is a serious problem.

Potential applicants to GP training are put off by well-documented reports of the stressful nature of working in general practice. In the most recent National Survey of GPs the level of overall job satisfaction reported was lower than in all surveys undertaken since 2001.[20] Of all BMA membership grades, GPs

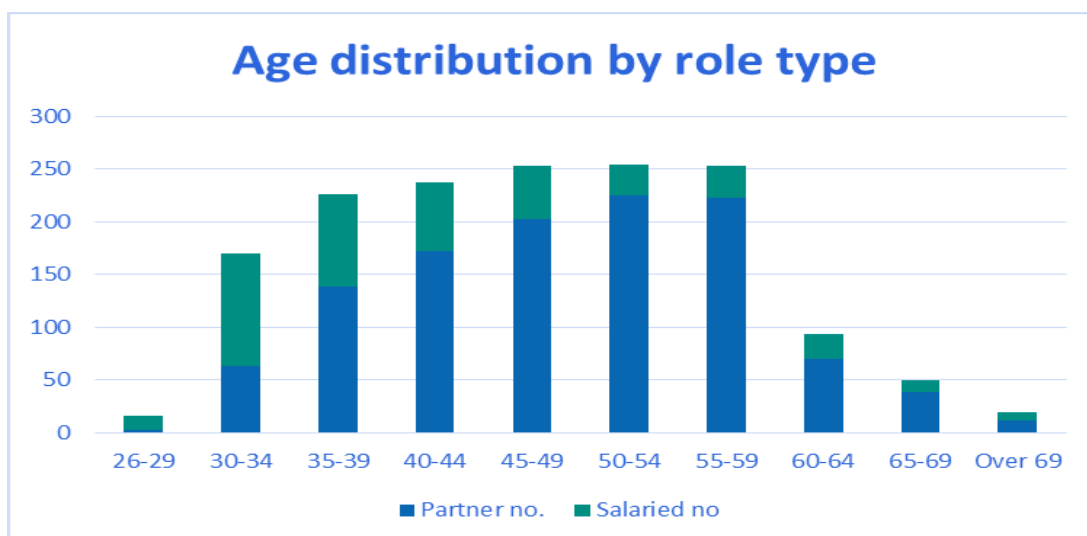
[16] BMA GPC online workforce survey, 26 March 2014
[17] BMA UK 2013 Omnibus Survey
[18] CFWI, July 2014. In-depth review of the general practitioner workforce; and HEE Securing the Future GP Workforce, Delivering the Mandate on GP Expansion - GP Taskforce Report 2014
[19] GMC p57 State of medical education and practice in the UK 2014
[20] http://www.population-health.manchester.ac.uk/healtheconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf

report the lowest average satisfaction with their work-life balance,[21] and GPs, by far, use 'Doctors for Doctors' (the BMA's 24/7 counselling and personal support service) the most.

GP training arrangements
Against the background of recruitment problems and an ageing workforce, it is imperative that adequate numbers of new GPs are trained – despite longstanding commitments to expand primary care, the overall number of training places in Wales has remained static. It is also imperative that they are trained appropriately to deal with the modern day pressures of general practice. Work also needs to be undertaken to dispel a number of negative perceptions about training and working in Wales – this includes myths around mandatory use of the Welsh language.

Partnerships and GP Principles
GP partnerships are increasingly being seen as unattractive, and therefore not sought after, due to the workload, bureaucracy and financial responsibility they involve – all for very little gain. In other circumstances, if such pressures are addressed, then many of the new generation of GPs have indicated that they would want to enter GP partnerships.

The graph below details the age profile of BMA GP members in Wales and their salaried/partnership split:



BMA GP members in Wales who work part-time comprise a quarter of those who are salaried GPs, compared to just 7% of those who are partners.

Lack of career flexibility
Flexible career schemes, for example posts that combine general practice partnership with an ability to undertake other roles within NHS Wales, are highly popular but very rarely supported.

Retainer and return-to-practice schemes
There is a lack of sufficient investment in making GP retainer and returner schemes accessible. The returner programmes are relatively inflexible in duration and content, regardless of the individual situation. They are costly, and the exit criteria often act as a deterrent for some individuals.

Out-of-Hours (OOH)
There has been under investment in OOH services since 2004. This is irreconcilable with Welsh Government commitments to improve unscheduled care. Without adequate investment, it is impossible to attract and retain capacity – particularly at weekends and over public holiday periods.

[21] BMA Quarterly tracker survey, September 2014

We note that there is no mention of OOH services in the Welsh Government's proposed primary care plan, despite the fact they operate for more hours of the day than in-hours services.

Barriers to recruitment and retention in specific areas
In more deprived areas poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas.[22] Current core GP funding arrangements do not properly recognise deprivation.[23]

Rurality causes similar recruitment difficulties. Issues in rural areas – such as limited choice of local schools, lack of career options for spouse or wider family members, lack of local amenities – act as disincentives, especially for younger GPs. Rural practices are also threatened by issues over their financial stability related to inadequate resourcing, threats to funding for dispensing practices and the forthcoming phasing out of Minimum Practice Income Guarantee (MPIG) funding.[24]

Hospital Waiting Times
The shift of work from secondary care to general practice has not been accompanied by resources moving in the same direction. This adversely affects the ability of GPs to do the job, puts services under immense strain, and further damages the morale of GPs.

This is further exacerbated by frustration over long secondary care waiting times, difficulties accessing some diagnostics, inadequate administrative systems within hospitals adding to GP workload (e.g. delayed clinic letters, poor discharge letters, chasing appointments), acute intakes regularly closing and the cancellation of routine surgery meaning that the patient's condition worsens in the interim and more GP appointments are required – often consuming more health resources, particularly around prescribing.

Successive adverse policies
Pension changes, a series of below-inflation pay increases, wide underinvestment (e.g. in premises) and the transfer of more work into primary care have added to the stresses on an already demoralised workforce, and pushed more and more GPs to consider leaving the profession. Government policies on extending GP access are unrealistic and irresponsible; there are not enough GPs to cover even core weekday hours let alone evenings and weekends.

Lack of incentives to work in Wales
There are no 'made in Wales' polices that act to attract GPs to Wales and which make Wales stand out as a positive place to work. We have put forward a number of suggested incentive options to Welsh Government to help address shortages across the medical profession – none of the ideas have, so far, been taken forward.

For Welsh GPs, this is compounded by that fact that they earn less than English counterparts[25] which impacts on a GP's decision as to where to work – whilst this is not the only factor affecting recruitment, in light of the higher workload and the other factors noted, it does need to be acknowledged.

Separate medical performers lists
The existence of separate performers lists for England and Wales has a number of detrimental impacts. For instance GPs on the English performers list may not be immediately able to take up vacancies that may exist within practices in Wales. In border areas, having separate lists can prevent GP colleagues in

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[22] Sibbald, B. (2005) Putting General Practitioners where they are needed: an overview of strategies to correct maldistribution. National Primary Care Research and Development Centre, University of Manchester. Available at: http://www.medicine.manchester.ac.uk/primarycare/npcrdc-archive/archive/PublicationDetail.cfm/ID/139.htm
[23] http://www.gponline.com/why-gp-funding-linked-deprivation/article/1328431
[24] BMA General Practitioners Committee Wales. 2014. GPCW Chair's speech to the national LMC Conference. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales/lmc-conference-speech
[25] HSCIC GP Earnings and Expenses, 2012/13, p6

nearby practices, on either side, from simply being able to cover for each other in the way that might often happen between practices on the same side of the border. In the same way, the separate lists also limit the availability of locums for border practices.

