



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

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

Dydd Mercher, 25 Chwefror 2014
Wednesday, 25 February 2014

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Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac ar gyfer Eitem 1 y Cyfarfod ar 5 Mawrth 2015
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the Public from the Remainder of the Meeting and for Item 1 of the Meeting on 5 March 2015

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Peter Black	Democratiaid Rhyddfrydol Cymru (yn dirprwyo ar ran Kirsty Williams) Welsh Liberal Democrats (substitute for Kirsty Williams)
Alun Davies	Llafur Labour
Janet Finch-Saunders	Ceidwadwyr Cymreig Welsh Conservatives
John Griffiths	Llafur Labour
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Gwyn R. Price	Llafur Labour
David Rees	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Lindsay Whittle	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Yr Athro/Professor Gillian Leng	Dirprwy Brif Weithredwr, y Sefydliad Cenedlaethol dros Ragoriaeth mewn Iechyd a Gofal Deputy Chief Executive, the National Institute for Health and Care Excellence
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Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Siân Giddins	Dirprwy Glerc Deputy Clerk
Llinos Madeley	Clerc Clerk
Siân Thomas	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 09:32.
The meeting began at 09:32.

Cyflwyniadau, Ymddiheuriadau a Dirprwyon
Introductions, Apologies and Substitutions

[1] **David Rees:** Good morning. Can I welcome Members to this morning's session of the Health and Social Care Committee? We continue our evidence collection on Stage 1 of the Safe Nurse Staffing Levels (Wales) Bill. Can I remind Members that the meeting is bilingual and if you wish to use the headphones, simultaneous translation is on channel 1 and amplification is on channel 2? Can I welcome Peter Black, in the place of Kirsty Williams

this morning, back to the committee for this evidence session? Good morning. Can I remind everybody to turn their mobile phones off, please, or any other electronic equipment that may interfere with the broadcasting equipment? If they don't interfere, please make sure they are on 'silent'. There is no scheduled fire alarm this morning, so if one goes off, please follow the directions of the ushers. We've had no other apologies.

[2] Before we start this morning, can I just make the point that we were supposed to have a second session with the chief nursing officer, but, unfortunately, she has had a family bereavement? I'm sure Members will join me in expressing our condolences to the chief nursing officer and her family on this occasion. In the light of that, obviously the day's business has been rearranged. Can I thank very much Professor Leng for actually rearranging the times as well to help us out? Therefore, we will have this session this morning and move on. So, shall we go straight into the session?

09:33

Y Bil Lefelau Diogel Staff Nyrsio (Cymru): Sesiwn Dystiolaeth 11 Safe Nurse Staffing Levels (Wales) Bill: Evidence Session 11

[3] **David Rees:** Can I welcome Professor Gillian Leng from the National Institute for Health and Care Excellence? Thank you very much for the written evidence we've received, and we've also got a copy of the guidelines from NICE in relation to this matter. We'll go straight into questions, if that's okay with you.

[4] **Professor Leng:** Absolutely.

[5] **David Rees:** Gwyn, do you want to start with the questions, please?

[6] **Gwyn R. Price:** Thank you, Chair. Good morning.

[7] **Professor Leng:** Good morning.

[8] **Gwyn R. Price:** Could you give NICE's view on the fact that the Department of Health did not include the setting of minimum staffing levels within NICE's remit to develop the safe staffing guidelines? Would you have preferred the scope to include ratios if the evidence suggested they were a valid tool?

