Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:
Ystafell Bwyllgora 3 - Senedd

Dyddiad:
Dydd Iau, 12 Chwefror 2015

Amser:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

I gael rhagor o wybodaeth, cysylltwch â:
Llinos Madeley
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Agenda

1 Cyflwyniadau, ymddiheuriadau a dirprwyon (09.00)

2 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 6 (09.00 - 09.50) (Tudalennau 1 - 29)

Yr Athro Fonesig June Clark
Yr Athro Peter Griffiths
Yr Athro Anne Marie Rafferty

3 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 7 (09.50 - 10.40) (Tudalennau 30 - 37)

Peter Meredith Smith, Bwrdd Cynghorau Iechyd Cymuned Cymru

Egwyl (10.40 - 10.50)

4 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 8 (10.50 - 11.40) (Tudalennau 38 - 42)

Kate Chamberlain, Arolygiaeth Gofal Iechyd Cymru
Alun Jones, Arolygiaeth Gofal Iechyd Cymru

5 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 9 (11.40 - 12.25) (Tudalennau 43 - 49)

Dawn Bowden, Unsain Cymru
Tanya Bull, Unsain Cymru

Cinio (12.25 - 13.30)

6 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 10 (13.30 - 14.20) (Tudalennau 50 - 62)

Cynrychiolwyr swyddogion gweithredol y byrddau iechyd

Paul Roberts, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Anne Phillimore, Bwrdd Iechyd Prifysgol Aneurin Bevan

7 Papurau i'w nodi (14.20) (Tudalennau 63 - 69)

Bil Lefelau Diogel Staff Nyrsio (Cymru): ymatebion i'r ymgynghoriad

Bil Lefelau Diogel Staff Nyrsio (Cymru): gohebiaeth gan yr Aelod sy'n Gyfrifol , Kirsty Williams AC (Tudalennau 70 - 81)

Cydsyniad Deddfwriaethol: y Bil Troseddu Difrifol: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Tudalennau 82 - 86)

Craffu ariannol: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol (Tudalennau 87 - 92)

8 Cynnig o dan Reol Sefydlog 17.42(vi) i benderfynu gwahardd y cyhoedd o weddill y cyfarfod (14.20)

9 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): trafod y dystiolaeth a ddaeth i law (14.20 - 14.35)

10 Ymchwiliad i sylweddau seicoweithredol newydd ("cyffuriau penfeddwol cyfreithlon"): ystyried yr adroddiad drafft (14.35 - 15.20) (Tudalennau 93 - 177)

11 Ymchwiliad i berfformiad y Gwasanaeth Ambiwlans yng Nghymru: ystyried y ffordd o graffu (15.20 - 15.30) (Tudalennau 178 - 179)

12 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: ystyried yr allbwn drafft (15.30 - 16.00)

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

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

Consultation on Safe Nurse Staffing Levels (Wales) Bill

Response from: Professor Dame June Clark

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

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

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

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

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

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

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

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

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

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

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

Provisions in the Bill

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

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

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

Duty applies to adult inpatient wards in acute hospitals only

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

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

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

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

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

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

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

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

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

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

Protection for certain activities and roles
These provisions are important

Requirement to consult

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

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

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

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

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

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

June Clark DBE PhD RN FRCN FAAN FLSW
January 2015

Consultation on the Safe Nurse Staffing Levels (Wales) Bill: written submission of evidence to the health and Social care Committee.

Professor Peter Griffiths, RN, BA, PhD
Chair of Health Services Research University of Southampton, England &
National Institute for Health Research Collaboration for Applied Research in Health and Care (Wessex)

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Introduction & overview

I am making this submission in a personal capacity. I draw on over 25 years of experience of working in and alongside the NHS as a clinical nurse, advisor and applied health services researcher.

I have undertaken research related to the impact of the size and configuration of the health care workforce on patient and staff outcomes. From 2006–2011 I was director of the National Nursing Research Unit in England, funded by the Department of Health's Policy Research Programme to undertake research into the nursing workforce. I lead the work on patient outcomes in the international RN4CAST study, exploring associations between the hospital nursing workforce and patient outcomes in 16 countries, in Europe and beyond. I also co-led the English arm of the study. Last year I led the team that undertook evidence reviews for the National Institute for Health and Care Excellence's Safe Staffing Committee as it developed guidance for nurse staffing on hospital wards and in emergency departments.

In addition to the evidence reviews for NICE, I have published extensively on this topic including contributions to recent papers of relevance, such as:

Aiken, L.H., Sermeus, W., Van den Heede, K., Sloane, D.M., Busse, R., McKee, M., Bruyneel, L., Rafferty, A.M., Griffiths, P., et al, 2012. Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States. BMJ 344 (7851), e1717.

Aiken, L.H., Sloane, D.M., Bruyneel, L., Van den Heede, K., Griffiths, P., et. Al. 2014. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. Lancet 383 (9931), 1824-1830.

Ball, J.E., Murrells, T., Rafferty, A.M., Morrow, E., Griffiths, P., 2014. 'Care left undone' during nursing shifts: associations with workload and perceived quality of care. BMJ Qual Saf 23 (2), 116-125.

Griffiths, P., Dall'Ora, C., Simon, M., Ball, J., Lindqvist, R., Rafferty, et. al, 2014. Nurses' shift length and overtime working in 12 European countries: the association with perceived quality of care and patient safety. Med Care 52 (11), 975-981.

Griffiths, P., Jones, S., Bottle, A., 2013. Is "failure to rescue" derived from administrative data in England a nurse sensitive patient safety indicator for surgical care? Observational study. Int J Nurs Stud 50 (2), 292-300.

Below I offer some observations and analysis drawing on this expertise and related to research evidence that are relevant to the committee's questions.

Nurse staffing and patient outcomes

It seems clear from extensive evidence that lower levels of nurse staffing in hospitals are associated with poorer patient outcomes.

- There are inconsistencies in the evidence. Not all studies show an association. However, for a number of outcomes, including death, the overall pattern of evidence is clear. There are a number of evidence overviews (including our recent reports to NICE) supporting this.[1–3] I am not aware of any recent substantial reviews that come to a different conclusion.
- Relatively little of the evidence is from the UK, but what there is tends to be broadly consistent with this pattern.
- It does not follow from this evidence that the relationship between nurse staffing and patient outcomes is *causal*. That is, just because hospital death rates are higher in hospitals with fewer nurses, this does not mean that it is a lack of nurses that causes the increase in deaths. There might be other factors at play and indeed, there must be. For example, hospitals with fewer nurses also tend to have fewer doctors. There is also evidence on the importance of *medical* staffing levels for mortality rates. [4 5]
- However, taken in the round, the evidence is consistent with poor nurse staffing *causing* some of the adverse patient outcomes observed in studies.[1–3]

A considered appraisal of the evidence supports a conclusion that low nurse staffing is one cause of the variation in death rates, and other adverse outcomes between hospitals.

Local determination

It does not necessarily follow that mandatory staffing levels are an effective approach to addressing the problem. In principle, the argument that staffing levels are best determined locally is appealing. However, the evidence available suggests that local determination is not sufficient to assure safety.

- The consequence of variation in staffing levels seen between hospitals does not clearly indicate the correct level of staffing on particular wards.

- However, our review for NICE found little evidence about the use of any formal systems for local determination of staffing levels.[1] Crucially we do not know whether patient outcomes / experiences are improved when such systems are used.
- In our RN4CAST study we found that most of the English Trusts we surveyed claimed to be reviewing nurse staffing regularly and a majority used formal tools to determine staffing levels.[6]
- Despite this, we still found that variation in staffing levels was substantial, with many Trusts routinely operating at staffing levels far below that recommended by international guidance or required by legislation, including the level of 1 registered nurse to 8 patients which was identified by NICE as a threshold.[7]
- Crucially, it also appears that this variation in staffing is still associated with variations in mortality.[6 8] The Mid-Staffordshire enquiry and the more recent Keogh review also highlight staffing deficiencies.

It is hard to conclude that 'local determination' alone (with or without the use of tools) is sufficient to assure safe staffing levels.

Mandatory staffing

By contrast, there is some evidence that points to improved outcomes for patients and nurses associated with various mandatory safe nurse staffing policies.

- Evidence from studies of mandatory staffing policies in the US and Australia, while not conclusive, do suggest that hospitals that meet the mandatory ratios have better outcomes than those that do not. There is some evidence of improvement over time and little evidence of adverse consequences. [9–15]
- Benefits attributed to the policies include improved patient outcomes and improved staff outcomes, including hospital's abilities to recruit and retain staff.[16]
- I am not aware of an unbiased comprehensive high quality review of this evidence. It is of note that NICE explicitly excluded consideration of such policies from their evidence review for guidance "safe staffing for nursing in adult inpatient wards in acute hospitals".

It appears that mandatory minimum staffing policies, which allow staffing to flex above specified minimums, can be beneficial to patient care.

Identifying the minimums

Recommended minimum staffing levels can operate (broadly) in one of two forms. A ratio of patients per nurse or an average number of number of nursing hours per day that are to be available to patients on wards of a given type.

- Typically, mandatory ratios from other countries are in the range of 4-6 patients per nurse in general wards. Ratios recommended for care of older people wards are sometimes lower, although the rationale for this is far from clear.[17]
- NICE identified ratios exceeding 8 patients to 1 nurse as a threshold associated with increased risk of harm and advised additional steps to assure safety once if this threshold was exceeded.[18] The emphasis is on assuring safety if the 8:1 threshold is exceeded, implying 8:1 is safe.
- This figure (8:1) is appears to originate from that identified by the Safe Staffing Alliance (SSA). It is worth noting therefore the basis of the Alliance's campaign.
- The SSA position is that a ratio of more than 8 patients per RN significantly increases the risk of harm and constitutes a breach in patient safety. This is the level at which care is definitely considered to be unsafe, putting patients at risk. The emphasis here is on demonstrating and determining a safe staffing level at a ratio of 8:1 or below.
- The figure of 8:1 does not directly emerge from any research evidence as a clear 'cut point'. However, for most UK studies where specific patient to nurse ratios can be identified, ratios above 8:1 are clearly in the higher risk group. However, insofar as there is evidence of a threshold, it may occur at a lower ratio than this. For example in our study on missed nursing care, rates of missed care were only significantly reduced for wards with the highest staffing levels, where nurses cared for about 6 patients or fewer (see figure 1 below).[19]