Lack of data
Assessment of the true performance of NHS Wales, and its workforce numbers or requirements, is difficult due to the inadequate availability and reliability of data.

2 - WHETHER THE COMMISSIONING AND DELIVERY OF MEDICAL TRAINING CURRENTLY SUPPORTS A SUSTAINABLE GP WORKFORCE

Improve the attractiveness of training in general practice
In 2014, across the UK only 5559 GP trainee applications were received during the first round of the selection process – the lowest number of applications since 2009.[26] General practice has become the least popular specialty, second only to psychiatry.

Unfilled training places are a problem across the UK – in Wales this is exacerbated by the fact that we have the lowest number of Foundation Level 2 (FY2) posts in general practice (24%[27] compared to a UK average of 55%). The Department of Health has committed to a 30% increase in training places in England.[28]

Whilst working to improve the image of general practice in medical schools, GP placements need to attract more doctors into general practice. 670 applicants who applied to general practice last year eventually chose other specialties.[29] Improving the attractiveness of training in general practice could include financial incentives, for example, and the provision of high quality accommodation for trainees and their families alongside adequate relocation expenses – this is especially needed in areas that are currently less popular.

The profession, the Welsh Deanery, medical schools and the Welsh Government need to work together to inspire and incentivise these applicants to choose a career in general practice. This will require new investment.

Increase exposure to general practice through foundation year placements
Consideration should be given to making foundation year GP placements mandatory for all doctors in training.

Increase the number of GP specialty trainee places
There needs to be a substantial increase in the commissioning of GP training numbers in Wales, phased in over several years. Based on an extrapolation of the data for England, which is not available in Wales, we estimate that Wales needs at least 200 GP speciality trainees each year, there are currently 136 places. The numbers need to be reviewed regularly and against sound evidence/data (currently lacking). If demand on GPs increases at a faster pace than projected, additional measures should be considered. As we have noted, an increase in numbers alone will not solve the recruitment problem.

Ensure lead employer for GP trainees is implemented
This would ensure stability and, for example, would enable access to such things as childcare vouchers and mortgages – as the individual would not be moving employer every six months. It would also enable consistent human resources advice to be given.

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[26] General Practice National Recruitment Office & HEE MWAG Specialty Recruitment Update, Feb 2014
[27] note current 1 year increase to 34% in Wales
[28] DoH HEE Mandate 2013
[29] General Practice Recruitment Data, HEE, 2014

Support training practices
Consideration should be given to an enhanced trainers' grant to recognise the impact that training has on the delivery of routine practice work. It is widely acknowledged that the workload involved, particularly the e-portfolio, is cumbersome and is becoming more onerous. The foundation placement fee and GP trainer's grant no longer reflect the current workload associated with training foundation and general practice trainees. An uplift proportionate to the workload is essential. The premises strategy also needs to ensure adequate space for GP training.

Extend GP Training
The RCGP makes a compelling case for extending GP training to four years[30] to prepare young doctors for the rigours of modern general practice. We recognise that this proposal would create a 'fallow' year where fewer GPs would exit training, temporarily compounding the already bleak environment of recruitment.

However, the GP specialty training programme needs to be planned to suit the challenges facing a 21st century GP, who is only part clinician, but also manager, commissioner, employer, negotiator, educator and book keeper. Many young GPs cite a lack of readiness as a reason they wish to defer joining partnerships following the completion of their training.

3 - THE ACTIONS NEEDED TO ENSURE THE SUSTAINABILITY OF THE GP WORKFORCE.

Increasing the GP workforce and training numbers should be a priority. However, as noted in the overview section above, we recognise that an increase in workforce numbers in isolation may not deliver better services to patients in the long-run.

In addition to supporting partnership working, we must also embrace new measures and ways of working to ensure the delivery of high quality, personalised and integrated care and to attract and retain GPs.

For instance we believe that a salaried service is valuable for supporting flexible careers and may help to retain doctors at the beginning and end of their careers, and thus plays an important role supporting the mainstream partnership model.

There are a number of measures that can be taken to support the partnership model and to help ensure the sustainability of general practice in Wales. It is important to realise that unless the attractiveness of general practice in Wales improves, and the working conditions for permanent staff are addressed, then the situation is only likely to worsen.

All of these have previously been put to Welsh Government, they include:

- ***Look at new models of care and practice viability, for example:***

i. Support flexible career and training schemes:

Wales needs to create environments where the new generations of both male and female GPs seeking different ways of working can flourish. Sessions spent in portfolio roles, for example, offers both variety and ways of preventing burnout.

More opportunities for flexibility are needed that combine general practice partnership with an ability to undertake other roles in NHS Wales. For example, where a GP works a certain amount of time in practice and then the rest of their contract time in a mix of out-of-hours work, or work on health board priorities (e.g. audit, network pathways, using or acquiring specialist skills).

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[30] RCGP, 2012 'Preparing the Future GP: the case for enhanced GP training'

The increase in the proportion of the medical school intake who are women has led to a more equal gender balance in GP training and has changed the composition of the profession – we celebrate the fact that there are more female doctors now than ever before; 48% of doctors on the GP Register in Wales are now female.[31] However, a dedicated piece of work needs to be commissioned to explore the multifactorial complexities behind why 40% of female GPs in the UK have left the profession by the age of 40.

Doctors in less than full-time training are expected to take at least five years to train, compared to three or four years for the majority of GPs in full-time training. This should be considered in workforce planning since it will reduce the rate of production of trained GPs.

ii. A salaried service

A salaried GP service is the most commonly promoted alternative to the independent contractor model and it remains attractive to some GPs. According to the King's Fund,[32] salaried GPs give flexibility, as they often have short-term contracts and do not have the financial commitment of GP partners.

Whilst having an important place in primary care provision, there is little reliable evidence to support the case for wholesale change. Evidence from health boards suggests that a salaried service is more expensive and requires a lot of management involvement.

iii. Encourage federations of practices where appropriate:

This could involve practices making informal arrangements to share staff or work collaboratively on the provision of services to patients, either in individual premises or in jointly-shared premises. It could, of course, also include practices formally merging or joining together.

The GPC UK paper 'Developing General Practice – providing health care solutions for the future' expands on the value and importance of the primary care health team working in collaboration with other health care providers, and the value of collaborative alliances and federations tailored to local population needs.[33]

iv. Develop opportunities for collaboration and innovation in primary care:

The expansion of the primary care team with pharmacists, health visitors, district nurses etc. can address some of the workload issues. There is currently a shortage of practice and district nurses, which has a knock on effect on GP workload. The King's Fund report on the future of general practice goes further by suggesting GPs, dentists and optometrists collaborate to create a much larger primary care team.[34] However, this is likely to be an option in the medium to long term rather than an immediate one.

GPs are part of a wider primary care workforce – we must ensure that each element is complimentary and presents an effective use of skill mix and, in line with the principles of prudent healthcare, [35] does not duplicate or complicate other parts of care pathways or delivery.

The GP Cluster Network also, if properly supported and operational, holds some potential to assist in the area of collaboration, the sharing of innovation and best practice.

v. Introduce an expanding practice allowance:

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[31] GMC State of Medical Education and Practice in the UK, 2014

[32] The King's Fund, 2011. Improving the quality of care in general practice: report of an independent enquiry commissioned by the King's Fund. Available at: http://www.kingsfund.org.uk/publications/improving-quality-care-general-practice

[33] GPC UK Vision Document. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision/improving-urgent-and-ooh-care

[34] Securing the future of general practice: new models of primary care, The King's Fund, July 2013

[35] http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en

Currently practices have to see a significant rise in population numbers in order to have enough funding to take on additional partners. An expanding practice allowance would enable the development of staff and succession planning. It could for instance be paid for 24 months, after which the rising list would self-fund the practice expansion.