[9] **Professor Leng:** You're right to ask about the Department of Health, because all NICE's work programme is referred by the Department of Health, or partly these days by NHS England. So we get a formal remit and we then follow what we've been asked to do. The remit that we had was to issue guidance on safe nurse staffing levels and that was a very focused piece of work. We had a very tight time frame to do it, so it didn't encompass all the literature that potentially it could have done, because it's a massive field. So, we focused on the process for setting the establishment in acute hospitals. We focused on what needed to be done on a day-to-day basis and what we would recommend nurses to do if things were sadly not going well. So, we followed the remit that we had; we consulted on the guideline, and clearly there is a bigger task that might have encompassed whether ratios work or not if they're formally set. We will review the guideline and, when we come to update it, I'm sure we will take a look at the scope and potentially extend it. But, that said, the important 'but' is that, although it wasn't formally in the remit and it wasn't therefore in the scope, the committee did look at some of the evidence that showed what was required to have safe nurse staffing levels, and that encompassed how many nurses you had at any one time, and there was indeed a recommendation in the guideline about 1:8 and that being a warning sign that things might be problematic. So, although it wasn't formally in the remit, or formally in the scope, the committee looked at relevant evidence and discussed and debated the question.

[10] **Gwyn R. Price:** So, basically, it would be a valid tool, really, in having a look at the whole situation.

[11] **Professor Leng:** What would be a valid tool, sorry?

[12] **Gwyn R. Price:** The staffing levels. As you said, you didn't look at it specifically, but you did touch on it there.

[13] **Professor Leng:** We didn't specifically look at the evidence that related to whether having a mandated ratio makes a difference, but we did look at the evidence that showed what safe staffing levels were. The committee was very clear that, in the scope that we had, which was adult wards in acute hospitals, there was an awful lot of variation in those types of wards. We can think from our own experience of the areas that that would include. It included older people's wards, it includes cardiology wards, it includes renal wards—a whole range of different patient types with different needs—and setting a minimum ratio or any sort of ratio that covered all of that is bound to be wrong, because of the requirements being so varied, and that was the key. One of the key things that the committee was concerned about was setting an absolute minimum level that was going to be wrong in many situations.

[14] **Gwyn R. Price:** Okay. Thank you very much, Chair.

[15] **David Rees:** We've got a question now from Lynne Neagle and then Lindsay. So, Lynne.

[16] **Lynne Neagle:** Just on this really, we took evidence last week from Professor Peter Griffiths who played a role in your work. His view is that there is no evidence that suggests using workforce planning systems without the underpinning of a ratio has any positive impact on patient care. Have you got any comment on that?

[17] **Professor Leng:** I read the transcript of what Peter had said, so I was interested in that comment. I'm not entirely clear exactly what he meant, but I would contest the fact that there is no evidence that planning makes any difference, because, indeed, I've seen some evidence that shows that it was planning rather than the ratio that made a difference in improved outcomes. I think the other important thing to remember in all of this is that none of the evidence is black and white, and I think Peter acknowledged that in what he said about ratios. It's not black and white; it's incomplete. It always, as with any evidence base around healthcare, needs interpretation. We set out a committee of mixed representation to look at the evidence that was there, that was presented to them, and we consulted with a whole range of stakeholders and came to a conclusion about the important way forward, supported by the Royal College of Nursing. I think you'd be hard-pressed to find anybody who said you shouldn't plan your workforce, so I'm slightly bemused by what Peter said, because you have to have an approach to plan both your establishment and what you need on a day-to-day basis and to be reactive to that.

[18] **David Rees:** Okay. Lindsay, is your question on ratios?

[19] **Lindsay Whittle:** Yes. I am just wondering what NICE's view is on the ratio on the types of wards patients are in. On the traditional ward, you could sometimes see eight patients at a glance, whereas now, the more modern hospitals have individual private rooms with doors closed and blinds drawn. That must be more difficult for the nursing staff. I'd be interested in your views on that, please.

[20] **Professor Leng:** We included, in the early scoping of the guideline, the environment that the nurses were working in and the patients were being cared for in, because—you're

absolutely right—the old Nightingale ward was much easier to observe. I've got a lovely photograph from 1935 of an open ward with a nurse standing by every bed, and I'm absolutely sure they didn't have a 1:1 ratio in 1935, but there we are. So, we recognise what you're saying about the challenges of single rooms, and we looked for evidence in that area. Again, it wasn't cut and dried. There is, sort of, a suggestion that you might need to factor up by a little bit if you've got lots of single rooms. So, we included reference to that in the guideline, that it should be a factor taken into account, but there's not enough to make a hard-and-fast rule. Of course, there are trade-offs in terms of your staffing requirements, with the need for privacy, with the need for intensive care that sometimes needs to get delivered in those rooms. So, again, it's a mixed picture.