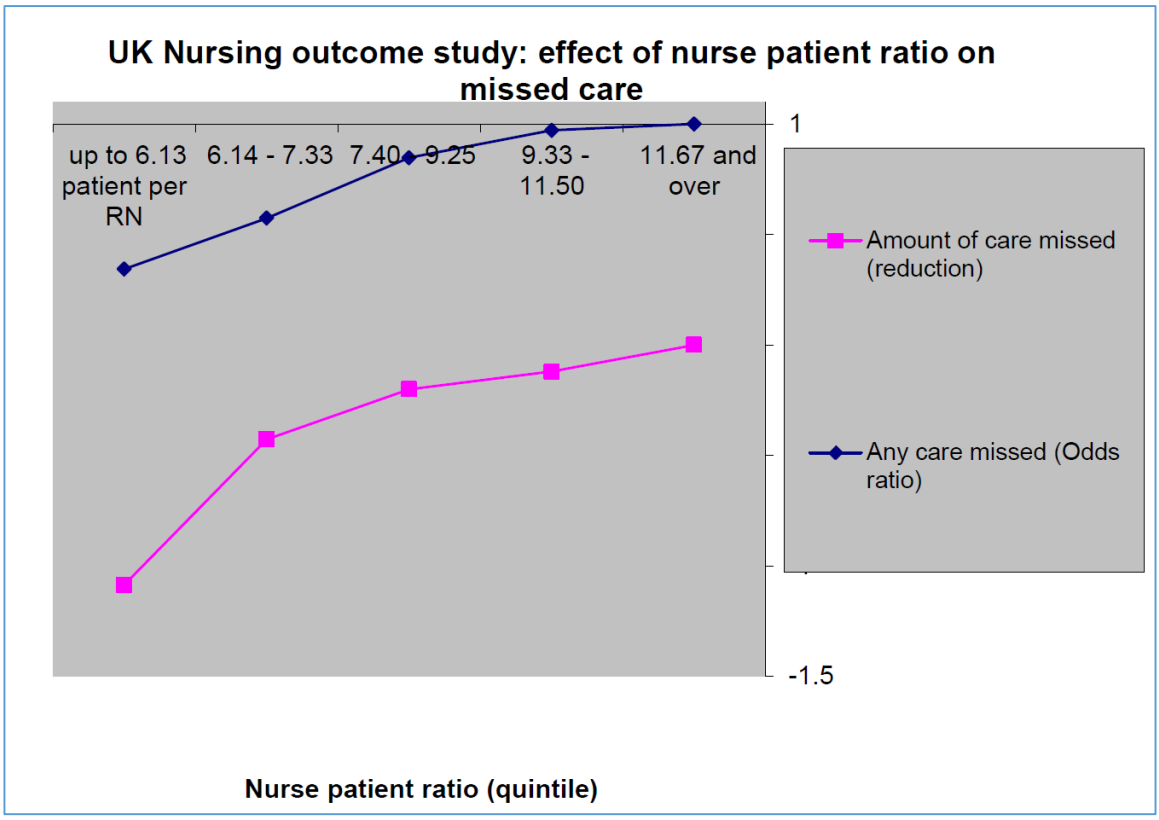

Figure 1: Data from 'Care left undone' during nursing shifts: associations with workload and perceived quality of care

- In all UK studies of nurse staffing patient outcomes, risk increases between the best-staffed hospitals compared to the next best-staffed group of hospitals. Risk is increased before staffing reaches levels that would be considered 'low' if benchmarked against the average (see addendum to the evidence review for the NICE safe staffing guidance[1]).

The correct minimum staffing level cannot be derived solely from the scientific evidence base. Professional and indeed social judgement must be exercised. The international evidence points towards levels of staffing that are much higher than currently found in many hospitals the UK.

It is at least conceivable that while a policy that specifies a minimum level of (say) 6 patients to 1 nurse may have a positive effect, a policy that specifies a different level may have a different effect.

The 'correct' mandatory staffing level remains unclear. However, the widely recognised figure of 8 patients to 1 nurse should not be regarded as a safe level. Ratios from other countries general identify safe staffing minimums for general wards as between 4 & 6 patients per RN, depending on the setting.

Other considerations

While attention is focussed on mandating a staffing level, with the Safe Staffing Alliance campaign focussing on daytime staffing, consideration needs to be given to other factors.

- There is substantial evidence that night-time staffing in some units is extremely low.[20] There is a danger that focussing on daytime staffing could exacerbate this.
- One strategy for increasing the efficiency of the nursing workforce is a move from a three shift per day system to a 2 shift system. The potential advantages are efficiencies from reduced handovers and overlaps between shifts.[21]
- The 2 shift system also means that 'night time' staffing levels, typically much lower, can be operated for a longer period of the day.
- While it may indeed be that in many wards the requirements for nursing care are lower at night, a reduction in staff in this evening period is not necessarily warranted.
- There is growing evidence that these so called '12 hour shifts' are associated with poorer patient outcomes irrespective of the nurse to patient ratios.[22–24] This could be in part because of reductions in the total amount of nursing care that is available or because of other factors.

While closely equivalent, mandating the average daily nursing hours per patient over 24 hours rather than the patient to nurse ratio at a given time, may be more appropriate than a mandatory ratio to be applied at particular times of day. This Nursing Hours Per Patient Day approach is taken in Western Australia.

The Nursing Hours Per Patient Day method gives some additional flexibility around how patient care is organised across the day but reduces perverse incentives to alter shift patterns and night-time staffing levels for reasons unrelated to patient need.

Conclusion

While the evidence is broadly in favour of mandatory minimum staffing levels, it is by no means conclusive and a careful, properly resourced evaluation of any such policy seems essential.

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Health and Social Care Committee: Written Evidence on Safe Staffing Bill, Anne Marie Rafferty CBE

I am making my comments in my capacity as Professor of Nursing Policy, King's College, London and researcher in the area of workforce, specifically, nurse staffing and patient outcomes, not as a member of an organisation or stakeholder.

General

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

Safe staffing legislation could provide a helpful vehicle to set and ensure adherence to 'best practice' staffing guidelines in the absence of responsiveness within the system to changes in demand such as acuity and dependency and alignment with capacity. There is significant evidence of variation in workload management and workforce planning practices and methodologies across England (see attached papers) including historical methods with consequent negative impacts on nurses and patients where these fall short. The chronic understaffing of wards had serious impacts on the welfare of patients and nurses and poses a major threat to the sustainability of the NHS. History suggests that nurse staffing patterns are sensitive to the economic cycle of 'boom and bust' and that variations are unrelated to demand or patient need though this is not the only driver of staffing as the draft Bill indicates. Setting staffing levels on a safe, secure and scientific footing would bring benefits to patients, carers, the multidisciplinary team and the system as well as nurses making it attractive to enter and remain in as a career. Safe staffing should, however, be seen as part of a wider Human Resources strategy with clear accountability for staffing at Board level and not an isolated event or end in itself.

Are the provisions in the Bill the best way of achieving the Bills overall purpose?

England has implemented 'safe staffing guidance' but stopped short of setting ratios. The provisions made in the proposed Bill have much in common with those proposed and currently being implemented in England but Wales would be unique in going a step further by enacting legislation. It is too soon to appreciate the impact of implementing safe staffing guidance in acute wards in England but setting out provision in legislation would provide a strong signal that the Welsh Assembly was serious about supporting safe staffing. It would also provide an opportunity to compare the impacts of different approaches to safe nurse staffing across devolved administrations, especially England, which has implemented guidance on the issue by comparing the differential implementation as a natural experiment.

What, if any, are the potential barriers to implementing the provisions of the Bill?

The Bill takes account of the potential costs but savings that can be off set against those costs, including the costs of operationalising implementation. Costs are not simply economic but have to

be considered in terms of the costs of not acting and the calculus of human suffering associated with poor staffing, which is well documented in The Report of the Francis Inquiry referred to in the background Memorandum. Barriers beyond the economic to implementation could be recruitment in 'difficult to recruit to areas' both in geographical and sub-speciality terms. Recent experience of implementing safe staffing guidance suggests that staff may be redeployed from better to less well staffed areas and this may not prove popular with staff but could form part of an evaluation and options appraisal framework underpinning the review outline in the Bill.

Are there any unintended consequences in the Bill?

These seem to be well covered in the Bill

Provisions in the Bill

The duty on health services bodies and holding Boards accountable for staffing decisions is essential for safeguarding standards and providing stewardship of resource. Specifically, the public reporting of data is and risk management surrounding decisions are central to ensuring public accountability for safe staffing. The wording on the other two provisions has changed from minimum to safe staffing and I concur with the provisions as outlined. It is prudent to adopt an incremental approach to implementation since different environments and specialities may have needs and demands.

The requirement for the Welsh government to issue guidance setting out methods and other items outlined in the draft Bill are positive in supporting the enactment of the Bill. The requirement to review the operation of the Act is to be welcomed.

Impact of existing guidance

It is too early to tell but liaising closely with experience in England would be crucial to guiding implementation of provisions made.

Powers to make subordinate legislation and guidance

These elements seem well covered at present.

Financial implications

I have no further evidence to add beyond that outlined in the Explanatory Memorandum.

Other comments

Only that safe staffing needs to go hand in hand with good human resource practice and be capable of responding to changes in patient acuity and dependency not seen as a 'magic bullet' or isolated event. Everything depends on how it is implemented at local level. The opportunity for implementing safe staffing as a complex intervention through a randomised controlled trial, for example, could also be considered.

Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study

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Summary

Background **Austerity measures and health-system redesign to minimise hospital expenditures risk adversely affecting patient outcomes. The RN4CAST study was designed to inform decision making about nursing, one of the largest components of hospital operating expenses. We aimed to assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data were associated with variation in hospital mortality after common surgical procedures.**

Methods **For this observational study, we obtained discharge data for 422 730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries. Administrative data were coded with a standard protocol (variants of the ninth or tenth versions of the International Classification of Diseases) to estimate 30 day in-hospital mortality by use of risk adjustment measures including age, sex, admission type, 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission. Surveys of 26 516 nurses practising in study hospitals were used to measure nurse staffing and nurse education. We used generalised estimating equations to assess the effects of nursing factors on the likelihood of surgical patients dying within 30 days of admission, before and after adjusting for other hospital and patient characteristics.**

Findings **An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% (odds ratio 1·068, 95% CI 1·031–1·106), and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7% (0·929, 0·886–0·973). These associations imply that patients in hospitals in which 60% of nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of nurses had bachelor's degrees and nurses cared for an average of eight patients.**

Interpretation **Nurse staffing cuts to save money might adversely affect patient outcomes. An increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.**

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Introduction

Constraint of health expenditure growth is an important policy objective in Europe despite concerns about adverse outcomes for quality and safety of health care.[1,2] Hospitals are a target for spending reductions. Health-system reforms have shifted resources to provide more care in community settings while shortening hospital length of stay and reducing inpatient beds, resulting in increased care intensity for inpatients. The possible combination of fewer trained staff in hospitals and intensive patient interventions raises concerns about whether quality of care might worsen. Findings of the European Surgical Outcomes Study[3] across 28 countries recently showed higher than expected hospital surgical mortality and substantial between country variation in hospital outcomes.

Nursing is a so-called soft target because savings can be made quickly by reduction of nurse staffing whereas savings through improved efficiency are difficult to achieve. The consequences of trying to do more with less are shown in England's Francis Report,[4] which discusses how nurses were criticised for failing to prevent poor care after nurse staffing was reduced to meet financial targets. Similarly, results of the Keogh review[5] of 14 hospital trusts in England showed that inadequate nurse staffing was an important factor in persistently high mortality rates. Austerity measures in Ireland and Spain have been described as adversely affecting hospital staffing too.[6,7]

Research that could potentially guide policies and practices on safe hospital nurse staffing in Europe has been scarce. Jarman and colleagues[8] reported an

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association between large proportions of auxiliary nurses (which implies a low overall mix of nursing skill) and high mortality in hospitals in England. Rafferty and colleagues[9] noted that low hospital mortality in England after common surgeries was associated with nurses each caring for few patients. Research in Belgium[10] found hospital mortality after cardiac surgery was significantly lower in hospitals with lower patient to nurse staffing ratios and in hospitals with a higher proportion of nurses with bachelor's education than in hospitals with higher staffing ratios and fewer nurses with bachelor's education. Likewise, data from a Swiss study[11] suggested significantly increased surgical mortality associated with inadequate nurse staffing and poor nurse work environments.