- ***Measures to retain existing GPs:***

i. Develop and invest in returner schemes:

Improving return-to-practice schemes should be a key area of consideration with regards to ways in which retention rates in Wales could be improved. It costs around £500K to train a GP[36] and around £30K to enable them to return. In addition, returners tend to be committed to the area in which they retrain. No matter how many individuals apply to the returner scheme, there should be sufficient funding available to enable them to return, and they should be supported to do so – in a flexible way if required.

We believe that for individuals who have been working in a country with a similar NHS system and doing general practice work, the 'returner scheme' should be of much shorter duration. We support the recent paper developed by the Welsh Government, the Royal College of General Practitioners (RCGP) Wales, the Wales Deanery and GPC Wales which proposes amendments to the current scheme and is currently with the Health Minister for consideration.

ii. Develop and invest in retainer schemes

Incentives and flexible working opportunities should be offered to retain older GPs, including perhaps to those approaching retirement age.

This would be designed to avoid performers in exceptional circumstances becoming returners and having to go through the associated formal processes. For example, there is a need to retain and develop GPs who are unable to work full-time for specified and short term reasons.

The Welsh Government must change its funding priorities and provide fully-funded retainer schemes. Work needs to be undertaken to discover why doctors choose to take early retirement or to leave the profession, and at the same time to ascertain if these doctors have any interest in alternative ways of remaining in practice – for example becoming mentors, or moving to part time working or flexible contracts/portfolio roles.

iii. Provide a full occupational health service

GPs in Wales have access to Health 4 Health Professionals, but there is no complete occupational health and well-being service. It is widely acknowledged that burnout, stress, low morale and risks of mental health illness are becoming increasingly prevalent.[37]

BMA Cymru Wales has previously called for a comprehensive all-Wales occupational health service to be developed for all NHS employees. Given the significant cost of training a GP it makes complete economic sense to preserve and protect that investment – a comprehensive service is long overdue. It has been over five years since the recommendations of Sir Mansel Aylward's One Wales report into Occupational Health were accepted by the Welsh Government, and yet we are still only in the 'pilot' stages of projects.

- ***Additional enhancements***

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[36] http://hee.nhs.uk/2013/05/28/new-education-and-training-measures-to-improve-patient-care/

[37] http://www.pulsetoday.co.uk/your-practice/battling-burnout/one-in-eight-gps-have-sought-help-for-stress-in-past-year/20003871.article

Incentives, such as ‘golden handcuffs’, can be very effective in recruiting GPs to certain areas. For example, in exchange for working in an area for a set amount of time, contributions could be made towards student loan repayments, or to training and examination fees. Incentives should especially be considered for rural and more deprived areas. Such schemes also would help efforts towards widening access to medical education.

Wider incentive schemes also need to be considered to increase the number of applicants to GP training places. For example medical schools could be incentivised to increase the proportion of their graduates selecting General Practice (and other shortage specialties) as first choice careers.

- ***Review of Out-of-Hours (OOH) services***

Out of Hours (OOH) services have been underfunded since health boards took over in 2004; this has a serious knock on effect on the whole of unscheduled care. There is an urgent need to review the way in which OOH services are provided – while considering the introduction of the 111 service and ensuring its appropriate use – as in many areas there simply are not enough GPs to fill rosters.

GPs should be more involved in the planning and development of OOH services through strengthened GP clusters working arrangements. Competitive remuneration rates should be set to create attractive OOH GP salaried careers and to encourage the participation of local GPs.

Dedicated funding for continuous professional development (CPD) within OOH work should also be considered.

- ***Capitalise on local commissioning expertise***

GPs needs greater involvement (and a stronger voice) in local NHS management and commissioning, but they have limited capacity to engage in this currently given other pressures on workload.

We are very supportive of GP Cluster Networks, but in many areas they are no more than irregular meetings organised by the health board to administer the Quality and Outcomes Framework (QOF). They will only work if they are given adequate resources and real decision-making power.

- ***Leadership***

The management of primary care requires a very different skill set from running hospitals. The specialist nature of this work may not be well suited to delivery by seven small primary care teams based in each health board. We believe that primary care management expertise should be consolidated into a Primary Care Authority for Wales.

Wales would also benefit from the reinstatement of a Primary Care Directorate within Welsh Government. Given the emphasis on primary care in Welsh health policy, the lack of a dedicated director level post in Welsh Government is, in our view, a major oversight.

- ***GP Premises***

There is no obvious funding stream for premises development; responsibility was handed to health boards in 2013 without a budget. A review of the condition of premises is required in order to identify a more affordable way of implementing the 2004 programme of development; it would need to take into account sufficient teaching and learning space. The requirement to sign leases with onerous terms and conditions is also a barrier to young GPs taking on partnerships.

This situation in Wales contrasts greatly with that in England, where £1.25 billion has been identified for investment in premises (£250 million a year for each of five years), meaning that Wales is now significantly lagging behind.

- ***Data availability***

There is a worrying lack of data available on service performance and on workforce numbers and workload – starkly portrayed by the fact that neither Welsh Government, nor Health Boards in Wales, hold data on vacancies.

Chapter seven of the General Practitioners' Committee Wales (GPCW) strategy[38] deals with data availability and continuous service improvement. It makes a series of recommendations as to how the paucity of data and evidence gathering can be turned around.

- ***Add General Practice to the Migration Advisory Committee (MAC) Shortage Occupation List***

The BMA has submitted evidence to the Migration Advisory Committee (MAC) in support of GPs being included on the shortage occupation list.

The MAC gives considerations to occupations within the UK suffering from workforce shortages on an annual basis. For shortage occupations on the list, individuals from outside of the European Economic Area (EEA) are then able to obtain a short term visa, i.e. two years, to enable them to apply for those vacancies in the UK.

The advantages of inviting non-EEA doctors to fill vacancies are twofold. First, it should alleviate some of the pressure on the overstretched workforce and, secondly, that will enable sufficient numbers of UK/EU GPs to train and qualify in the intervening period.

It is of note that there is a separate shortage occupation list for Scotland; while shortages in Wales and England are contained within the same list (which has the potential to skew specific shortage variations between the two).

- ***Retired GPs***

We need to look at avenues to enable retired GPs to return in the event of a major outbreak/emergency situation without having to go through the hurdles of the medical performers' list, GP returner scheme, revalidation etc.

- ***Patient Expectations***

Patient's expectations have changed over the last decade, as have the lifestyle factors affecting population health. As individuals we all need to take better responsibility for our health and well-being, and use health services appropriately.

Patients need to be able to access advice as to whether they need to see a health care professional or not; and where the most appropriate place to do so is. There are many advertising campaigns warning patients not to miss symptoms of illness and diseases. These campaigns have been introduced without taking into consideration the need to educate patients on the use of online and other resources to signpost them to relevant services, in line the Welsh Government-backed principles of prudent healthcare.[39] Although many patients are beginning to do this, it is poorly advertised at present.

Education (for example on first aid, CPR, and the role of healthy and active lifestyles in warning off a number of illnesses and diseases) should be a compulsory part of the curriculum. The lack of implementation in an effective self-help agenda encourages the inappropriate use of healthcare resources.