[21] **Lindsay Whittle:** Okay; thank you.

[22] **David Rees:** John.

[23] **John Griffiths:** Just going back to the ratio, you rightly pointed out, I think, there's quite a mix of patients on any one ward at any one time. So, a minimum ratio could be a fairly blunt tool, in effect. Nonetheless, that 1:8 figure was arrived at, so was that on the basis that, whatever the mix on a particular ward, you shouldn't go below that 1:8 figure? Was it also on the basis that much else needs to be done to decide the safe staffing level on a ward at any particular time, over and beyond the 1:8 figure?

[24] **Professor Leng:** There was clear evidence that things were likely to go wrong if the ratio went below 1:8, so we referenced that in the guideline as a reason why the nurse in charge would need to be double-checking that care was being provided appropriately. So, it's very much a, sort of, baseline level. But if you then look at needs and you do the bottom-up calculation, if you like, of the patients on the ward and how much care they would need, in many cases it's much, much more than 1:8. So, the risk of setting a flat ratio and not emphasising planning, looking at the patients' needs on the ward, is that you get it wrong in many cases, and patients are not being cared for appropriately. If you think of the extreme example, at intensive care, you'd have a 1:1 ratio—the nurses on our committee were very keen to say that you could have a patient arrive on the ward who needs 1:1 care, and that it disrupts everything that you had carefully planned in advance, and you need to bring in additional staff. So, the approach that says, 'Look at the dependency and the acuity of the patients on the ward—on a regular basis, on an ongoing basis—and staff accordingly', is the really, really important thing to have in place in your hospital. A flat minimum ratio, across the board, will be wrong in most cases, I fear.

[25] I've thought about this a lot since we did the guideline, because there are some really interesting questions. Just to digress on the ratio issue for a moment, with our maternity guideline that's coming out, there is a 1:1 ratio in that guideline, and that relates to the point of delivery, because it's a pretty clear-cut scenario that's pretty standard. You can safely say, 'One midwife to one woman in labour'. I think, if we all wanted to go down a road of dividing up hospital wards very, very tightly, so that we know that we can reduce the variation in that scenario, we would be safer—we'd be on much surer footing—to say the ratio on that ward for this type of patient is X:1, or whatever it might be. But, actually, that's really, really difficult. We could go down that road, we could pursue the data as much as we like, but it would be really hard, and there would still be scenarios where things changed and a patient became suddenly unwell, or in fact the patient—. Do you understand what I'm saying?

09:45

[26] **David Rees:** Yes. Elin?

[27] **Elin Jones:** In light of what you've just said, the legislation that we're scrutinising at this point does make it a statutory requirement for local health boards to set a minimum nurse-patient ratio—obviously, with recognition of the acuity on the ward. So, do you think that it's inappropriate to legislate for a minimum ratio, given what you've said, and the risk that the minimum ratio could become what the health board aims for, rather than what it should be providing for the ward to ensure safe staffing?

[28] **Professor Leng:** I think you're absolutely right. I think the risk is that the minimum becomes the target, so I think that's one problem. I've talked about the variation problem, and I think the other thing to be concerned about in setting something in legislation is that we know that the nurse requirements vary with time, and you'd have set that out, clearly fixed, in your legislation. I was slightly light-hearted about 1935, but it's important to remember what's happened, and the things that we now do in hospitals that we didn't do. The increase in the types of interventions that we put in place, and the technology that's there might, in fact, mean we need fewer nurses in future. Who knows? The length of stay has gone down. We've got different types of skill mix that is continuing to evolve, and that was another challenge for the committee—what's the balance of registered versus unregistered. The types of staff that we have in hospital are going to continue to change, so I think a key risk of setting something in legislation is that it's fixed, and actually we need to be tracking on an ongoing basis what we need, and continuing to plan in our hospital services.