This nascent but growing scientific literature about nursing outcomes in Europe is complemented by research from North America showing that improved hospital nurse staffing is associated with low mortality.[12] Additionally, growing evidence exists that bachelor's education for nurses is associated with low hospital mortality.[13–17]

Research into nursing has had little policy traction in Europe compared with the USA where almost half the 50 states have implemented or are considering hospital nurse staffing legislation.[18,19] On the basis of findings showing improved outcomes for patients, the Institute of Medicine recommended that 80% of nurses in the USA have a bachelor's degree by 2020,[20] and hospitals have responded with preferential hiring of bachelor's nurses. European decision makers might be unclear about the applicability of research done in individual countries in Europe or North America to Europe more generally. Specifically, scientific evidence is needed to inform the continuing European Union policy debate about harmonisation of professional qualifications for nurses.[21]

RN4CAST, funded by the European Commission, was designed to provide scientific evidence for decision makers in Europe about how to get the best value for nursing workforce investments, and to guide workforce planning to produce a nurse workforce for the future that would meet population health needs.[22] Investigators of the study of 488 hospitals in 12 European countries noted substantial variation between countries with regards to patient to nurse workloads and the percentage of nurses qualified at the bachelor's level.[23] These variations in nursing resources are important predictors of patients' satisfaction with their care and in nurses' assessments of quality and safety of care.[24]

We aimed to assess whether differences in patient-to-nurse workloads and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data are associated with variation in hospital mortality after common surgical procedures. The nine countries are representative of variation in Europe with respect to organisation, financing, and resources given to health services. The study's findings provide previously unavailable evidence to guide important decisions about improvement of hospital care in Europe in the context of scarce resources and health-system reforms.

Methods

Study setting

Data for this observational study were from administrative sources on hospital patients and characteristics of hospitals, and surveys of 26 516 bedside care professional nurses done in 2009–10 in 300 hospitals in nine European countries (Belgium, England, Finland, Ireland, the Netherlands, Norway, Spain, Sweden, and Switzerland). Similar patient discharge data consistent with the patient mortality protocol were not available for three RN4CAST countries (Germany, Poland, and Greece). The study included most adult acute care hospitals in Sweden, Norway, and Ireland, and geographically representative samples of hospitals in the other countries.[22]

The European study protocol received ethical approval by the lead university, Catholic University of Leuven, Belgium. Each grantee organisation in the nine participating countries received ethical approval at the institutional level to do nurse surveys and analyse administrative data for patient outcomes. We also obtained country level approvals to acquire and analyse patient outcomes data.

Outcomes

We obtained patient mortality data for postoperative patients discharged from study hospitals in the year most proximate to the nurse survey for which data were available, which ranged between countries from 2007 to 2009. Our analyses included patients aged 50 years or older with a hospital stay of at least 2 days who underwent common general, orthopaedic, or vascular surgery, and for whom complete data were available for comorbidities present on admission, surgery type, discharge status, and other variables used for risk adjustment. We used the procedures published by Silber and colleagues[25] to define common surgeries and comorbidities (appendix). We selected common surgeries for study because almost all acute hospitals undertake them, risk adjustment procedures for surgical patients have been well validated, and risk-related comorbidities can be more accurately distinguished for surgical patients than for medical patients because they are present at admission by contrast with complications arising in the hospital. We coded data in all countries with a standard protocol by use of variants of the ninth or tenth version of the International Classification of Diseases.[26] Researchers are not able to validate coding in administrative hospital discharge files. Countries can have validation protocols for administrative data but this information is not available. Findings of studies in Europe show that routinely collected administrative data predict risk of hospital death with discrimination similar to that obtained from clinical databases.[27] We restricted

See Online for appendix

hospitals to those with 100 or more targeted patients. The primary outcome measure was whether patients died in the hospital within 30 days of admission. Risk adjustment variables included patient age, sex, admission type (emergency or elective), 43 dummy variables suggesting surgery type, and 17 dummy variables suggesting comorbidities present at admission, which are included in the Charlson index.[28]

Nurse staffing and education measures were derived from responses to surveys of nurses in each hospital with the RN4CAST nurse survey instrument.[22] The term nurse refers to fully qualified professional nurses. In all countries except Sweden, hospitals were sampled in different regions, after which a variable number of adult medical and surgical wards were randomly sampled in each hospital, depending on hospital size (between two and six wards in each hospital in every country except England, where all wards were sampled, up to a maximum of ten). All nurses providing direct patient care in these wards were surveyed. In Sweden, all hospitals and all medical and surgical wards were included by sampling all medical surgical nurses nationally.

In the RN4CAST study, nurse staffing for each hospital was calculated from survey data by dividing the number of patients by the number of nurses that each nurse reported were present on their ward on their last shift, and then averaging ratios across all nurse respondents in each hospital. Low ratios suggested more favourable staffing. Collection of data for hospital nurse staffing directly from nurses avoided differences in administrative reporting methods across countries and ensured that only nurses in inpatient care roles are counted. We measured nurse education by calculating the percentage of all nurses in each hospital that reported that the highest academic qualification they had earned was a bachelor's degree or higher.

Statistical analyses

We estimated associations between nurse staffing and nurses' education and 30 day inpatient mortality for patients before and after adjusting for additional hospital characteristics and risk-adjusting for differences in patient characteristics. Hospital characteristics included country, bed size, teaching status, and technology; we defined high technology hospitals as those that undertook open heart surgery or organ transplantation. We included the hospital nurse work environment, measured by the Practice Environment Scale of the Nursing Work Index, as a control variable like in previous studies of nursing and mortality.[15] Patient characteristics included age, sex, admission type, type of surgery (with 43 dummy variables for the specific surgery types), and presence of 17 comorbidities (appendix). Because individual patient outcomes were modelled with a combination of hospital and patient characteristics, we estimated the effects of different characteristics with population average models using a generalised estimating approach and random intercept models using hierarchical linear modelling. Both approaches took into account patients being nested within hospitals, and in both types of models we included dummy variables to allow for unmeasured differences across countries. Because the results were almost identical, and the estimated effects of nursing characteristics were the same in terms of their size and importance, we show only the generalised estimating results. We tested for the effects on mortality of an interaction between nurse staffing and education, which was not significant and is not included in the results. All statistical analyses were done with SAS (version 9.2).

Role of the funding source

The sponsors of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Results

We obtained mortality data for 422 730 patients; the number of hospitals and surgical discharges varied across countries (table 1). The percentage of surgical patients who died in the hospital within 30 days of admission was 1·3% across the nine countries combined, and was lowest in Sweden and highest in the Netherlands (table 1).

Response rates for surveys of nurses ranged from less than 40% (2990 of 7741) in England, to nearly 84% (2804 of 3340) in Spain, and averaged 62% (29 251 of 47 160) across the nine countries. Differences in both nurse staffing and nurse education were large both between

	Number of hospitals	Mean discharges per hospital (range)	Deaths/discharges (%)
Belgium	59	1493 (413–4794)	1017/88 078 (1·2%)
England	30	2603 (868–6583)	1084/78 045 (1·4%)
Finland	25	1516 (175–3683)	303/27 867 (1·1%)
Ireland	27	738 (103–1997)	292/19 822 (1·5%)
Netherlands	22	1419 (181–2994)	466/31 216 (1·5%)
Norway	28	1468 (432–4430)	518/35 195 (1·5%)
Spain	16	1382 (186–3034)	283/21 520 (1·3%)
Sweden	62	1304 (295–4654)	828/80 800 (1·0%)
Switzerland	31	1308 (158–3812)	590/40 187 (1·5%)
Total	300	1308 (103–6583)	5381/422 730 (1·3%)

Only hospitals with more than 100 surgical patient discharges were included in the analyses. Data shown are for discharged patients for whom information about 30 day mortality, age, sex, type of surgery, and comorbidities were complete. Data were missing for those characteristics for less than 4% of all patients.

Table 1: **Hospitals sampled in nine European countries with patient discharge data, numbers of surgical patients discharged, and numbers of patient deaths (RN4CAST data)**

countries and between hospitals within each country (table 2). In Spain and Norway, all nurses had bachelor's degrees. The mean age of the patient sample was 68 years (SD=10); table 3 shows other patient characteristics. Of 439 800 patients studied more than 50% had orthopaedic surgeries, whereas roughly four in ten underwent general surgeries, and slightly less than one in 10 underwent vascular surgeries. The most common comorbidities were diabetes without complications, chronic pulmonary disease, metastatic carcinoma, and cancer.

	Nurse staffing (patients to nurse)		Nurse education (% of nurses with bachelor's degrees)	
	Mean (SD)	Range	Mean (SD)	Range
Belgium	10·8 (2·0)	7·5–15·9	55% (15)	26–86%
England	8·8 (1·5)	5·5–11·5	28% (9)	10–49%
Finland	7·6 (1·4)	5·3–10·6	50% (10)	36–71%
Ireland	6·9 (1·0)	5·4–8·9	58% (12)	35–81%
Netherlands	7·0 (0·8)	5·1–8·1	31% (12)	16–68%
Norway	5·2 (0·8)	3·4–6·7	100% (0)	100–100%
Spain	12·7 (2·0)	9·5–17·9	100% (0)	100–100%
Sweden	7·6 (1·1)	5·4–9·8	54% (12)	27–76%
Switzerland	7·8 (1·3)	4·6–9·8	10% (10)	0–39%
Total	8·3 (2·4)	3·4–17·9	52% (27)	0–100%

Means, SDs, and ranges are estimated from hospital data—eg, the 59 hospitals in Belgium have a mean patient-to-nurse ratio of 10·8, and the patient-to-nurse ratio ranges across those 59 hospitals from 7·5 to 15·9. Similarly, the 31 hospitals in Switzerland have, on average, 10% bachelor's nurses, and the percent of bachelor's nurses ranges across those 31 hospitals from 0% to 39%.

Table 2: **Nurse staffing and education in nine European countries**

	Number (%)
Men	189 815 (45%)
Emergency admissions	141 584 (34%)
Inpatient deaths within 30 days of admission	5381 (1·3%)
Surgical categories	
General surgery	162 974 (39%)
Orthopaedic surgery	220 301 (52%)
Vascular surgery	39 455 (9%)
Comorbidities	
Cancer	15 297 (4%)
Cerebrovascular disease	7400 (2%)
Congestive heart failure	10 274 (2%)
Chronic pulmonary disease	28 373 (7%)
Dementia	5744 (1%)
Diabetes with complications	6478 (2%)
Diabetes without complications	35 450 (8%)
AIDS/HIV	50 (0%)
Metastatic carcinoma	17 911 (4%)
Myocardial infarction	12 002 (3%)
Mild liver disease	5953 (1%)
Moderate or severe liver disease	1354 (0%)
Paraplegia and hemiplegia	2043 (1%)
Peptic ulcer disease	2323 (1%)
Peripheral vascular disease	12 452 (3%)
Renal disease	10 085 (2%)
Connective tissue disease or rheumatic disease	6962 (2%)

Table 3: **Characteristics of surgical patients (n=422 730) in the study hospitals**

Table 4 shows results of modelling the effects of the two nursing factors (staffing and education) on mortality after adjustment for differences across countries in mortality (in the partly adjusted model) and for differences in the full set of potentially confounding factors (in the fully adjusted model). After we considered severity of illness of the patients and characteristics of the hospitals (teaching status and technology) in the adjusted model, both nurse staffing and nurse education were significantly associated with mortality (table 4). The odds ratios (ORs) suggest that each increase of one patient per nurse is associated with a 7% increase in the likelihood of a surgical patient dying within 30 days of admission, whereas each 10% increase in the percent of bachelor's degree nurses in a hospital is associated with a 7% decrease in this likelihood. These associations suggest that patients in hospitals in which 60% of the nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of the nurses had bachelor's degrees and nurses cared for an average of eight patients. We worked out this 30% reduction (reduction in mortality by a factor of 0·70) by applying (and multiplying) the reciprocal of the OR associated with nurse staffing across two intervals (from eight to six patients per nurse) and the OR associated with nurse education across three intervals (from 60% to 30%)—ie, $1/1{\cdot}068 \times 1/1{\cdot}068 \times 0{\cdot}929 \times 0{\cdot}929 \times 0{\cdot}929 = 0{\cdot}703$.