CONCLUSION/SUMMARY

[38] BMA Cymru Wales 'General Practice – a prescription for a healthy future' 2014. Available at: http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-wales

[39] http://wales.gov.uk/topics/health/nhswales/prudent-healthcare/?lang=en

We hope the recommendations in this paper, and those contained in our strategy document, will inform the committee's work in this area.

The BMA is currently undertaking a national survey of GP members, covering many of the areas touched upon in this paper – models of working, premises, opening hours, workload, morale, consultation times with patients, and career motivators. We would be happy to share the results for Wales when the survey has concluded.

In representing GPs in Wales, we are wholly committed to working with the Welsh Government, the Wales Deanery, RCGP and others to bring forward lasting change for primary care in Wales.

It is clear that the solution is not a simple turning on of a switch, but a complex, multifactorial change in culture and strategy within the NHS and government, to recognise the clear problem facing us all and to implement action with both immediate and longer-term effects.

A recent BMA survey found that a staggering six in ten GPs in the UK were 'actively considering' leaving the profession.[40] We are at a watershed moment, and the time to act really is now.

Thank you for the opportunity to respond to this inquiry.

[40] BMA quarterly tracker survey, Quarter 4, 2014

Eitem 10

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

Inquiry into the GP workforce in Wales / Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru
Evidence from Royal College of General Practitioners – GP 02 / Tystiolaeth gan Coleg Brenhinol yr Ymarferwyr Cyffredinol – GP 02

Briefing paper for the Health and Social Care Committee inquiry into the GP workforce in Wales

The general practice workforce across Wales and the UK faces significant challenges due to the following key factors:

- Increasing size of workload i.e. increasing number of consultations
- Increasing complexity of patient illnesses – an ageing population, many with long term conditions and multi-morbidities
- Ageing workforce: a significant proportion of the workforce – among both GPs and Practice Nurses in the difficult to recruit areas are over 55
- Prolonged period of underinvestment – funding for general practice in Wales has been decreasing year on year and now receives 7.7% of total NHS funding compared with 8.5% in 2005/06.
- Training places have had a reduction in applicants and a growing number of qualified GPs are choosing to emigrate, retire early or change medical specialty. In 2014, 45 Welsh medical graduates chose to practice outside the UK.
- Onerous returner scheme requirements and lack of single medical performers list

There is growing evidence that the capacity of the general practice workforce to meet the changing and increasing demands of patients is under threat. Firstly, demand for general practice is increasing and this is causing additional workload pressures for GPs and their teams. There is also strong evidence that the care general practice is required to deliver is

becoming more complex as we are becoming an ageing population.

The general practice workforce is ageing. In Wales, over 23% of our GPs are over 55 and many are choosing to retire early, often due to work pressures and stress.

Wales ranks third in the UK in GP coverage per population and RCGP Wales estimates that we will need an additional 95 GPs this year just to reach the UK average. We will need even more to replace those who leave and far more to meet the needs and challenges ahead.

The RCGP's Put Patients First: Back General Practice campaign focuses on the need for urgent additional resources as well as focusing on the key themes that are inhibiting GPs from building on the excellent quality of care they currently provide despite these challenges.

The new Primary care plan is a step in the right direction but without a robust GP workforce, RCGP Wales questions how we will be able to match the aspirations set out in the plan.

As well as restoring funding levels, there is an urgent need to:

- Improve recruitment into general practice
- Retain doctors within general practice
- Support those wishing to return to general practice

The solutions:

Improving recruitment/training capacity in general practice

The Welsh Government must help fund additional training places for general practice and help ensure a more positive experience for medical students and foundation year doctors within general practice.

A positive marketing campaign would be beneficial to raise Wales' profile as a great place to live and work. The Scottish Highlands recently launched a new ad campaign targeting medical students in parts of England with the aim of attracting them to work in the Highlands. We have also seen similar activity to promote parts of Cumbria to medical students.

Retaining doctors within general practice

Incentives are needed to attract GPs to under-doctored areas such as parts of south west Wales/north west Wales.

Improved conditions should result in retention of more GPs in Wales, particularly among those who are currently looking to retire early but we also need newly qualified doctors to consider moving to these areas to work as family doctors.

Easy return to practice

RCGP Wales has met with the Welsh Government to discuss the Returners Scheme. Urgent change is needed if we are to see a significant number of GPs return to the profession after an extended period of leave e.g. assistance with the cost of returning, creating an all-Wales performers list.

The role of the GP

Enhancing access to the range of care available in our communities is vital if co-production is to be more than just an aspiration. GPs are eager to play their part. Here are some of the developments already taking place, albeit to a limited degree, in our profession but could become more standardised and widespread following increased investment in general practice:

- Ability to routinely structure care around multi-morbidity, as well as individual conditions
- Take on extended roles in areas of clinical care that require the skills of a GP practitioner
- Work with GPs from other disciplines to deliver coordinated care
- Lead service planning and quality improvement

- Develop extended roles in areas such as public health, community development, education, training and research
- Offer continuity of relationship between GP, the wider healthcare team, the patient and their carers over time
- Coordinate services around the needs and shared decision of patients and carers
- Deliver health promotion and disease prevention strategies to identified populations
- Act as a gatekeeper and navigator to specialist services, to ensure effective resource utilisation and coordination

LHBs

Resources are tight across the entire NHS and local health boards are facing the difficult challenge of ensuring proper investment in a range of services whilst balancing an extremely tight budget. In the context of an ageing population with patients increasingly living with multiple long term conditions, we believe there is a strong case for investing in the generalist skills that GPs and their teams provide. That is why RCGP is campaigning for a wider shift of investment towards the front line of care in the community to help reduce the burden on hospitals and the NHS as a whole.

We hope that local health boards throughout Wales will be convinced of the need to reverse the decline in investment in general practice. A boost in investment for general practice is vital if we are to meet the changing needs of patients, reduce pressure on the rest of the NHS and place our health services on a stronger long-term financial footing. Whilst GP workloads are increasing, funding for general practice in Wales has been falling year on year in real terms, from £451.3m in 2009/10 to £438.0m (HSCIC, September 2014 and Autumn Statement, December 2014) in 2013/14, with total investment falling by 2.9%.

This is having a concerning impact on patients – with as many as 650,000 people finding it difficult to get an appointment to see a GP in Wales last year.

In closing, the Royal College of General Practitioners believes that for general practice to play its critical role in caring for patients in the future NHS, it is important that there are enough GPs; that these doctors have sufficient time, both in and outside the consultation, to provide the interventions needed; and that they receive sufficient training to develop the capabilities required to deliver the high quality services that patients, carers and families rightly expect.

The pressures on general practice to deliver effective care are mounting, as is the need to deliver continuity of care and accessible services. The crisis of demand versus capacity in the health service is not new; it has not arisen overnight and neither can it be solved quickly. Sustainable solutions must be found to increase workforce capacity and enable general practices to continue to deliver the level of service that their patients expect now, as well as taking on the challenge of providing more complex care, spending longer with their patients and communities and taking on new roles and responsibilities.