[29] For me, a strong approach that's not quite legislation is the approach around monitoring, making sure we're checking outcomes, checking the number of nurses who are there balanced against the patient needs, and emphasising that. You might want then to think about sanctions alongside that, but that would be my preference.

[30] **David Rees:** Just to be clear, as I said, the actual ratio itself is not on the face of the Bill. It's the concept of a ratio, of minimum standards, that is in the Bill. Lynne, do you want to come in?

[31] **Lynne Neagle:** Not on that.

[32] **David Rees:** It's okay.

[33] **Lynne Neagle:** I just wanted to ask about compliance with the NICE guidelines. We've had some members of the committee expressing the view that things are much better in England than they are in Wales. I'm not sure you would be in a position to comment on that, but I would be interested to know how well you feel health bodies in England are complying with the NICE guidance in this area, and also what particular steps are in place to monitor compliance.

[34] **Professor Leng:** I think we've been lucky as regards this area of guidance, the staffing guidance, because there's been a particular focus on it. I'm saying this in the context that sometimes we issue NICE guidance and it's quite hard to drive improvements, because what you need to drive improvements is backing from a number of other initiatives that sort of sit around the guidance; here we've had strong support from NHS England and the chief nurse and the Secretary of State, which has driven a focus on training, to make sure we've done the work around what this means for future training, and getting nurses back on the wards. There's been the clear support around monitoring, and, as I mentioned before, my experience over the years at NICE is that measuring definitely drives improvement, so that's really important. We've got some good indicators now in place. They're not perfect, because actually I think that the data collection around nurse staffing—in fact, any staffing—isn't particularly brilliant, and we've needed to put a lot of effort into that, but I think that focus, and the fact that that's been being published, makes a big difference. It's also part of the inspection that's going on through the Care Quality Commission. So, there are pros and cons

to inspection that you're probably familiar with, but it is ratcheting up the focus on the staffing. So, you'd be hard pressed, I think, to find a hospital trust that wasn't aware of the guidance, and aware that they needed to do something about it.

[35] **Lynne Neagle:** I understand what you're saying, but being aware of the guidance and knowing it's there isn't the same as actually delivering on it, is it? So, how confident are you, and to what extent do you feel that it is actually making a difference on the ground, or do you think it's too early to say?

[36] **Professor Leng:** Well, I think you can see that there has been an increased focus on staffing, and that the data are showing that there are improvements. Because there have been those other things in play, can I put my hand on my heart and say it's all down to the NICE guideline? I couldn't. I think we facilitated and informed that through evidence-based work. The other piece that we've done that I haven't mentioned yet is the endorsement of the safer nursing care tool, which you're probably familiar with. That was a tool that some hospitals were using before, and we looked at data that had informed that, as well as the literature that Peter Griffiths looked at, and we have endorsed that as a tool to support hospitals to do that careful planning.

[37] **Lynne Neagle:** Can I just ask one other question?

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

[39] **Lynne Neagle:** Have you got any concerns that the focus of the NICE guidance being on staffing in particular areas will lead to resources being pulled from other areas that aren't covered by the guidance, such as community nursing?

[40] **Professor Leng:** I think that is a reasonable concern, isn't it? In terms of NICE's programme of work around nurse staffing, there are nine topics that will be coming through, so they will gradually cover other areas, including community nursing, and possibly also nursing in residential care homes. There's a whole suite that will come through in the next couple of years.

[41] Interestingly, though, there is also now awareness—I think because the guidance is having impact, and anecdotally, if nothing else—that we should roll out our programme of staffing to look at other professions. So, we've got the portfolio that will cover nurses in a range of areas, but we should be looking at, perhaps, GPs. We should be looking at teams—and team working is, I think, a really important issue. We're doing a guideline on accident and emergency, where clearly multiprofessional teamworking is really important. So, perhaps, subject to referral from Government, and whatever, we might do that. But I think that sense that we've had of teamworking, multiprofessions, plays back into the point of, 'Let's be careful about not setting things in stone', because the way we all work and the way we're all trained changes.

[42] **Lynne Neagle:** Thanks.