Discussion

Our findings shows that an increase in nurses' workload increases the likelihood of inpatient hospital deaths, and an increase in nurses with a bachelor's degree is associated with a decrease in inpatient hospital deaths (panel). Findings of the RN4CAST study showed more

	Partly adjusted models		Fully adjusted model	
	OR (95% CI)	p value	OR (95% CI)	p value
Staffing	1·005 (0·965–1·046)	0·816	1·068 (1·031–1·106)	0·0002
Education	1·000 (0·959–1·044)	0·990	0·929 (0·886–0·973)	0·002

The partly adjusted models estimate the effects of nurse staffing and nurse education separately while controlling for unmeasured differences across countries. The fully adjusted model estimates the effects of nurse staffing and nurse education simultaneously, controlling for unmeasured differences across countries and for the hospital characteristics (bed size, teaching status, technology, and work environment), and patient characteristics (age, sex, admission type, type of surgery, and comorbidities present on admission). OR=odds ratio.

Table 4: **Partly and fully adjusted odds ratios showing the effects of nurse staffing and nurse education on 30 day inpatient mortality**

variation in hospital mortality after common surgical procedures in European hospitals than is generally understood. Variation in hospital mortality is associated with differences in nurse staffing levels and educational qualifications. Hospitals in which nurses cared for fewer patients each and a higher proportion had bachelor's degrees had significantly lower mortality than hospitals in which nurses cared for more patients and fewer had bachelor's degrees. These findings are similar to those of studies of surgical patients in US and Canadian hospitals in which similar measures and protocols were used.[14,15]

Our finding that each 10% increase in the proportion of nurses with a bachelor's degree in hospitals is associated with a 7% decrease in mortality is highly relevant to the recent decision by the European Parliament (Oct 9, 2013) to endorse two educational tracks for nurses—one vocational and one higher education.[21] In view of the RN4CAST findings, the goal of standardised qualifications of professionals as expressed in the Bologna process[29] is a long way off from being achieved. Our findings support the recent EU decision to recognise professional nursing education within institutions of higher education starting after 12 years of general education. However, our results challenge the decision to continue to endorse vocational nursing education after only 10 years of general education because this training might hamper access to higher education for nurses in some countries—eg, Germany where no nurses in the 49 hospitals studied in RN4CAST had a bachelor's degree.[23]

The RN4CAST finding that improved hospital nurse staffing is associated with decreased risk of mortality might be inconvenient in the present difficult financial context and amid health-system reforms to shift resources to community-based settings. Nevertheless, this study is the largest and most rigorous investigation of nursing and hospital outcomes in Europe up to now, and has robust results. Our findings reinforce those of smaller studies in Europe,[8–11] and a large body of international published work.[12,14] Our data suggest a safe level of hospital nurse staffing might help to reduce surgical mortality, as called for by the European Surgical Outcomes Study.[3]

Beyond improvements in care, investments in nursing could make good business sense. In the USA, each US$1 spent on improvements to nurse staffing was estimated to return a minimum of $0·75 economic benefit to the investing hospital, not counting intangible benefits.[30] Furthermore, a move from less qualified licensed vocational nurse hours to qualified professional nurse hours is estimated to save lives and money.[31] Improved nurse staffing in US hospitals is associated with significantly reduced readmission rates, which is compelling in view of financial penalties in 2013 to 2225 hospitals for excessive readmissions.[32] Although hospital finance and payment policies differ between the USA and Europe, the underlying goal of better value for investments is the same.[33]

Panel: Research in context

Systematic review

We searched PubMed for original research articles published in English between Jan 1, 1985, and Aug 10, 2013, with the search terms (separately and in combination): "nursing", "staffing", "administrative data", "outcomes", "mortality", "European Union", and "cross-national" and "international." We also did a manual search based on bibliographies of papers we found. Studies linking nursing and clinical patient outcomes were restricted in Europe to one country studies[8–11] and to research in North America.[12–17] In Europe, cross-national studies assessing how hospital nursing affects patient outcomes are restricted to assessment of outcomes based on patient or nurse report rather than objective clinical outcomes.[24]

Interpretation

We report the first study to use detailed information about nursing workforce such as staffing and education level to investigate how these factors affect patient mortality across countries in Europe. We relied on unique data from direct-care nurses collected with a common method across many hospitals in different countries. We used a standardised approach across countries to measure and adjust the risk of mortality on the basis of administrative records. Findings of our analysis of 300 hospitals in nine countries show that an increase in nurses' workloads by one patient increases the likelihood of inpatient hospital mortality by 7%, and a 10% increase in bachelor's degree nurses is associated with a decrease in odds on mortality by 7%. These findings emphasise the risk to patients that could emerge in response to nurse staffing cuts and suggest that an increased emphasis on bachelor's education for nurses could reduce preventable hospital deaths.

Our study has several limitations. We assessed one outcome, mortality, and only in patients undergoing common general surgeries. Our measure of education relied on each country's definition of bachelor's education for nurses, which differs by country. Our global measure of nurse staffing shows nurse workloads across all shifts, and might be skewed in some hospitals if nurses working at night (when patient-to-nurse ratios are higher than in the day) responded to our survey at different rates than nurses on day shifts. The models we used to measure associations allowed us to control for unmeasured differences in mortality across countries and for measured differences across patients and hospitals, but unmeasured confounding factors at the individual, hospital, and community level could have affected our results. We cannot link the care of individual patients to individual nurses. Additionally, mortality outcomes for patients were taken from the year that most closely matched the nurse survey year, but because of lags in patient data availability, the two data sources were not always perfectly aligned. Finally, our data are cross-sectional and provide restricted information about causality.

Additional research in Europe is needed to establish whether our multicountry findings can be replicated for high mortality surgeries and for medical patients; and whether in Europe, like in the USA, nursing is related to a range of adverse outcomes that contribute to high costs. Longitudinal studies of panels of hospitals would be especially valuable to help to establish causal associations between changes in nursing resources and outcomes for patients. Comparative effectiveness research is needed to identify what workforce investments return the greatest value, and under what circumstances. Research beyond simple mortality outcomes would be welcome to help to establish standards of care by which performance of health-care organisations could be more fully assessed. In a context of widespread health-system redesign and reforms, increased funding for studies of health workforce investments could result in high-value health care.

In summary, educational qualifications of nurses and patient-to-nurse staffing ratios seem to have a role in the outcomes of hospital patients in Europe. Previous findings from RN4CAST show that patients are more likely to express satisfaction with hospital care when nurses care for fewer patients each.[24] To add to these findings, our data suggest that evidence-based investments in nursing are associated with reduction in hospital deaths.

Contributors

LHA, WS, LB, MM, PG, RB, and MTM-C did the literature search. LHA, WS, DMS, KVdH, AMR, PG, MM, RB, AS, and CT designed the study. WS, LHA, KVdH, RB, PG, MD, JK, MK, MTM-C, AMR, RS, AS, CT, and TVA collected data. LHA, DMS, LB, MM, WS, and TVA analysed data. All of the authors contributed to data interpretation, writing, and revision of the report.

RN4CAST consortium

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Conflicts of interest

We declare that we have no conflicts of interest.

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Tudalen y pecyn 23

Nurse staffing and education in Europe: if not now, when?

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By financing the RN4CAST project,[1] the European Union (EU) showed its concern about patient safety: the project's aim was to measure the value of nursing care. Such measurement has long been recognised as challenging. Drawing on discharge data from nine of the 12 RN4CAST countries for more than 420 000 patients aged 50 years or older, Linda Aiken and colleagues[2] in *The Lancet* show that an increased workload of one patient per nurse was associated with an increase in the odds of surgical inpatient mortality, within 30 days of admission, by 7% (odds ratio 1·068, 95% CI 1·031–1·106). Patients in hospitals in which 60% of the nurses had a bachelor's degree, who looked after an average of six patients, had a mortality rate almost 30% lower than patients in hospitals where only 30% of the nurses had a bachelor's degree and cared for an average of eight patients. The investigators included hospitals from two countries of the European Free Trade Association (Switzerland and Norway) and seven of the 28 countries in the EU. The EU is a vast area linked by bilateral agreements in which the prevailing objective of a European market has recently introduced a social dimension to address inequalities (eg, workers' rights and safe working conditions);[3] patients can circulate freely to get the best care, and nurses can travel for optimum occupational working conditions.[4,5]

To search for associations between mortality and nurse staffing and educational level, the investigators developed a European study with an ecological design. The analytical methods applied were consistent with the state of knowledge in the specialty, and researchers introduced the necessary control variables to account for differences in the environment in which patients and nurses were surveyed. The investigators recognise the limitations of the study and possible effects on their results. However, the findings are consistent with those already documented in the USA[6] and Europe,[7,8] and contribute to a body of knowledge that should provide information for health-care policies of several countries.

The study is the first pan-European public report to monitor how many patients were managed by nurses during their last work-shift. This method is more accurate than the nurse–population ratio, which often includes midwives too,[9] and is more informative than other measures (eg, number of full-time equivalent nurses), which provide information about how many nurses are in employment, but not how many work in the clinic. The data suggest important variability within and between countries, possibly because no homogeneous standards exist, even in countries with a public health service where patients should receive a standard level of nursing care and nurses should work in similar conditions. The study includes information about how decisions with respect to university nursing education were indicative of the composition of daily nursing staff and their patients, which raises an important question about variability despite the tenure in Europe, since 1999, of the Bologna Process. This declaration includes more than 47 EU, European Free Trade Association, and other countries (ie, European higher education area), and aims to harmonise university education.[10]

Results of the study by Aiken and colleagues[2] show that the skills of the staff acquired at university create the conditions for safe staffing. The investigators report a 7% reduction in patient mortality for every 10% increase in the number of nurses with bachelor's degrees. The continuing presence of graduate nurses in the staff (ie, at least one per shift), able to guarantee surveillance and clinical judgment, creates a protective environment for surgical patients.

The data refer to the years 2007–10, so the researchers did not document the situation immediately before the EU economic crisis or the effects of austerity

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measures introduced in several countries.[11] If the study was replicated, the results might be different; in many countries, austerity measures have caused a reduction in the number of nurses at patients' bedsides.[12] The nurses remaining at the bedside have large workloads, with negative results on patients, and as a result the public image of nurses is worsening in several countries.[13]

Recession has highlighted the cost of graduate education for nurses; therefore, health-care organisations could be attracted by vocationally trained nurses, in the belief that costs might be lower and the nurses more effective. Paradoxically, and notwithstanding the support for research (including from the EU's Seventh Framework Programme), in November, 2013,[5] the EU decided to approve two pathways for nursing education: a vocational school or training after 10 years of general education; and a higher education or university pathway after 12 years of education, which is a change from the previous directive that envisioned at least 12 years of general education before nursing education.

The study by Aiken and colleagues[2] provides evidence in favour of appropriate nurse–patient ratios and also provides support for graduate education for nurses. Whether these findings are used to inform health-care policy or how they are implemented in practice will be interesting to see. We fear that the evidence here will not be tried and found wanting, but will rather be deemed too expensive to act upon.

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We declare that we have no competing interests.

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Caring nurses hit by a quality storm

Low investment and excessive workloads, not uncaring attitudes, are damaging the image of NHS trusts, argue the authors of groundbreaking research into Europe's nurse workforce

Nurses are getting a bad press in England for being 'uncaring' at a time when nursing in the United States is benefiting from favourable public perceptions, supportive policy initiatives and the largest and most talented pool of applicants to nursing schools in history.

Interestingly, both countries had nursing commissions that released reports in 2010 heralding the future of nursing; the responses could not have been more different.

The US Institute of Medicine's report called for nurses' scope of practice to be broader, for nurses to lead innovative care models, for at least 80 per cent of the nurse workforce to have bachelor's degrees, and the number with doctoral degrees to be doubled by 2020. Media coverage was positive and initiatives to implement recommendations came swiftly.

In contrast, much of the media response to the Prime Minister's Commission on the Future of Nursing and Midwifery accused nurses of having uncaring attitudes and scoffed at recommendations for them to receive bachelor's education.