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

Inquiry into the GP workforce in Wales / Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru
Evidence from Wales Deanery – GP 03 / Tystiolaeth gan Deoniaeth Cymru – GP 03

Health & Social Care Committee inquiry into the GP workforce in Wales: An invited paper from the GP Section of the Wales Deanery

January 2015

1. **Introduction**

1.1. The Health and Social Care Committee has asked the Deanery (The School of Postgraduate Medical and Dental Education in Wales) to give evidence to this inquiry. Here we outline the most important factors as we see them. We trust this will facilitate the Committee's further exploration of matters with two Deanery representatives:

Dr Martin Sullivan (Associate Dean for GP Training in Wales)
Ms Mary Beech (Operational Lead for GP Training in Wales)

1.2. To aid discussion we provide an overview of a fairly typical GP training/working continuum. **Deanery supervised stages in bold**

- 5-6 years Medical School education
- **2 years working and training as a Foundation doctor**
- **3 years working and training as a GP registrar (based in hospital posts and accredited GP training practices)**
- 1–5 years working as a GP locum
- 15-30 years working as a GP partner or as a salaried GP

2. **What are the barriers to GP recruitment and retention in Wales?**

Firstly, we provide our understanding of the extent of recruitment and retention problems in Wales relating to the GP training continuum:

2.1. Attraction and recruitment of 2nd year Foundation doctors into GP Specialty Training is a well established and growing problem throughout most of the UK, including Wales.

2.2. In Wales, the GP Specialty Training applicant to recruitment target ratio is around the already low UK average and (as everywhere else in the UK) has been declining significantly over the last decade.

2.3. Comparing GP training recruitment targets in isolation however masks an even greater problem for Wales, than for other areas of the

UK. The current recruitment target (given to The Wales Deanery by Welsh Government 10 years ago) is now much lower comparatively per head of population than elsewhere in Britain.
Roughly, GP training recruitment target: population ratios are
Wales *136 to 3 million;* ***England*** *3225 to 50 million;* ***Scotland*** *296 to 5 million.*

2.4. On completion of annual recruitment rounds, the vast majority, of the already low number of GP Training entrants recruited in Wales, consistently refuse to take up employment/training offers outside of North East, South East or South Central Wales.

2.5. The following factors add further to the growing deficit of new GPs available to work in Wales:

- significant attrition (for various reasons) during GP training
- a growing preference for part time training (currently 40% of final year GP specialty trainees currently work part time in Wales)
- choosing not to work in this hard pressed specialty once qualified
- significant and increasing emigration to perceived better opportunities for newly qualified GPs in Australia and elsewhere.

2.6. Monitoring retention of the fully qualified GP workforce in Wales is outside the Deanery's organisational remit; but, through our networks, we are aware that career change and premature retirement amongst established GPs is another highly significant and increasing problem.

Secondly, we provide an overview of barriers to recruitment and retention. The factors listed here apply to recruitment into and attrition from both the established GP workforce in Wales and GP Specialty Training. Some factors are more pertinent at certain stages of the continuum; but most interplay throughout.

2.7. Most importantly GPs, GP specialty trainees, foundation doctors and students increasingly see the impact of unfettered demand for GP services, which in many areas has become unmanageable.

- They experience a more demanding and rapidly ageing population with increased co-morbidity and complexity as well as increasing expectations fuelled by media campaigns and huge numbers of single interest pressure groups.
- They also see little governmental support to try to alleviate these pressures e.g. public awareness campaigns to reduce demand; and restraining pressure groups promoting poorly evidenced health campaigns which further increase GP workload.
- They (along with the public) perpetually read ill-conceived and politically driven press reports undermining GPs' worth and belittling their contributions, whilst, as they see it, day in day out

GPs work very long days, striving to keep some a lid on pressures on secondary care and keeping the NHS in general from imploding.

2.8. Failings of secondary care conveyed regularly to GPs by patients (e.g. frequent patient dissatisfaction with hospital communication and other systems); as well as illogical denial of direct GP access to investigative facilities, create needless further burdens, reduce GPs' ability to create efficiencies for patients and further deflate GP morale.

2.9. The unrelenting diversion of activity from secondary care, without adequate accompanying resource to an already undermanned primary care workforce, adds to the rapidly deepening gloom.

2.10. A recognition that 24/7 access to General Practice in tandem with other political promises of continuity of care, is a circle that cannot be squared. GPs working long, pressurised day shifts, know that existing out of hours primary care services (mainly staffed by local GPs choosing to earn their living in this way) are well organised and exemplary in most parts of Wales when compared to large parts of England. These GP Out of Hours services in Wales could be even more cost effective and further reduce pressure on A&E if this service was appropriately trumpeted by health care managers where it is so effective; and should be much more appropriately resourced.

2.11. The integration of primary and secondary care into unified LHBs in Wales has not led to significant integration of services. There is a strongly held view amongst GPs that currently imposed and poorly resourced (rather than voluntary and reasonably incentivised) practice federations and networks will inevitably fail. Primary care in Wales feels much more disenfranchised than under previous NHS administrative structures. This widespread feeling exacerbates a parallel appreciation of the hugely diminished proportion of overall NHS budget committed to primary care in recent years.

2.12. The potential GP workforce is very different to past generations. World-wide urbanising forces are a major issue in attracting trainees to more remote parts of many countries.

2.13. The geography and infrastructure of Wales requires some practices serving widespread populations to have multiple premises. The redirection of The Minimum Practice Income Guarantee (MPIG) has been somewhat ameliorated in Wales. But for many practices there will now be no reparation for operating multiple premises; and this can only exacerbate recruitment and retention problems in rural areas.

2.14. The established GP workforce, meanwhile, well understands that options for liberation from perceived intolerable working conditions are attainable for many of them. Pay and pension changes are adding

fuel to these fires, stoking increasing trends in career change, emigration and the early retirement of many GPs.

3. Does the commissioning and delivery of medical training currently support a sustainable GP workforce?

3.1. The quality of training for GP in Wales compares favourably with the best in the UK (GMC trainee feedback) and is also the most highly rated specialty for overall training experience in Wales (GMC trainee feedback). Thus any failure to attract applicants cannot be attributed to the quality, reputation or experience of GP training in Wales. The production, once recruited, of new GPs of appropriate quality (in terms of UK GMC standards) is strongly promoted by a highly committed, well trained and well supported faculty of GP medical educators and trainers throughout the whole of Wales.

3.2. The numerical sufficiency of new GPs produced and staying in Wales is a very different matter. The factors relating to working pressures as well as terms and conditions and the consequential unattractiveness of the job of General Practice apply everywhere in the UK. However, global trends in urbanisation impact more on Wales and many other more remote (as the available applicant pool sees it) parts of Britain. The potential applicant pool specific reasons behind this insufficiency are multiple; and many have been covered earlier in this paper.

3.3. The Deanery regularly attends careers events at regional, Wales and UK levels to attract would be trainees to Wales and to the specialty of General Practice. Professionally produced internet materials add support to the acknowledged very good reputation of GP training in Wales. Sadly, the prevailing “push” forces outlined in this paper increasingly trump all efforts, as in most of the rest of the UK, to attract anything like enough applicants.

4. Which actions are needed to ensure the sustainability of the GP workforce?

Radical training initiatives need to be introduced in Wales:

4.1. Ensure that much more student time and a much more appropriate proportion of existing Welsh Medical School funding is spent on General Practice placements. This will increase exposure to this excellent learning environment and to more credible role models.

4.2. Set significant quotas for appointees to Welsh Medical Schools who have proof of perhaps 2 or 3 years’ prior recent residence in Wales. There are examples in other countries of this type of policy working well in terms of retaining doctors services once qualified.

4.3. Fund a significant and permanent increase in the percentage of foundation trainees in Wales able to undertake just one of their six required foundation placements in General Practice during their two year programmes. Foundation doctor exposure to GP in Wales is still by far the UK's lowest (average in UK 55%), despite temporary funding for a small uplift from 24% to 30% for academic years 2014 and 2015.