[43] **David Rees:** Well, we have received evidence from other allied health professions, which actually have expressed exactly the viewpoint that there needs to be a review of the team aspect, rather than the single, one profession.

[44] **Professor Leng:** Yes, absolutely.

[45] **David Rees:** Elin?

[46] **Elin Jones:** I think you've just covered what I was going to ask.

[47] **David Rees:** Oh, sorry.

[48] **Elin Jones:** I wanted to ask about the work that you will be doing in other areas, then—health settings, because we have discussed, in the context of scrutinising this Bill, that it is narrowly focused just on adult in-patient wards. I've been particularly concerned about the issue of community nursing, because the structures in Wales mean that the health board is responsible for nursing both in the community and in a hospital setting, and this could shift resource then, in order to meet the statutory requirement. Do you have any timetable for us on when you're likely to be publishing guidelines on safe staffing in a community setting?

[49] **Professor Leng:** I can't give you an exact date; there is on the website, and we could send it through, I'm sure, the ordering, because we have agreed with NHS England and the Department of Health the order that we'll do them in. I don't think community—well, I know it's not coming out in this coming year. I think it will be towards the end of 2016, but we can confirm that, if you like. It was something that Jane Cummings, the CNO in England, did raise with us, because she had similar concern about potential movement of staff, so it's been prioritised against everything else.

[50] **David Rees:** As a consequence of that, one of the concerns our Members have had, as I said, is the question as to where staff would come in to meet the needs. As you're looking at the different settings now—I know maternity is next and you're looking at A&E—are you also looking at the actual staffing numbers as a totality to ensure that they can be delivered by health boards, so that if you are recommending guidelines for safe nursing levels on particular wards that you're taking the whole picture of the nursing staffing levels within the health board to ensure that's delivered?

[51] **Professor Leng:** Just to check I've understood, do you mean are we looking at whether there are actually enough available nurses across the system?

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

[53] **Professor Leng:** Well, we are working with Health Education England, which is the English body that's planning for staffing across the health service. So, we are looking at the guidance we've issued, calculating up what we think that means in terms of staff numbers, talking to Health Education England, who've got the data of the various trajectories about staff and training and whatever, and looking at whether they match at all. Where there's likely to be a gap, Health Education England will pick that up in terms of their future training. So, we're doing as best as we can, bearing in mind it's not our remit.

[54] With the midwifery guideline which is, in fact, publishing next week, it's pretty positive. It looks as though there isn't going to be an issue and that we're not going to need more midwives based on what we said, so that's good. But clearly with the general nursing workforce, there's the challenge of encouraging nurses to stay in the workforce, to come back to the workforce, or to train more nurses. It is a sense of there being a gap at the moment.

[55] **David Rees:** Okay, thank you. Peter, do you want to ask a question?

[56] **Peter Black:** What evidence have you looked at in other countries where this minimum ratio is actually in place? We've had evidence that, where they've put it in place, nurses have come back into the profession because they feel the working environment is better suited to what they hoped to get out of working in the NHS.

[57] **Professor Leng:** As I said at the very beginning, we didn't look at the evidence that says, 'If you introduce a minimum ratio, what happens?' We looked at the evidence around

how many nurses you need at any one time and how you plan for that to make sure the wards are safe. But related to the second point about encouraging nurses back into the workforce because the environment is better, it has also been fed back to us following publication of the first guideline, in a slightly different way. The questions that have been raised are, ‘How do you make sure that hospitals are being run in such a way as to make them supportive of staff, make them good places to work and to make staff feel engaged?’—all those positive things that you’d want to have in place. I think it came back to us because the guideline has a very small section on organisational support for staff. That was all we could do in the time and the scope of that guideline.

[58] The important point is we have now been referred another topic that is about organisational approaches to staff. How do you manage to engage staff to make them feel engaged, to have less time off sick, and all of those things that are about being a good employer. There’s a lot of research in that area, which was pointed out to us when we did the first guideline: the Michael West work. I don’t know if you’ve spoken to Michael West, but there’s another body of literature about running your hospitals that do all those positive things. So, that’s the angle that we’ve now been asked to look at, which will hopefully address the issue of it being a good environment for—

[59] **Peter Black:** Is there any evidence that your guidelines have actually encouraged more returning to work?