The annual Gallup public opinion poll in the US shows nurses leading all other occupations when it comes to trust. What is different about nurses in England? They are the public face of the NHS, as exemplified by the tribute in the opening ceremony of the London Olympics. As such, they may be revered in good times and blamed when the NHS disappoints.

The context of caring

Instead of blaming nurses and expecting care to improve, it may be more productive to consider complaints about nurses as early warning signs that the quality of health care is being eroded, and then consider how to avert the 'quality storm'.

As a result of an EU-funded study of the nurse workforce in 12 European countries, RN4CAST, we know much about the challenges faced by nurses working in NHS hospitals in England. We are also able to compare nurses' reports on conditions of practice in NHS hospitals with nurses' experiences in 11 other European countries and the US (Aiken *et al* 2012). RN4CAST's findings about 488 European hospitals through the eyes of 33,659 nurses, including 2,918 nurses practising in 46 NHS hospitals in England, are revealing and informative.

In Box 1 (see page 24) we show England's rank compared with the best-ranking

SUMMARY

Research by the authors, some of it unpublished, indicates that nurses in England are not 'uncaring'. On the contrary, they score highly on measures of caring. Negative perceptions of nurses in England can be explained by their excessive workload and inadequate skill mix. Put simply, nurses in England do not have the time to show how much they care.

Authors Linda Aiken, Anne Marie Rafferty, Walter Sermeus. For details see page 25

European country, based on five hospital nurse workforce dimensions: job-related burnout; staffing and resource adequacy; skill mix; proportion of nurses with a bachelor's degree; and work environment quality.

Countries were ranked based on averages across all hospitals in each country. While we use nurses as informants about their hospitals, our ranking is related to resources and nurse workforce outcomes at the hospital level because policies to address quality concerns will likely be directed to hospitals rather than to nurses. This approach also takes into account that some hospitals are better than others on these dimensions, but public perceptions of hospital care are likely to be a result of the experiences of patients and their families.

Nurse burnout, measured with a well-validated instrument, revealed that, on average, 44 per cent of bedside care nurses in the representative sample of NHS hospitals studied scored in the 'high burnout' range. Indeed, only one other country has hospitals with a higher percentage of 'burned out' nurses than England.

England ranks unfavourably compared to many other countries in Europe on dimensions that suggest why nurses in NHS hospitals may suffer from high burnout. Nurses in each study hospital in the 12 countries rated the overall adequacy of staffing and resources. Only four of the 12 countries ranked worse than England on nurses' assessments of staffing adequacy. Nurses also rated their hospitals on the quality of their work environments, and England again ranked near the bottom.

COMPLAINTS ABOUT 'UNCARING' NURSES CAN BE EXPLAINED BY THE UNDER-RESOURCING OF SERVICES

On another measure of staffing, known as nursing skill mix, which is the proportion of all hospital care staff who are professional nurses, England scored worse than all but two other countries. A significant proportion of caregivers in NHS hospitals are not professional nurses, although the public may not be aware of this.

A growing research literature shows that hospitals with a higher proportion of nurses qualified at bachelor's degree level have lower risk-adjusted mortality and fewer adverse patient outcomes (Aiken *et al* 2014). However, hospitals in England averaged only 28 per cent of bedside care nurses with a bachelor's degree, compared with 45 per cent across Europe. Only four countries had lower proportions than England. All hospital nurses in Norway and Spain held at least a bachelor's degree.

Despite high rates of burnout in England and resources that are less generous than elsewhere in Europe, we found no evidence that the attitudes of nurses in England towards their ▶

PETE ELLIS

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Box 1: England's rank among 12 European countries

	England's rank	Best-ranking country
Nurse burnout	11	Netherlands
Staffing and resource adequacy	7	Switzerland
Skill mix (% of registered nurses)	10	Germany
Nurses with bachelor's degree	8	Norway and Spain
Work environment quality	10	Norway

Source: unpublished results from RN4CAST. The countries included are Belgium, England, Finland, Germany, Greece, Ireland, Netherlands, Norway, Poland, Spain, Sweden and Switzerland.

Note: Rankings are based on hospital averages for each characteristic (for example, the percentage of nurses with high burnout, and the percentage reporting adequate staffing and resources, was calculated for each hospital, and then the average across all hospitals in each country was calculated). On the four favourable characteristics, countries were ranked from high (rank 1) to low; on nurse burnout, countries were ranked from low (rank 1) to high.

▶ patients are negative and no support for media reports that nurses are uncaring. We asked nurses in each country how frequently they felt that they 'don't really care what happens to some patients'. Nurses in England nurses ranked best on this dimension, with 89 per cent responding 'never'.

Some media stories suggest that recent requirements for nurses in England to obtain a bachelor's degree are responsible for less caring behaviour. We explored our data to see whether nurses in England with a bachelor's education had more negative perceptions of patients than other nurses. The answer was no; they showed high regard for patients regardless of their educational qualifications.

Rationing of comfort

We did find a possible explanation for why some patients might perceive nurses in England to be uncaring – and it relates to workload.

Box 2 examines the types of care nurses say they cannot complete because of their heavy workloads. Norway was selected as a comparison country because of its well-resourced healthcare system, and because most of its hospitals were ranked by nurses as having good work environments.

A significant share of nurses in hospitals in both countries report that not all of their patients have all of their care needs met because of nurses' demanding workloads. But, overall, nurses in England are significantly more likely than nurses in Norway to report omitted care.

These findings suggest that nurses may be implicitly rationing some kinds of care because of their high workloads. Critical needs such as pain control and medication and treatment administration are less likely to be omitted than educating patients and families about self-care after discharge and spending time talking with patients and families about their concerns (Ball *et al* 2013).

Two-thirds of nurses in hospitals in England report that they do not have time to comfort and talk with patients. This is consistent with higher nurse workloads in NHS hospitals, fewer professional nurses among care staff at the bedside, and poorer nurse work environments than is the case in Norway and many other European countries.

Box 3 provides additional insight into unmet care needs, particularly the comforting functions of nurses that may be important to patients' positive perceptions of care. Nurses who assess their work environments as poor are twice as likely as those who assess them as excellent to report a lack of time to comfort and communicate with patients.

Our findings suggest that increasing nurse resources and improving work environments in NHS hospitals are more likely than blaming nurses for uncaring attitudes to result in patient-centred care (Aiken *et al* 2012).

Box 2: tasks for which nurses (%) say they lack time

	England	Norway
Pain management	7	4
Treatments and procedures	11	7
Prepare patients for discharge	20	14
Skin care	21	30
Administer medications on time	22	15
Oral hygiene	28	30
Adequately document nursing care	33	21
Patient surveillance	34	25
Educate patients and family	52	24
Comfort and/or talk with patients	66	38

Source: unpublished data from RN4CAST provided by authors.

The difficult economic context in Europe and elsewhere is contributing to the gathering 'quality storm'. Cost containment, especially as applied to hospitals, results in higher intensity of services delivered in less time and more rapid patient throughput from admission to discharge. These changes require more nurses, not fewer, to prevent deterioration in care quality and safety that can harm patients and lead to higher costs if expensive complications such as infections result (Cimiotti *et al* 2012).

Increasing the intensity of services and patient throughput in inpatient care, while maintaining quality and safety, is not possible if nursing resources are reduced, as documented in the Francis report on failures of care at Mid Staffordshire NHS Foundation Trust. Also, having too few nurses can cost more if complications increase.

Early warning signs

We make a case here for thinking more broadly about the meaning of negative perceptions of nursing care in the NHS and elsewhere.

Policy solutions rely on an accurate diagnosis of problems. Getting nurse resource levels and hospital culture correct are crucial. We found no evidence that public concerns about a lack of caring by nurses in England is associated with less professionalism, commitment or hard work.

On the contrary, the high rate of burnout in England suggests that nurses are trying their best under difficult circumstances. It is likely that complaints about 'uncaring' nurses can be explained by the fact that nursing services are comparatively under-resourced in hospitals in England.

Investments in evidence-based strategies to improve nurse work environments, as exemplified in the Magnet Recognition Program (McHugh *et al* 2013); applying evidence to achieve safe nurse staffing and nursing skill mix; and moving to a bachelor's qualified nurse workforce (Aiken *et al* 2014), hold promise for stabilising quality and safety gains and staving off the gathering quality storm in health care in England.

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Journal Club #NursingJC

Join our First Friday Twitter discussion about issues raised in this article. Friday May 2 from 12.30-1.30 using #NursingJC

In the US, close to 10 per cent of hospitals have qualified for Magnet status by demonstrating excellence in nursing care, a distinction that is recognised by national quality benchmarking organisations as the mark of a high-performing healthcare organisation. There is no equivalent form of recognition of nursing excellence in England or elsewhere in Europe.

Hospitals in the US are preferentially hiring bedside care nurses with bachelor's degrees, a market indicator of their higher value to their employing organisations.

The Institute of Medicine of the US National Academy of Sciences has elected nurse members, creating a forum for high-level interprofessional discourse on healthcare challenges, an organisational model that again does not have an equivalent in Europe.

Nurses' concerns about quality of care, patients' reports of negative care experiences, and press reports about uncaring nurses are harbingers of declining quality and safety, and should be considered warning signs that austerity measures may be risking harm to patients **NS**

Box 3: care linked to environment

Nurse rating of work environment	% of nurses lacking time to comfort and/or talk with patients
Poor	83
Fair	72
Good	56
Excellent	41

Source: unpublished data from RN4CAST provided by authors

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22 January 2015

Ms Sian Giddins
Deputy Clerk
Health & Social Service Committee
National Assembly for Wales
Cardiff Bay
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Dear Ms Giddins

HSSC Inquiry – Safe Nurse Staffing Levels (Wales) Bill

As requested, herewith is the evidence of the Board of Community Health Councils in Wales in relation to the above inquiry.

I look forward to attending the meeting of the Health and Social Care Committee that is scheduled for 12th February in order to speak to this submission and take questions from Assembly Members. I would be happy to hear from you should you need to speak with me before then.

Yours sincerely,

PMS

Peter Meredith-Smith
Director
Board of Community Health Councils in Wales

Ffôn/Tel: [redacted] / [redacted]

Board of Community Health Councils in Wales

Health & Social Care Committee Submission: Safe Nurse Staffing Levels (Wales) Bill	
SUBJECT:	Safe Nurse Staffing Levels (Wales) Bill
STATUS:	Board of CHC Submission to H&SCC Committee (Final Draft)
CONTACT:	Peter Meredith-Smith, Director of the Board of CHCS in Wales
DATE:	22nd January 2015

INTRODUCTION

This submission to the Health and Social Care Committee of the National Assembly for Wales, relating to the Safe Nurse Staffing Levels (Wales) Bill, is submitted by the Board of Community Health Councils in Wales in advance of their attendance at a meeting of the committee scheduled for 12th February 2015.

Supported by the Board of Community Health Councils (CHCs), the 8 CHCs across Wales represent the interests of and act as the independent voice for the citizens of Wales regarding their NHS services. They fulfil these functions by: (a) continuously engaging with the populations they represent and the health service providers serving those populations, (b) systematically monitoring and scrutinising local health services, through service inspections and visits, (c) supporting the public to engage in consultations about major NHS service changes that have an impact on them and (d) enabling users of the NHS in Wales to raise concerns about the services they receive, primarily by providing an Independent Advocacy Service.

The views represented in this submission are informed by feedback from individual CHCs across Wales relating to this issue of interest to the Health and Social service Committee, and from data and information derived from the Board of CHCs' information systems (pertaining the monitoring of the core functions of the CHCs across Wales).