4.4. Restore the reduced salary supplement for GP trainees in Wales; from 45% back to the 65% it was only a few years ago. This would once more match the salaries achieved by trainees in competing hospital specialties and also afford serious advantage for Wales over competitor nations in attracting young Drs into GP training in Wales.

4.5. Establish schemes, post GP qualification, to allow development of supplementary specialist (GP special interest) skills and other career development pathways (e.g. GP network leadership and management training opportunities). This approach is supported by the Shape of Training Review (Greenaway Report) of 2013 and by the GMC's current work on 'credentialing'.

4.6. Commit to the introduction, once all the devolved nations can agree, of four year long General Practice Specialty Training; the very strong educational case for which has been accepted widely.

Well targeted initiatives, meaningfully affecting the attraction and retention of qualified GPs, in Welsh localities are needed

4.7. Consider meaningful contractual incentives in appropriately identified "hard to recruit" areas. Payment should occur only on satisfactory completion of, perhaps, 2 -3 year contracts. GPs attracted in this way may well "put down roots" and choose to stay.

4.8. Value and trumpet the GP partnership model where this works very well (in the majority of settings throughout Wales, as LHB managers can readily evidence) AND actively promote complimentary GP career models (including contracts with mixes of hospital front door; out of hours; conventional general practice and GP network support and management roles).

4.9. Encourage, support and appropriately incentivise practices that have mutual respect for each others work to voluntarily federate (or continue to try to compel often very disparate GP practices to form networks purely on a locality basis, as now, and ensure failure).

4.10. Introduce schemes to recognise and hence retain talented and highly efficient older GPs. Many might well extend their working lives, continuing to offer effective expertise at the front line patient interface on a part time basis, if balanced, for instance, by appropriate resource to support roles in federation strategy and management.

4.11. Commit to a fully funded GP returner scheme (paying returners at the same rate as a third year GP registrar for 3 to 6 months). This would affordably reveal how many ex-GPs might be prepared to return to the coalface, by reducing the financial stress of doing so.

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Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 15 Ionawr 2015**
Amser:	**09.30 – 12.40**

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://senedd.tv/cy/2665

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnodion Cryno:

Aelodau'r Cynulliad:	**David Rees AC (Cadeirydd)** **Alun Davies AC** **Janet Finch-Saunders AC** **John Griffiths AC** **Elin Jones AC** **Darren Millar AC** **Lynne Neagle AC** **Gwyn R Price AC** **Kirsty Williams AC (ar gyfer eitemau 1 i 5)** **Peter Black AC (yn lle Kirsty Williams AC ar gyfer eitemau 7 a 10)**
Tystion:	**Dan Greaves, Y Swyddfa Gartref** **Angela Scrutton, Y Swyddfa Gartref** **Kirsty Williams AC** **Philippa Watkins** **Lisa Salkeld**
Staff y Pwyllgor:	**Llinos Madeley (Clerc)** **Helen Finlayson (Ail Clerc)** **Sian Giddins (Dirprwy Glerc)** **Enrico Carpanini (Cynghorydd Cyfreithiol)**

Gareth Howells (Cynghorydd Cyfreithiol)
Amy Clifton (Ymchwilydd)

Trawsgrifiad
Gweld trawsgrifiad o'r cyfarfod.

1 Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Cafwyd ymddiheuriadau gan Lindsay Whittle.

2 Papurau i'w nodi

2.0a Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 10 Rhagfyr.

2.1 Ymchwiliad i broses gwynion y GIG: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
2.1a Nododd y Pwyllgor yr ohebiaeth.

2.2 Ymchwiliad dilynol i'r cyfraniad a wneir gan fferyllfeydd cymunedol i wasanaethau iechyd yng Nghymru: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
2.2a Nododd y Pwyllgor yr ohebiaeth.

2.3 Ymchwiliad i sylweddau seicoweithredol newydd ("cyffuriau penfeddwol cyfreithlon"): gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
2.3a Nododd y Pwyllgor yr ohebiaeth.

2.4 Blaenraglen waith y Pwyllgor: gohebiaeth gan y Pwyllgor Plant, Pobl Ifanc ac Addysg
2.4a Nododd y Pwyllgor yr ohebiaeth.

2.5 Craffu ar waith Comisiynydd Pobl Hŷn Cymru: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
2.5a Nododd y Pwyllgor yr ohebiaeth.

2.6 Gohebiaeth gan y Pwyllgor Deisebau: P-04-570 Argaeledd Anghyfartal o ran Triniaethau nad ydynt wedi'u Harfarnu'n Genedlaethol gan GIG Cymru
2.6a Nododd y Pwyllgor yr ohebiaeth a chytunodd i ysgrifennu at Gadeirydd y Pwyllgor Deisebau i dynnu sylw at ei waith diweddar mewn perthynas â'r broses Cais Cyllido Cleifion Unigol.

3 Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitemau 4 a 5

3.1 Derbyniwyd y cynnig.

4 Ymchwiliad i gamddefnyddio alcohol a sylweddau: paratoi ar gyfer gweithgarwch ymgysylltu

4.1 Cytunodd y Pwyllgor ar y trefniadau ar gyfer gweithgaredd ymgysylltu'r ymchwiliad i gamddefnyddio alcohol a sylweddau.

5 Gwybodaeth ddilynol am yr ymchwiliad undydd i farw-enedigaethau yng Nghymru: ystyried y dystiolaeth

5.1 Ystyriodd y Pwyllgor y dystiolaeth a gafwyd a'r adroddiad diweddaru gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol. Cytunodd yr Aelodau i ysgrifennu at y Gweinidog i nodi'r cynnydd a wnaed hyd yn hyn, ac i ofyn am ragor o wybodaeth am rai materion penodol a godwyd yn y dystiolaeth.

6 Ymchwiliad i sylweddau seicoweithredol newydd ("cyffuriau penfeddwol cyfreithlon"): sesiwn dystiolaeth 8

6.1 Bu'r tystion yn ateb cwestiynau gan aelodau'r Pwyllgor.
6.2 Cytunodd y tystion i ddarparu rhagor o wybodaeth am y broses a ddefnyddiodd cydweithwyr yn y Swyddfa Gartref i ymgynghori â'r gweinyddiaethau datganoledig ynghylch deddfwriaeth Ewropeaidd arfaethedig ym maes sylweddau seicoweithredol newydd.

7 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 1

7.1 Ymatebodd yr Aelod sy'n gyfrifol am y Bil (Kirsty Williams) i gwestiynau gan yr Aelodau.
7.2 Cytunodd yr Aelod sy'n gyfrifol i roi amlinelliad i'r Pwyllgor o ba ddangosyddion nyrsio diogel a amlinellir yn adran 3(5) o'r Bil Lefelau Diogel Staff Nyrsio (Cymru) sy'n deillio o ganllawiau'r Prif Swyddog Nyrsio a chanllawiau NICE a pha rai a gafodd eu cynnwys o ganlyniad i'r ymatebion i'w hymgynghoriadau ar y Bil.

8 Cynnig o dan Reol Sefydlog 17.42 (vi) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod

8.1 Derbyniwyd y cynnig.

9 Ymchwiliad i sylweddau seicoweithredol newydd ("cyffuriau penfeddwol cyfreithlon"): ystyried y dystiolaeth a ddaeth i law.