[60] **Professor Leng:** Not that I know of. I couldn’t confidently answer that.

[61] **Peter Black:** Okay. So, on the basis of the guidelines, we’ve already referred, I think, to the impact on other services. Is there any evidence that you’ve had a negative impact on other allied health professionals as a result of your guidance going in in England?

[62] **Professor Leng:** Again, I don’t know of any data that show that nurse numbers have gone up and allied health professional numbers have gone down, although I have heard the concerns that clearly you have, that people feel there is a risk of that. But I don’t know that it actually has happened or hasn’t happened.

[63] **Peter Black:** Okay, thanks.

[64] **David Rees:** Just to add to that question, are you seeing any data as to whether there’s been an increase in the number of bank nurses or agency nurses who are now being employed within the hospital to ensure that they comply with the guidance?

10:00

[65] **Professor Leng:** Do I know if there have been any data?

[66] **David Rees:** If there are any data reported on it.

[67] **Professor Leng:** I think there are data, but, again, I can’t confidently tell you the answer to that, I’m afraid.

[68] **David Rees:** Okay. Chapter 3 of the guidance actually highlights what it claims are gaps in the evidence, and it’s quite interesting to see some of those gaps that are identified in relation to the evidence for supporting the safe nursing levels and minimum levels. But you’re now talking about looking at different settings. Have you reviewed the evidence from initial guidelines to the new settings, and, therefore, is there more evidence now to support the introduction of the levels?

[69] **Professor Leng:** Sorry, in terms of the gaps that we identified in the first guidelines, is there now more evidence that will fill those gaps?

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

[71] **Professor Leng:** I don't know, but I doubt in the time frame since we've published the guideline that there have been additional data to fill those gaps. Usually, it takes a piece of research several years to be commissioned and then to be available and published for us to look at. So, it's unlikely. We've got the guidance on a fairly rapid review timetable, so we will take a look in a couple of years after publication to see what has been published and what we might do in terms of updating it. We will look not just at the published research, but, hopefully, some of the data that are now being collected that weren't available before will help us to inform the update. Perhaps you have better data systems in Wales, but, in England, the data around nursing were pretty coarse—sort of at a hospital level—and we wanted to look at nurse levels on wards and to be able to tally that with the types of patients that they were caring for and those data just weren't routinely available.

[72] **David Rees:** Okay, thank you. Also, we've talked about the guidelines in place, but what about the mechanisms for when there is non-compliance? Are you aware of what mechanisms are in place if hospitals and boards are actually not in compliance with the guidelines?

[73] **Professor Leng:** I don't think there are any absolute sanctions that relate strictly to the nurse staff levels or indeed the outcomes, other than what happens through the inspection. The inspection and the Care Quality Commission will pick up on that, so it might inform their overall rating or put them down as an organisation at risk. There might be issues that are raised through the open publication of the data, so that will be spotted and highlighted and might be an indirect sanction. Other than that, I don't think there is anything in place. Clearly, we know that, when staffing levels are low, we get more complaints, and there's more litigation. There was some evidence we looked at in terms of costs of litigation that relates to staff levels being poor, but there's no—. I'm not aware of anything that's more direct than that.

[74] **David Rees:** Okay, thank you. Lynne, do you want to come in?

[75] **Lynne Neagle:** Yes. We've had evidence previously that, should this Bill be implemented, it would give front-line nurses the confidence to raise concerns if, say, for example, a nurse is on a shift and they're worried that the nursing levels are substandard, and that having a statutory framework would give them the backup to flag up concerns like that. I was just wondering whether you know whether the NICE guidance has had a similar impact through your discussions with people like the Royal College of Nursing. Has it made nurses more confident in raising concerns?