GENERAL COMMENTARY

The CHCs support the proposal to introduce this legislation. There is a general feeling amongst those who have contributed to this response that without the force of law, against the present background of severe financial restraint within NHS Wales, the well-publicised staffing pressures across our health services will continue. It is likely that this will have a consequent negative impact on the safety, efficacy and quality of patient care.

Feedback from CHC members who are involved in service visiting and scrutiny programmes frequently indicate a health service landscape across Wales that is characterised by a system that is under extreme strain. It is apparent to our members that nursing staffing shortfalls are often contributory factors to this unacceptable situation.

Having clarity about agreed safe staffing levels in clinical areas across the NHS in Wales would assist our members and staff to more effectively fulfil their health service scrutiny role.

We believe that the making of this legislation would be a key step towards strengthening public confidence in the safety of their NHS services.

The three most helpful sources of information available to the Board of CHCs to inform its views on the nursing staffing situation across the NHS in Wales are data and information derived from the CHCs':

- Continuous Engagement Work
- Service Monitoring and Scrutiny programmes
- Independent Advocacy Service

On the basis of what we learn from our continuous engagement and service monitoring and scrutiny work, it is possible to offer in general terms an overview of what the users of NHS services that we engage with "want" from their NHS. In summary, we are frequently told that they want:

- Services that keep them safe
- Reasonable quality of care
- Care delivery that assures that they are treated with respect
- Their privacy and dignity to be assured whilst in hospital
- Good engagement with clinical staff (being kept informed about their care)
- To be assured that services are safely staffed

Quite clearly, appropriate and safe levels and skill mix of nursing staffing are necessary if these expectations are to be met.

We are also able on the basis of our engagement work to provide a summary of how, in general terms, patients describe their experiences of the NHS. Typical perspectives offered being:

- Despite evident pressures, services are generally adequate
- When things go wrong nursing staffing problems are often significant
- When things go wrong it is not generally the "fault" of individual nurses
- Problems are usually a consequence of the situation that nurses are in
- Lack of nursing workforce stability leads to a lack of continuity of care

Specific themes directly related to nursing staffing that often feature in feedback from our members or the patients and relatives that we engage with include:

- Suggestions that nurses are often not readily available to provide assistance "at the time that they are needed"
- Nursing staff are constantly "rushed with too much to do"
- Nurses seem to be on duty for very long periods and often seem to be very tired at the end of what appear to be very long shifts
- Health Care Support Workers are often more visible that Registered Nurses

The Board of CHCs in Wales' *Concerns and Complaints Database* is another source of information relevant to this debate. Although the explicit issues of "nursing shortages" or "inadequate nursing staffing levels" do not feature in the data available to us, other information derived from the database may provide a "proxy indication" of staffing deficiencies across the NHS in Wales.

A recent review of information derived from the database indicated that, of the concerns or complaints logged on the system, 14% related to nursing in secondary care. Most of those complaints, in general terms, related either to failures or shortcomings in the "Clinical Practice" (61% of complaints reviewed) or "Poor Engagement or Communication" between clinical staff and patients (19% of complaints reviewed).

Drilling down into these overarching areas highlighted five specific areas of concern or complaint raised by those who contact us. They being:

- Failures in the Fundamentals of Care
- Failures in Treatment Delivery
- Negative Staff Attitudes
- Lack of Information
- Compromised Privacy & Dignity

Again, these are areas of service shortcoming or failure that can directly relate to staffing pressures (be they inadequate staffing numbers or skill mix problems).

The CHCs that have contributed to this response have also provided specific examples of serious issues that they have or are dealing with, that have inadequate nursing staffing as one of the root causes of significant clinical or service failings. For reasons of patient confidentiality, it would not be appropriate to detail these herein.

SPECIFIC QUESTIONS POSED BY THE HEALTH AND SOCIAL SERVICES COMMITTEE

Are the provisions in the Bill the best way of achieving the Bill's overall purpose?

The CHCs who offered a view agreed that the provisions in the Bill are generally the best way of achieving the Bill's overall purpose.

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

The CHCs have offered the following suggestions:

- Inadequate numbers of staff "in the system" to support an acceptable nursing staffing model
- Inadequate numbers of student nurses "in training" to support future nursing staffing needs
- Poor workforce planning throughout the NHS in Wales
- Inadequate financial resources to support an adequate nurse staffing model
- An approach to workforce planning (and workforce management) in Wales that prioritises financial planning over a needs-based workforce

Are there any unintended consequences arising from the Bill?

Because the proposed law would only require safe staffing on adult inpatient wards in acute hospitals, against the background of resource pressures referred to above, there is a risk that HNS managers would denude staffing levels in other clinical areas to ensure that adult in-patient wards are compliant with the law. This would lead to potentially unsafe staffing levels in clinical areas that are not subject to the legislation.

There is a risk that establishing "safe staffing levels" could set a "ceiling on staffing numbers" that could fetter appropriate workforce development – i.e. minimum "safe" staffing levels do not always ensure the best quality care (which may require higher numbers of staff than minimum numbers).

Provisions in the Bill

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 CHCs fully support this provision.

- There must be a standardised methodology for approaching this across all Health Boards. Workforce planning needs to be strengthened from the bedside to the Board (and across Wales).

- The LHB Chief Executive should be clearly identified in the legislation as the accountable officer regarding this provision.

- Safe staffing is not easy to quantify and monitor using current systems and approaches employed in Wales; such systems need urgent development.

- Safe staffing should be included as a key "quantifiable" LHB Health Board performance measure, open to scrutiny in public Board meetings.

- The Francis Report was very specific on the need for enhanced "Ward to Board" ownership and communication of front-line care and performance. Such clear measures could help in addressing this Board-level communication and scrutiny.

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 patient wards in acute hospitals.

- CHCs agree with this but "reasonable steps" need to be defined to avoid ambiguity.
  .
- The sanctions for failure in this duty need to be clear.

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

- Safe staffing should be a legal requirement in all clinical environments, not just adult inpatient wards (this should include community and primary care environments too).

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)?**

  The CHCs very strongly endorse the requirement for guidance to be provided as stated. Welsh Ministers should keep such guidance under continuous review.

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

  The CHCs fully support this and regard such an approach as essential (see relevant comments above).

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

  Such transparency is crucial. It will engender public confidence. Some CHCs have suggested that the *Annual Quality Assurance Statement* could provide a vehicle for informing the public regarding this in general terms .

  It is also crucial that patients and their relatives are made aware of the numbers of staff that should be on duty against those that are actually on duty "in real time" at ward level (and other clinical area level). The CHCs would be happy to explore how they might support LHBs to keep the public informed reading safe staffing levels.

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

  These protections are absolutely essential and are fully supported by the CHCs. The activities listed in the Bill must be considered and properly accounted for in workforce planning methodologies.

The requirement for Welsh Ministers to consult before issuing guidance?

This is supported by the CHCs.

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

This is supported by CHCs. Such transparency is essential if public confidence is to be maintained.

The requirement for Welsh Ministers to review the operation and effectiveness of the Act?

Supported. CHCs would like firm assurance that Welsh Ministers will review the operation and effectiveness of the Bill. If legislation is agreed, CHCs would expect that regular close monitoring of implementation takes place with regular performance reports provided, with a formal evaluation being undertaken. There should be active involvement from professional and academic bodies to support the development and monitoring of any measures.

View on the effectiveness and impact of existing guidance?

Current guidance has not sufficiently improved staffing levels; hence the need for legislation. We would expect agreed nurse/patient ratios to be met

consistently, although there may be an argument for sensible tolerances to be built into any workforce planning and management systems. Where agreed nursing staffing ratios are not met, we would expect to see urgent recovery plans developed and implemented, and for Welsh Government to take action if problems persist.

Balance between what is included on the face of the Bill and what is left to subordinate legislation and guidance?

No specific comments.

Financial implications of the Bill.

Quite clearly, if nursing staffing establishment have been under-resourced to date, there may be additional cost implications as a consequence of this legislation. However, this could be significantly offset by a concomitant reduction in spend on nursing bank and agency staff and overtime. Additionally, we might expect reduced sickness levels amongst nurses as staffing levels improve (so mitigating the extra costs that might be associated with the introduction of this legislation). Finally, we are aware that international evidence indicates a positive impact on treatment and care outcomes when nursing staffing levels are optimum. It has been argued that this too contributes to cost reduction across the "whole system" of healthcare.

Other Issues

No additional comments.

- ENDS-

Eitem 4

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

Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Healthcare Inspectorate Wales – SNSL(Org) 21 / Tystiolaeth gan Arolygiaeth Gofal Iechyd Cymru – SNSL(Org) 21

Ymateb i ymgynghoriad ar y Bil Lefelau Diogel Staff Nyrsio (Cymru)

Ynglŷn ag Arolygiaeth Gofal Iechyd Cymru

Arolygiaeth Gofal Iechyd Cymru (AGIC) yw'r arolygiaeth a rheoleiddiwr annibynnol ar gyfer gofal iechyd yng Nghymru.

Mae AGIC yn canolbwyntio'n bennaf ar y canlynol:

- Gwneud cyfraniad at y gwaith o wella diogelwch ac ansawdd gwasanaethau gofal iechyd yng Nghymru
- Gwella profiad dinasyddion o ofal iechyd yng Nghymru boed hynny fel claf, defnyddiwr gwasanaeth, gofalwr, perthynas neu gyflogai
- Atgyfnerthu llais cleifion a'r cyhoedd yn y modd y caiff gwasanaethau iechyd eu hadolygu
- Sicrhau bod gwybodaeth amserol, ddefnyddiol, hygyrch a pherthnasol am ddiogelwch ac ansawdd gofal iechyd yng Nghymru ar gael i bawb

Ein hymateb:

Cyffredinol

- ***Oes angen deddfwriaeth i ddarparu ar gyfer lefelau diogel staff nyrsio?***

  Mae Arolygiaeth Gofal Iechyd Cymru (AGIC) yn gadarn yn cefnogi amcanion y Bil i:

  - Alluogi bod gofal nyrsio diogel yn cael ei ddarparu i gleifion bob amser
  - Gwella amodau gwaith staff nyrsio a staff arall
  - Cryfhau atebolrwydd ynglŷn â diogelwch, ansawdd ac effeithiolrwydd cynllunio a rheoli'r gweithlu

Mae'r rhan fwyaf o'n canfyddiadau sy'n ymwneud â staffio yn codi o'n harolygiadau urddas a gofal hanfodol a'n harolygiadau iechyd meddwl. Yn ystod y flwyddyn bresennol, rydym wedi cyhoeddi 30 arolygiad urddas a gofal hanfodol. Rydym wedi nodi problemau yn ymwneud â staffio yn hanner yr arolygiadau hyn.

Mae'r problemau a nodwyd wedi tueddu i fod yn ymwneud â phrinder staff, anawsterau wrth recriwtio a chadw, a chyfradd uchel o ddibyniaeth ar staff banc ac asiantaeth. Mewn tair enghraifft, gwnaethom geisio sicrwydd ar unwaith gan y Byrddau Iechyd eu bod yn mynd i'r afael â'r problemau.

Cyhoeddwyd canllawiau ar yr egwyddorion sy'n sail i nyrsio diogel i Fyrddau Iechyd yng Nghymru gan y Prif Swyddog Nyrsio ym mis Ebrill 2012, a chyflwynwyd offeryn aciwtedd ar gyfer wardiau ysbytai acíwt i oedolion ym mis Ebrill 2014. Mae cynnydd yn digwydd, ond rydym yn dal i ganfod bod gweithredu'n anghyson: nid yw pob ardal ward wedi pennu isafswm ei lefelau staffio diogel lleol, ac nid yw wardiau'n defnyddio offeryn aciwtedd yn rheolaidd i adlewyrchu a chydweddu niferoedd staff ag anghenion cleifion.