9.1 Ystyriodd y Pwyllgor y dystiolaeth.

10 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): ystyried y dystiolaeth

10.1 Ystyriodd y Pwyllgor y dystiolaeth a ddaeth i law.

Eitem 12.1

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref LF/MD/0055/15

Mr David Rees AC
Cadeirydd
Y Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru
SeneddHealth@Assembly.Wales

21 Ionawr 2015

Annwyl David,

Diolch am eich llythyr dyddiedig 13 Ionawr 2015 ynglŷn ag ystyriaeth y Pwyllgor Iechyd a Gofal Cymdeithasol o'r Memorandwm Cydsyniad Deddfwriaethol ynghylch Bil Arloesi Meddygol y DU – sy'n gofyn am eglurhad o'r trafodaethau â'r Adran Iechyd ynglŷn â'm pryderon am y Bil.

Mae fy swyddogion wedi cael nifer o drafodaethau â chydweithwyr yn yr Adran Iechyd, ac ysgrifennais yn ffurfiol at Earl Howe ar 13 Tachwedd 2014, gan amlinellu fy mhryderon yn ogystal â chynnig rhai gwelliannau i'r Bil, er mwyn lleddfu'r pryderon hynny. Nid yw'r ymateb a dderbyniais i'r llythyr gan Earl Howe, er ei fod yn ateb y pwyntiau a godais, yn bodloni'r pryderon sydd gennyf, ac nid yw'n newid fy marn, sef na ddylai darpariaethau'r Bil fod yn berthnasol i Gymru.

Yn dilyn cael cyngor pellach gan y Dirprwy Brif Swyddog Meddygol, nid yw fy marn wedi newid, ac rwy o'r farn nad yw'r Bil yn angenrheidiol nac yn gyson â'r egwyddorion sylfaenol, yr ydym am eu hysgogi i wella'r GIG yng Nghymru.

Yn ein barn ni nid yw'r Bil yn angenrheidiol gan nad oes unrhyw dystiolaeth bod gofal arloesol yn cael ei atal oherwydd bod ofn ar feddygon ynglŷn ag esgeuluster clinigol. Enghraifft ardderchog ddiweddar yw'r defnydd o driniaethau arloesol yn y DU, yn Ewrop ac yn Affrica wrth drin cleifion Ebola. Mae'r profiad hwn wedi dangos yn glir y gall gofal arloesol gael ei ddarparu o dan y trefniadau presennol.

Mae'n ymddangos inni, felly, fod rheol y gyfraith gyffredin bresennol, sef nad esgeuluster yw gwyro o'r ystod presennol o driniaethau meddygol arferol ar gyfer cyflwr, os yw gwneud hynny'n cael ei gefnogi gan gorff cyfrifol o farn feddygol, yn gweithio'n dda, ac nid oes angen llwybr arall sy'n caniatáu i feddyg ymgymryd â 'gofal arloesol cyfrifol' yn ôl yr hyn

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

Wedi'i argraffu ar bapur wedi'i ailgylchu (100%)
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sydd wedi'i amlinellu yn y Bil. Mae'n peri pryder inni na fydd y Bil yn gwneud y sefyllfa'n fwy clir.

Mae Cymal 1 o'r Bil yn darparu nad yw'n esgeulus i feddyg wyro o'r ystod presennol o driniaethau meddygol arferol i drin cyflwr, os yw'r penderfyniad i wneud hynny'n un cyfrifol. Mae hefyd yn pennu cyfres o gamau y mae'n rhaid i feddyg eu cymryd er mwyn gwneud penderfyniad cyfrifol, er enghraifft, cael barn un neu fwy o feddygon cymwys priodol mewn perthynas â'r driniaeth arfaethedig.

Mae gwelliannau wedi'u gwneud i'r Bil, yn ystod Camau'r Pwyllgor a'r Adrodd yn Nhŷ'r Arglwyddi, er mwyn ceisio diogelu cleifion ymhellach. Safbwynt Llywodraeth Cymru yw nad yw'r gwelliannau hyn yn gwella diogelwch cleifion yn ddigonol, ac yn sicr nid ydynt yn gwneud y Bil hwn yn ddylanwad cadarnhaol ar ofal iechyd yng Nghymru. O dan y gyfraith bresennol, ni fyddai meddyg yn esgeulus os yw'n gallu dangos bod corff cyfrifol o farn feddygol yn cefnogi ei benderfyniad. Fodd bynnag, yn y Bil, er mwyn gallu gwneud penderfyniad cyfrifol i wyro o'r ystod presennol o driniaethau, y prawf yn benodol yw bod yn rhaid i'r meddyg gael barn un neu fwy o feddygon cymwys addas. Yr hyn sy'n peri pryder inni yw y gallai meddygon arloesol ystyried ei bod yn angenrheidiol i gael barn un meddyg arall yn unig, hyd yn oed o dan amgylchiadau pan fo corff cyfrifol ehangach o farn feddygol y dylid ymgynghori ag ef.

Mae'r gwelliannau hefyd yn gofyn i'r meddyg ystyried barn a lles gorau'r claf ac i'r meddyg gofnodi ei benderfyniadau clinigol, ond mae'r rhain eisoes yn rhai o'r gofynion cyfreithiol ar gyfer pob meddyg, felly nid yw'r Bil yn ychwanegu at hynny'n sylweddol.

Rydym yn pryderu, felly, y gallai'r Bil gael effaith sy'n groes i'r egwyddorion sy'n tanseilio ein polisi yng Nghymru am ofal iechyd darbodus. Mae gofal iechyd darbodus yn gofyn am y defnydd cyson o ofal sy'n seiliedig ar dystiolaeth mewn ffordd sy'n lleihau'r posibilrwydd o niwed y gellir ei osgoi. Gallai'r Bil annog triniaethau arloesol nad ydynt o reidrwydd yn gyson â pholisi Llywodraeth Cymru o ran iechyd gofal darbodus. Bydd llawer o'r cleifion sy'n awyddus i gael y triniaethau arloesol a ystyrir yn y Bil hwn yn wirioneddol sâl, a gallent fod yn agored i niwed. Byddem yn dymuno iddynt gael eu trin â thosturi, gan gynnwys trafodaethau am ofal sy'n seiliedig ar dystiolaeth. Credwn y gallai pennu llwybr arall i feddygon ei dilyn wrth awgrymu dull arloesol o drin arwain at ddryswch o ran y mathau o driniaethau y dylid eu cynnig i'r cleifion hynny. Gallai hynny arwain at ddefnyddio triniaethau arbrofol a allai fod yn anniogel, ac nad oes iddynt debygrwydd hysbys o lwyddo.

Am y rhesymau hyn, nid yw'r Bil, gan gynnwys y gwelliannau, yn darparu dylanwad cadarnhaol ar gyfer gofal iechyd yng Nghymru, ac rwy o'r farn o hyd na ddylai'r darpariaethau yn y Bil hwn fod yn berthnasol i Gymru.

Yn gywir

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

Y Pwyllgor Deisebau
Petitions Committee

David Rees AM
Chair
Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
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Caerdydd / Cardiff
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Our ref: P-04-600

22 January 2015

Dear David

Petition Title – P 04-600 Petition to Save General Practice Wales

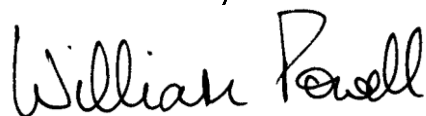
The attached petition, from the Royal College of General Practitioners Wales (RCGP), collected over 15,000 signatures and was considered by the Petitions Committee for the first time in October last year. The Committee agreed to write to the Minister for Health and Social Services seeking his views on the petition.