[76] **Professor Leng:** Again, I don't have data to back up what I'm saying, but, informally, I've heard that it has. You'll be aware of the section of the guideline that talks about red flags and that was very much about empowering nurses, and, indeed, patients and relatives, to say, 'Look, these things aren't happening; there aren't enough nurses on the ward'—a flag to the management to make sure that nurses were either moved from ward to ward or brought in from a bank, or something was done, because things were going wrong. So, we very much wanted to empower nurses through that process, and we've asked that, as part of the data collection, any of those things are collected as exception reports. Whether the Bill and a mandated minimum could help, I don't know, because that would be about saying, 'Well, my ratio is less than has been set here', but, on the other hand, as we've sort of agreed, I think, in many cases you need more nurses. So, is that scenario going to help then, when actually you need far more than the minimum nurse ratio? That's not backed up in the

legislation.

[77] **Lynne Neagle:** Okay, thank you. To what extent is the public in England aware of the NICE guidance, then, in order to take the opportunity to raise it under a red-flag system?

[78] **Professor Leng:** That's a good question. We do our best to publicise our guidance to the public and the press helps at the point of launch, it's on our website, and we make sure it's also linked from the NHS Choices website, which is patient-facing. Some hospitals publish things as you go into the wards so that it's clear for patients what they should be expecting. But I couldn't say—

[79] **Lynne Neagle:** It's not uniform, then, that each ward would say—you know, that it would be on the ward that this is what the public can expect.

[80] **Professor Leng:** No. It would be nice if it was, but it isn't.

[81] **David Rees:** John.

[82] **John Griffiths:** Just further to that, would you have a view on how realistic it is to expect a shift-by-shift reporting of the ratio of nurses on a ward? Would you consider that to be impractical or is that something that ought to be achieved and could be achieved?

[83] **Professor Leng:** I think it's—well, I know it's achievable in some hospitals. We had our staffing committee debate these questions around data collection, with mixed views. There were one or two nurses who said, 'This isn't practical', and others clearly of a different opinion, saying, 'Well, it is, because it's happening here, it's happening there, and it's happening in my hospital'. I think a lot about its being practical depends on the technology, to be honest, and, if the technology's supporting it, it happens without much difficulty, and, in other cases, it's much more challenging. I have a personal view that's nothing to do with NICE guidance: it's that hospitals could much more easily collect data if we introduced those card systems—. Well, we all have entry cards, don't we, but if you had cards for nurses entering on to a ward, you'd just have those data collected centrally in the hospital. But, for whatever reason, they've never been introduced. I think there's some resistance, but, if nurses all carried an entry card that swiped them in and out of the wards, you'd just know where the nurses were. That's a personal perspective. [*Laughter.*]

[84] **David Rees:** Can I ask the question—

[85] **Elin Jones:** GPS trackers. [*Laughter.*]

[86] **Lindsay Whittle:** You could say the same thing about patients as well—

[87] **Professor Leng:** Yes, you might, yes.

[88] **Lindsay Whittle:** Seriously, because patients go missing in hospitals. There was the tragic case in Bristol of a young mother who walked out, you know. We protect bottles of whisky and expensive jackets with tags in superstores, but we don't protect patients and, indeed, staff as well.

[89] **Professor Leng:** Yes. It's interesting, isn't it?

[90] **David Rees:** Okay, let's go back to the Bill, and there's one question. As part of the evidence-gathering that you had for your guidelines and your guidance, did you actually look at the potential cost saving that the safe staffing levels may have?

[91] **Professor Leng:** Yes.

[92] **David Rees:** And what was your view on that?

[93] **Professor Leng:** We published a very short report, which you might have found on the website, on the cost impact of the guidance, and we factored into that potential savings. There is a more detailed report that, if you were interested, we could send. I can't remember the numbers, but it included savings from adverse events, if you like: things like pressure ulcers, which generate longer stays, so the cost goes up. It included things like things going wrong—adverse events—and it also included, as I say, the litigation costs, because we know that there's more litigation that's associated with poor care and you reduce that. So, those things were factored into the report. I can't give you a number off the top of my head.