Mae'n bosibl y gallai deddfwriaeth yn y maes hwn helpu i roi'r pwyslais a'r ysgogiad angenrheidiol i wneud y canllawiau hyn yn sail i arfer dyddiol.

Rydym yn falch o weld bod y cynigion yn cydnabod ei bod yn bwysig edrych y tu hwnt i gymarebau syml. Mae staffio diogel yn ddibynnol ar fwy na rhifau: rhaid iddo hefyd adlewyrchu anghenion y cleifion, yr amgylchedd y mae'r gofal yn cael ei ddarparu ynddo, sgiliau a phrofiad yr aelodau staff, a'r gyfran o'r gofal a ddarperir gan staff banc ac asiantaeth sydd, o bosib, â phrofiad cyfyng yn y maes. Rydym felly'n cefnogi'r bwriad i sicrhau bod cymarebau staff gofynnol yn cael eu gweld fel sylfaen ac nid fel targed.

- ***Ai'r darpariaethau yn y Bil yw'r ffordd orau i gyflawni bwriad cyffredinol y Bil (a noder yn Adran 1 o'r Bil)?***

- ***Beth yw'r rhwystrau posib, os oes unrhyw rwystrau, i weithredu darpariaethau'r Bil? Ydi'r Bil yn talu digon o sylw iddynt?***

Mae faint o Nyrsys Cofrestredig sydd ar gael i weithio, a'r gallu i recriwtio, yn debygol o fod yn rhwystr. Bydd angen i'r Bil gael cefnogaeth gan gynllunio gweithlu effeithiol a darpariaeth addysg i sicrhau bod digon o nyrsys hyfforddedig a phrofiadol ar gael i gwrdd â'r anghenion dynodedig.

Mae'n iawn cydnabod nad yw pennu lefelau staffio priodol yn syml ac na ellir ei wneud trwy ddefnyddio fformiwla syml. Fodd bynnag, bydd yr angen i gydbwyso barn broffesiynol, a natur y galw sy'n newid yn gyson, yn ei gwneud yn anodd i'r canllawiau fod yn benodol. Bydd hyn yn ei dro'n gwneud cyfathrebu'n eglur â chleifion ynghylch sut mae'r staffio'n cwrdd â'r canllawiau yn heriol. Bydd hefyd yn gwneud dal cyrff iechyd yn atebol am gyflenwi mewn perthynas â'r ddeddfwriaeth yn fwy heriol.

Mae'r amgylchedd ariannol presennol y mae Byrddau Iechyd yn ei wynebu'n debygol o achosi her iddynt wrth gwrdd â lefelau staffio diogel bob amser.

- ***Oes yna unrhyw ganlyniadau anfwriadol yn codi o'r Bil?***

  Mae'n bosib, yn y tymor byrrach o leiaf, y byddai ymdrechion i gynnal niferoedd staff yn cynyddu cyfradd y staff banc ac asiantaeth yn sylweddol. Gall hyn gael effaith ar gysondeb ac ansawdd y gofal.

  Mae'n bosibl y gall Byrddau Iechyd symud adnoddau o ardaloedd heb ganllawiau statudol er mwyn cwrdd â gofynion y canllawiau mewn wardiau acíwt i oedolion. Er enghraifft, rydym eisoes wedi nodi problemau staffio mewn arolygiadau Iechyd Meddwl y GIG ac wedi tynnu sylw at y rhain ym mhob adroddiad ar yr arolygiadau hyn sydd wedi cael ei gyhoeddi hyd yma.

Darpariaethau yn y Bil

Mae gan y Pwyllgor ddiddordeb yn eich barn ar y darpariaethau unigol yn y Bil ac a ydynt yn cyflenwi eu dibenion a nodwyd. Er enghraifft, beth yw eich barn chi am:

- ***y ddyletswydd ar gyrff gwasanaethau iechyd i ystyried pwysigrwydd sicrhau lefel briodol o staff nyrsio ble bynnag y darperir gofal nyrsio'r GIG?***

  Ceir diffyg eglurder ynghylch y cwmpas a fwriadwyd ar gyfer y ddarpariaeth hon. Byddai o gymorth i sefydlu a yw'r ddarpariaeth wedi ei bwriadu i gynnwys gofal wedi ei gomisiynu gan ddarparwyr mewn gweinyddiaethau eraill fel Lloegr neu wedi ei gomisiynu gan, neu ei ddarparu o fewn, lleoliad gofal annibynnol.

- ***y ddyletswydd ar gyrff gwasanaethau iechyd i gymryd pob cam rhesymol i gynnal cymarebau gofynnol rhwng nyrsys cofrestredig a chleifion a chymarebau gofynnol rhwng nyrsys cofrestredig a gweithwyr cymorth gofal iechyd a fydd yn berthnasol i ddechrau mewn wardiau cleifion i oedolion mewn ysbytai acíwt?***

- ***y ffaith bod y ddyletswydd yn berthnasol, yn y lle cyntaf, i wardiau cleifion i oedolion mewn ysbytai acíwt yn unig?***

  Rydym hefyd wedi canfod heriau staffio amlwg mewn wardiau iechyd meddwl ac mewn ysbytai cymunedol na fyddent yn cael eu cynnwys yn y canllawiau dechreuol. Rydym felly'n croesawu'r ddarpariaeth i alluogi darparu canllawiau yn y lleoliadau hyn a lleoliadau eraill.

  Fodd bynnag, o ystyried ein sylwadau am gwmpas mewn perthynas â darpariaeth 1(a), byddem yn cwestiynu a yw'r cyfeiriad at "lleoliadau o fewn y GIG" yn rhy gyfyngol ac a fyddai'n fwy priodol i gyfeirio atynt fel "lleoliadau y mae gofal GIG yn cael ei ddarparu ynddynt".

- ***y gofyniad bod Llywodraeth Cymru'n cyhoeddi canllawiau mewn perthynas â'r ddyletswydd a nodir yn adran 10A(1)(b) a fewnosodwyd gan adran 2(1) o'r Bil sy'n:***

  - ***Nodi dulliau y dylai sefydliadau'r GIG eu defnyddio i sicrhau lefel briodol o staff nyrsio***

  - ***Cynnwys darpariaeth i sicrhau nad yw'r cymarebau gofynnol yn cael eu defnyddio fel terfyn uchaf***

  - ***Nodi proses ar gyfer cyhoeddi gwybodaeth i gleifion am nifer y staff nyrsio ar ddyletswydd a'u rolau***

    Rydym yn cefnogi'r angen i fod yn agored a thryloyw wrth gyfathrebu â chleifion.

  - ***Cynnwys amddiffyniadau o weithgareddau penodol a rolau arbennig pan fydd lefelau staffio'n cael eu pennu***

    Rydym wedi cynnal tri arolygiad ble mae Prif Nyrs y Ward wedi gorfod ymgymryd â rôl gofal uniongyrchol oherwydd anawsterau staffio ac felly'n cael anhawster i ymgymryd â'i rôl o arwain a chydlynu gofal a chymorth i staff eraill. Gall hyn arwain at gyfathrebu gwael, diffyg sylw i gynllunio gofal a dogfennau, ac i gynllunio gwan o ran rhyddhau cleifion i fynd adref. Rydym felly'n croesawu cynnwys amddiffyniad o statws ychwanegol unigolion sy'n darparu swyddogaethau goruchwylio arbenigedd clinigol ac arweinyddiaeth.

    Rydym hefyd yn croesawu cydnabod yr angen i roi amser i hyfforddiant. Mae nifer o'n harolygiadau wedi tynnu sylw at hyfforddiant gorfodol anghyflawn. Rydym hefyd wedi tynnu sylw at enghreifftiau lle nad oedd staff wedi gallu cael eu rhyddhau ar gyfer hyfforddiant neu lle'r oeddent wedi cwblhau hyfforddiant yn eu hamser eu hunain.

- ***y gofynion monitro a nodir yn y Bil***

- ***y gofyniad bod pob corff gwasanaeth iechyd yn cyhoeddi adroddiad blynyddol***

  Rydym yn croesawu'r gydnabyddiaeth yn y Bil y gellid cynnwys y gofynion uchod o fewn prosesau monitro ac adrodd sy'n bodoli eisoes. Mae'n bwysig nad yw gofynion y Bil yn gorfodi gorbenion biwrocrataidd ychwanegol a gorfodol ar gyrff iechyd.

Effaith canllawiau presennol

- ***Beth yw eich barn ar effeithiolrwydd ac effaith y canllawiau presennol?***

  Dim ond i wardiau meddygol cyffredinol a llawfeddygol y mae'r canllawiau presennol yn berthnasol. Maent yn sylfaen defnyddiol, ond nid ydynt yn ddigon ar eu pennau eu hunain, ac mae angen iddynt gael

eu defnyddio ochr yn ochr ag offerynnau aciwtedd a barn broffesiynol. Ar hyn o bryd, mae'r offeryn aciwtedd yn cael ei orfodi dwywaith y flwyddyn. Er y gellid ei ddefnyddio'n amlach, nid ydym yn gweld hyn yn aml yn ystod ein harolygiadau, a gellid annog ei ddefnydd ymhellach.

Pwerau i wneud is-ddeddfwriaeth a chanllawiau

- ***Beth yw eich barn ar y cydbwysedd rhwng yr hyn sy'n cael ei gynnwys yn y Bil a'r hyn sy'n cael ei gynnwys mewn is-ddeddfwriaeth a chanllawiau?***

  Mae'r cydbwysedd a gynigir yn darparu digon o hygyrchedd, yn ôl pob golwg, i'r canllawiau sylweddol gael eu diwygio'n rhwydd yng ngoleuni ymchwil a dealltwriaeth newydd ac mewn ymateb i newidiadau mewn cyflenwi gofal.

Goblygiadau ariannol

- ***Beth yw eich barn ar oblygiadau ariannol y Bil fel sy'n cael eu nodi yn rhan 2 o'r Memorandwm Esboniadol?***

  Nid yw AGIC mewn sefyllfa i wneud sylwadau ar oblygiadau ariannol y Bil.

National Assembly for Wales / Cynulliad Cenedlaethol Cymru
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Safe Nurse Staffing Levels (Wales) Bill / Bil Lefelau Diogel Staff Nyrsio (Cymru)
Evidence from Unison Cymru Wales – SNSL(Org) 06 / Tystiolaeth gan Unison Cymru Wales – SNSL(Org) 06

Safe Nursing Staffing Levels Bill
UNISON Cymru Wales written evidence (January 2015)

Introduction

UNISON is the UK's largest healthcare union with over 400,000 members working in the NHS. In Wales, UNISON represents 35,000 members providing NHS services. Our health members are nurses, student nurses, midwives, health visitors, healthcare assistants, paramedics, community care workers, cleaners, porters, catering staff, medical secretaries, clerical and administration staff and scientific and technical staff.

Unless there is a mandatory minimum, quality patient care will suffer. Over 90% of respondents in UNISON's 2013 staffing levels survey said they support mandatory minimum staffing levels, but it has to be acknowledged that quality is more important than quantity; staff numbers are only part of the problem. We believe that compassionate care would not only benefit the patient but also the working lives of our members.

General

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

UNISON believes that there should be a legally enforceable minimum nurse to patient ratio. We support and recognise the role which workforce planning tools have to play in helping organisations identify the right levels, but the use of these must be mandatory and, in the absence of this, the default position should be a legal minimum.

UNISON Cymru Wales has extensively sought the opinions of our members about the Bill, as we believe ongoing consultation with staff on the ground is crucial. Our Welsh members are overwhelmingly in favour of mandatory minimum nurse staffing ratios as they believe that this is the only way to provide a better quality of service for patients, increase staff morale and increase satisfaction in the workplace. For example, some of our members have

described scenarios where they have had to oversee 26 patients in acute areas at one time. This is not only clinically for patients, but also a dangerous working environment for staff.