The Minister's response reached us in early December and we considered it, along with comments from the Chair of RCGP Wales, Paul Myres, at the first available opportunity, which was at our meeting on Tuesday this week.

The Committee agreed that it would be helpful if your Committee could consider the issues raised by the petition and in the associated correspondence. I understand that your Committee is undertaking a short inquiry into the GP workforce in Wales and is taking evidence (including from the RCGP) next week.

It may be that the petition and responses to it will assist you in your consideration. I would be most grateful if you could keep me informed of any developments.

Yours sincerely



William Powell AC / AM
Cadeirydd / Chair

Enclosures: Petition, Letter from Health Minister, Letter from RCGP Wales

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Croesewir gohebiaeth yn y Gymraeg a'r Saesneg/We welcome correspondence in both English and Welsh

P-04-600 Petition to save general practice – Wales

Petition Wording

Despite carrying out 90% of all NHS patient contacts, general practice only receives 8.39% of the NHS budget in the UK — an historic low. By 2017, this is projected to plunge to just 7.29%

As a result, general practice is facing a growing crisis.

Due to the sheer volume of GP workloads, in this year alone, patients will have to wait longer than a week to see their GP on at least 27m occasions.

And, according to a poll carried out in March, more than three fifths of the public now believe that the number of patient consultations carried out by GPs — up to 60 per day — is threatening the level of patient care.

To protect high quality services for all patients, I call on the First Minister to increase the share of the NHS budget spent on general practice in Wales to 11% by 2017.

This shift in funding would enable general practice to deliver: Shorter waiting times for appointments and more flexible opening hours

Longer consultations, especially for people with long term conditions.
More opportunity for patients to see a GP who knows them
Better care co-ordination and planning, especially for the elderly and those with complex needs

Positive benefits for the NHS as a whole, reducing pressure on hospitals

GP surgeries sit at the heart of local communities. I demand that the Welsh Government acts now to ensure practices have the resources they need to continue to provide the high quality care patients deserve.

Petitioner: Royal College of General Practitioners.

Lead petitioner: Eurwen Petitti

First Consideration: 7 October 2014

Signatures:15,000 paper signatures and over 500 electronic signatures collected on an alternative e-petition website.

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-04-600
Ein cyf/Our ref MD/05470/14

William Powell AM
Assembly Member for Mid & West Wales
Chair
Petitions Committee
Ty Hywel
Cardiff Bay
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Petition@Wales.gov.uk

29 October 2014

Dear William,

Thank you for your letter of 17 October on behalf of the Petitions Committee regarding Petition: P-04-600 Save General Practice, from the Royal College of General Practitioners.

Thank you for bringing my attention to this petition. I support fully General Practice as an integral part of the NHS, and recognise that GPs, along with other healthcare professionals across Wales, are facing increased daily pressures.

The Welsh Government is committed to continuous investment in the health service and ensuring Health Boards align their services to provide the maximum benefit for patients within the resources available. We are working towards a preventative primary care-led NHS; one that is integrated with social care and has close links with services provided by the third and independent sectors.

Since 2003, investment in general practice has increased by £137m; from £322m in 2003-04 to £459m in 2013-14, demonstrating our commitment to provide safe and sustainable health services in the community and close to people's homes. In relation to 2014-15, in line with the recommendations of the Review Body for Doctors and Dentists, investment in general practice has been increased by a further 0.28% or £1.3m.

In addition, I announced recently a further investment of £3.5m for primary health care services in 2014-15. This investment reflects the need to rebalance on the principles of prudent healthcare the way the NHS provides services.

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The funding will be targeted at 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.

The additional funding will help to realise our ambition to create a strong, highly-trained primary care workforce, which can deliver a wide-range of services in local communities, reducing our dependence on hospital-based care, together with tackling poverty and reducing inequalities which are key priorities for the Welsh Government.

Yours sincerely,

Mark

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

January 14 2015

The Petitions Committee
National Assembly for Wales
Cardiff Bay

Dear Chair of the Petitions Committee

The Royal College of GPs Wales is grateful for the Minister's response and his recognition of the pressures facing General Practice.

We were disappointed that his letter did not acknowledge the fall in funding in real terms over the last four years. This shortfall will hinder the essential development of general practice to meet the needs of the Welsh population and the aspirations of the Welsh government. A boost in investment for general practice is vital if we are to meet the changing needs of patients, reduce pressure on the rest of the NHS and place our health service on a stronger long-term financial footing.

Whilst GP workloads are increasing, funding for general practice in Wales has fallen, in real terms, from £451.3m in 2009/10 to £438.0m (HSCIC, September 2014 and Autumn Statement, December 2014) in 2013/14, with total investment falling by 2.9%. This is having a concerning impact on patients – with as many as 650,000 people finding it difficult to get an appointment to see a GP in Wales last year.

There is growing evidence that the capacity of the general practice workforce to meet the changing and increasing demands of patients is under threat. Firstly, demand for general practice is increasing and this is causing additional workload pressures for GPs and their teams. There is also strong evidence that the care general practice is required to deliver is becoming more complex as we are becoming an ageing population.

The general practice workforce is also ageing. In Wales, over 23% of our GPs are over 55 and many are choosing to retire early, often due to work pressures and stress.

Wales ranks third in the UK in GP coverage per population and RCGP Wales estimates that we will need an additional 95 GPs this year just to reach the UK average. We will need even more to replace those who leave and far more to meet the needs and challenges ahead.

The RCGP's Put Patients First: Back General Practice campaign, a collaborative of General Practice staff and partner organisations, focuses on the need for urgent additional resources as well as focusing on the key themes that are inhibiting GPs from building on the excellent quality of care they currently provide despite these challenges.

We believe that for general practice to play its critical role in caring for patients in the future NHS, it is important that there are enough GPs and practice nurses; that these doctors and nurses have sufficient time, both in and outside the consultation, to understand the patient's needs and concerns to provide the interventions needed. They need to receive sufficient training to develop the capabilities required to deliver the high quality services that patients, carers and families rightly expect.

RCGP Wales welcomes the £10m fund identified in the primary care plan but it still falls far short of the investment needed to address the shortfall in funding for general practice alone. General practice received 8.5% of total NHS expenditure in 2005/06, it now receives 7.7%. The primary care plan mentions the "transfer of resources from hospitals to the community" over the next four years. The Minister has given us no assurance as to whether or how that will happen as it remains within the remit of LHBs to decide how the money is distributed.

Recent research commissioned by the Royal College of GPs shows that an increase in access to general practice would lead to a reduction in the number of A&E attendances in Wales. Estimates place the proportion of attendances that could have been dealt with in general practice at between 15 and 26% and thereby lead to a saving of up to £21.5m each financial year at a cost of £3.5m, rising to annual savings of up to £34m by the end of 2019/20. The economic argument is palpable.

The pressures on general practice to deliver effective care are mounting, as is the need to deliver continuity of care and accessible services. The crisis of demand versus capacity in the health service is not new; it has not arisen overnight and neither can it be solved quickly. Sustainable solutions must be found to increase workforce capacity and enable general practices to continue to deliver the level of service that their patients expect now, as well as taking on the challenge of providing more complex care, spending longer with their patients and communities and taking on new roles and responsibilities.

We hope that the Minister will take action to ensure that investment in general practice is secured for the long-term and that the resources will therefore be made available to meet demand before it is too late.

Yours sincerely,

Paul Myres
Chair
RCGP Wales