[94] **David Rees:** Thank you for that, but we would be grateful if you could actually forward that to the committee. Do any other Members have any questions? Then I will take the prerogative of one final question in the sense of—. The work between the chief nursing officer, and obviously the CNO has issued guidance here—. Has there been a relationship between the CNO in Wales and the work you've done in your guidance?

[95] **Professor Leng:** Yes. Not a formal link, insomuch as we were asked to produce the guidance for England, but we have had conversations with the CNO, the CNO's office, about what we were doing to make sure there was understanding and briefing about what was going on.

[96] **David Rees:** Okay. We'll explore that further when the CNO comes. There are no further questions. Can I thank you very much for coming this morning?

[97] **Professor Leng:** Thank you.

[98] **David Rees:** It was remiss of me to actually not to give you your title when you first came, which is deputy chief executive of NICE. Your evidence obviously has been very helpful to us to see the implication of guidance in England. You will receive a copy of the transcript for any factual inaccuracies you may be able to identify, and please let us know if there are. So, once again, thank you very much for the evidence this morning.

[99] **Professor Leng:** Thank you.

10:11

Papurau i'w Nodi Papers to Note

[100] **David Rees:** Members, if we move on to the next item on the agenda, which is papers to note, can we note the following, please? Minutes from the meeting of 4 and 12 February 2015. Okay. Correspondence from the Minister for Health and Social Services regarding the older people's commissioner's report.

[101] **Lynne Neagle:** Can I raise something?

[102] **David Rees:** On the minutes?

[103] **Lynne Neagle:** Not on the minutes, on the letter that you just talked about.

[104] **David Rees:** On the older people's commissioner's letter. Yes, that's what I was just

talking about now. Okay. So, you want to comment upon it.

[105] **Lynne Neagle:** Yes. I was just wondering, the letter we've had off Mark is very helpful, but the older persons' commissioner will have had a series of responses from health boards and the Minister on the report on residential care. I know that she's taking some time to analyse them, but I was just going to ask if, in due course, we could get her back in to discuss how happy she is with the responses and the action that's going to be taken.

[106] **David Rees:** We'll discuss that next week in the forward work programme session. We can look at the timescales and everything else then.

[107] **Lynne Neagle:** I know.

[108] **David Rees:** Okay. Other than that, are we happy to note the letter? Correspondence from the Petitions Committee regarding day care centres for older people: I wish to propose that we respond noting that we do not have capacity, at this point in time, to undertake the inquiry in relation to day care centres, as we will find out again next week, particularly with the Bills that are now being placed before us and the legislation. We will report and comment that we scrutinised the Social Services and Well-being (Wales) Bill, which, as the Deputy Minister said in her letter, requires local authorities to assess the needs for care and support for people in their local areas, and we have received an update briefing on the implementation of the Social Services and Well-being (Wales) Act 2014 in November, and we will provide links to the papers for that briefing to the Petitions Committee. So, we'll respond with those points if that's suitable to Members. I'll take that as a 'yes'. Okay. In that case, that's all the papers to note.

10:13

**Cynnig o dan Reolau Sefydlog 17.42(vi) a (ix) i Benderfynu Gwahardd y
Cyhoedd o Weddill y Cyfarfod ac ar gyfer Eitem 1 y Cyfarfod ar 5 Mawrth 2015
Motion under Standing Orders 17.42(vi) and (ix) to Resolve to Exclude the
Public from the Remainder of the Meeting and for Item 1 of the Meeting on 5
March 2015**

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod ac ar gyfer eitem 1 y cyfarfod ar 5 Mawrth 2015 yn unol â Rheol Sefydlog 17.42(vi) and (ix).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting and for item 1 of the meeting on 5 March 2015 in accordance with Standing Order 17.42(vi) and (ix).

Cynigiwyd y cynnig.

Motion moved.

[109] **David Rees:** Now, under Standing Order 17.42 (vi) and (ix), I resolve to meet in private for the remainder of this meeting and for the first item on next week's agenda. Are Members content with that? Thank you very much. Therefore, we now go into private session.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10:13.

The public part of the meeting ended at 10:13.