Our UNISON survey in 2013 found that an alarming 45% of nurses were caring for eight or more patients on their shifts which highlights the need for a safe staffing levels bill. Validated workforce planning is effective in producing safe staffing levels as it is predictive, rather than retrospective and takes into account the fluctuations among the Local Health Boards. It is known that hospitals are the busiest at the weekends and on Mondays, when they are dealing with the backlog of pressures from the weekend's admittances. A workforce planning tool would take into account these issues and therefore could weigh staffing levels differently at the weekend to during the week. On the other hand a legislated ratio is static and does not take these factors into account. UNISON welcomes the reference to validated workforce planning tools in the Bill under Clause (6), but argues that further work needs to be undertaken to decide whether they can be used further.

Q: 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 highlighted in our original consultation response UNISON believe that, as the proposed application of safe staffing levels doesn't apply to all staff in every health care setting, it detracts from the overall impact and purpose. From our perspective, this is a signification omission and we are disappointed that the Bill does not develop the point further. Extending application to all healthcare staff would allow our dedicated and hardworking members, in all pay bands and in all clinical areas, the time to provide the high level of care they desire, in a safe environment that engenders compassion.

We welcome that the Bill does make reference to healthcare support workers but this definition needs to be tightened up in several regards. The application of ratios of health care workers, other than nurses, should be applied to safe staffing levels in adult care in acute hospitals and beyond. Our members have described situations in which nursing staff are drawn away from clinical duties to undertake basic cleaning duties. Similarly, if inadequate numbers of clerical staff in medical records or wards are employed, nurses end up being diverted from their clinical tasks to clerical duties.

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

The chief barrier to successful implementation of the Bill and consequential improvements in the Welsh health care system would be the adoption of unrealistic nurse staffing ratios.

UNISON advocates a 1:4 nurse to patient ratio as we believe this will provide the best quality patient care at all times. Studies have shown that there are better clinical outcomes with a ratio of 1:6 or lower and that harm starts to occur when nurses are caring for 8 patients or more, although, clearly, "one size does not fit all". Therefore, each ward/clinical

area must be assessed for its particular appropriate staffing levels both in the day and at night.

Moreover, by only applying a safe staffing ratio to nurses the Bill does not adequately consider the pressure on nurses' duties that are the consequence of inadequate numbers of other healthcare workers, e.g. domestic and clerical staff as previously stated.

The Safe Staffing Alliance, of which UNISON is a member, recommends that nurses must at all times be supported by a sufficient number of healthcare assistants. Yet, the Bills' priorities remain solely focussed on the employment of qualified nurses, often at the expense of Healthcare Assistants. Whilst UNISON welcomed the additional £10 million given by Welsh Government to Health Boards for the employment of additional nursing staff, we have seen examples of Health Boards in Wales downgrading Healthcare Assistants' posts to pay for additional qualified nurses. This is not acceptable and means that qualified nurses are not getting the appropriate level of support to enable them to undertake their duties effectively.

Q: Are there any unintended consequences arising from the Bill?

On no account should the Bill lead to a 'plug gap' situation where staff are robbed from one unit and moved into the inpatient adult acute sector.

The majority of our members believe that there should be a requirement in the legislation for "protected time", for staff training and development built into nurse staffing ratios. Currently there are too many incidences when staff are pulled off mandatory training days to cover sickness on the ward, leaving those staff without the training they need. It should not be an unintended consequence that the Bill increases such situations.

Q: 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?

UNISON agrees with Clause 2.5 (b) 'allow for the exercise of professional judgement' as NHS employees are often in the best position to know when systems in the Service are working efficiently and therefore when an appropriate level of nurse staffing is provided.

Education is a crucial force in the protection of both the patient and the worker. Aiken et al. 2004 found that a 10% increase in employment of degree-level educated nurses led to a 7% reduction of an inpatient dying. Increased staffing levels would also alleviate the pressures on practice placement settings, which would make it easier for nurses to dedicate time to support students. This would also benefit the health community at large.

Q: 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?

It is important that there is a duty on health service bodies in Wales to take all steps to maintain these recommended nurse to patient ratios.

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

We understand that the duty will first apply to adult inpatient wards in acute hospitals because this is where the main body of evidence lies, however UNISON believes that agreed ratios should not only be restricted to adult care in acute hospitals. UNISON believes that in order for patients to receive the highest possible quality of care, the agreed ratios should be applied and extended to all clinical areas, including Community settings. Applying the duty only to acute hospitals will not sufficiently meet the standards required across the NHS. We understand that in order to extend the ratio there needs to be robust data collection methods and results in place. For this to occur, data collection in other healthcare setting should commence as soon as possible in order to identify reasonable staffing levels.

3 Ibid- the requirement for the Welsh Government to issue guidance 4 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 welcome the use of validated workforce planning tools and the exercise of professional judgment within the planning process as methods. However, we believe there should be further consultation and agreement with all interested stakeholders, including employee representative organisations on the tools and methods to be used in establishing staff ratios.

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

UNISON believes that the Bill highlights the importance that minimum ratios are not applied as an upper limit in Clause (5) of the guidance and Clause 6 (b). Safe staffing levels should represent a high quality of staffing levels, and agreed ratios should reflect requirements and circumstances in each hospital. Hospitals should be monitored to ensure that the agreed ratios are not regarded as upper limits, instead ensuring that the applied ratios mean they can deliver a high quality level of care. It is important that NHS organisations regard the agreed ratios as an absolute minimum, and broadly view these minimum ratios as “a level of care below which standards do not fall”.

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

The Francis Report was clear about the positive role that information sharing can play. We believe that transparency of staffing levels is an important driver of patient confidence, and patient awareness of roles. Detailing responsibilities and numbers of staff on duty will aid this process.

UNISON agree that information on the numbers and roles of nursing staff on duty should be published in areas accessible to patients and their families, but it is essential that the recording, monitoring and reporting process is streamlined. This view has been echoed in both the Francis Report and the Berwick Review which both found that there needs to be a systematic and responsive approach to determining nurse staffing levels. There are too many examples where nurses, and other health care workers have been caught up in bureaucratic systems which force them to take time away from the patient. NHS staff are already over-worked so any process for reporting data must not increase this burden. The streamlining of the process will not only improve administration for nurses and ward clerks and other staff, but will ensure the clarity required for an accurate system of monitoring.

Publication of such figures is meaningless unless the standards are clearly set and allow for the fluctuations of patient acuity and dependency.

Includes protections for certain activities and particular roles when staffing levels are being determined:

- the requirement for Welsh Ministers to consult before issuing Guidance?

UNISON strongly welcomes the requirement for Welsh Ministers to consult before issuing Guidance.

- the monitoring requirements set out in the Bill?

We suggest that the monitoring requirements set out in the Bill are extended to first include collecting data on whether a nurse's break was taken at an appropriate time, for example if a healthcare worker is working a long day and doesn't receive a break until 8 hours into their shift. Secondly, we believe that indicator 3.1 (h) should be expanded to include staff wellbeing alongside nursing overtime and sickness levels. Thirdly, an additional monitoring requirement that should be included is 'care undone'. In UNISON's report 'Running on Empty: NHS Staff Stretched to the limit', 55% of our members said that due resource constraints care was left undone, even though many of them had not taken their breaks and had worked overtime.

- the requirement for each health service body to publish an annual report?

We welcome the requirement for each health service body to publish an annual report and that it can be published as part of a wider report.

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

UNISON would suggest that for the first year, internal reviews in operation and effectiveness of the Act should be taken on alternative months to confirm that the staffing levels are appropriate. This would increase after the first year of the organisation. In conjunction, we agree that a first whole system review must be carried out as soon as practicable after the end of the one year period beginning with the date when the Act comes into force. We do not agree that subsequent reviews should be carried out at intervals of no more than 2 years. This has the potential to leave long periods of where harm could have occurred, this is especially true for the second review. The monitoring of the Act should be built in to the annual review to ensure that there is continuity across the processes.

We also believe that success of the Bill would be demonstrable improvements in the measures of healthcare as set out in 3(5), including for example, the measures should also include a monitoring of reductions in length of stay in hospital.

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

UNISON supported both the 2012 All Wales Nurse Staffing Principle Guidance and the 2014 NICE guidelines on 'Safe staffing for nursing in adult inpatient wards in acute hospitals'. The All Wales Nurse Staffing Principle Guidance was based on acuity rather than solely patient numbers and many of the Local Health Boards defined a range of safe staffing nurse's levels rather than a single defined figure. The 2012 guidance issued to the Health Boards in Wales recommended that the number of patients per registered nurse should not exceed 7 by day, which although is a move in the right direction, is still too high to provide a safe level of care. The guidance also lacked effective implementation as it was not a statutory requirement. The 2014 NICE guidelines are more similar to the proposed Bill and share similar issues such as 'plugging the gap' and the lack of reference to 'care undone' (where a number of staff reported that care was left undone).

Q: 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?

The ability to extend the bill to additional healthcare settings that is currently subordinate legislation is welcomed and should not be disregarded.

<u>Financial implications</u>

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

Costs are always a concern and how the upfront costs impact the Welsh Public Health service is extremely important. However, findings by Bray et al. 2004 suggest that there is no evidence of overall cost increases, as the increase in funding for more nurses balances out with reduced costs associated with the length of stay of a patient and fewer infections. We would like a commitment from the Government that upfront costs will not be cut to the disadvantage of the Welsh Healthcare worker.

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

This Bill, if enacted properly, should lead to a marked improvement in the standards of healthcare in Wales. The 2009 Boorman Review into NHS Health and Wellbeing established solid links between understaffing, stress, job satisfaction and patient care.

While safe staffing levels are a positive move we believe that this should be applied to the whole health care system. To be a truly first class health care system the Welsh Government need to improve staffing ratios for all healthcare workers.

UNISON welcome further consultation throughout this process and look forward to speaking to the Committee in due course.

THE WELSH NHS CONFEDERATION
CONFFEDERASIWN GIG 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)

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

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Lleoliad:	**Ystafell Bwyllgora 1 – Y Senedd**
Dyddiad:	**Dydd Iau, 29 Ionawr 2015**
Amser:	**09.02 – 15.58**

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Gellir gwylio'r cyfarfod ar Senedd TV yn:
http://senedd.tv/cy/2667

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
Lindsay Whittle AC
Kirsty Williams AC (ar gyfer eitemau 9 i 14)
Peter Black AC (yn lle Kirsty Williams AC ar gyfer eitemau 1 i 7)

Tystion:

Tina Donnelly, Goleg Brenhinol y Nyrsys
Lisa Turnbull, Coleg Brenhinol Nyrsio Cymru
Rory Farrelly, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
Ruth Walker, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Dr Phil Banfield, BMA Cymru
Dr Victoria Wheatley, BMA Cymru Wales
Dr Rhid Dowdle, Coleg Brenhinol y Ffisigwyr
Dr Sally Gosling, Cymdeithas Siartredig y Ffisiotherapyddion
Philippa Ford, Cymdeithas Siartredig y Ffisiotherapyddion

	Dr Alison Stroud, Coleg Brenhinol y Therapyddion Lleferydd ac Iaith Dr Charlotte Jones, BMA Cymru Wales Dr Philip White, BMA Cymru Wales Dr Peter Horvath-Howard, Cymdeithas Feddygol Prydain Cymru Dr Paul Myers, Coleg Brenhinol yr Ymarferwyr Cyffredinol Dr Rebecca Payne, Coleg Brenhinol yr Ymarferwyr Cyffredinol Mary Beech, Deoniaeth Cymru Dr Martin Sullivan, Deoniaeth Cymru
Staff y Pwyllgor:	Llinos Madeley (Clerc) Helen Finlayson (Ail Clerc) Christopher Warner (Clerc) Sian Giddins (Dirprwy Glerc) Rhys Morgan (Dirprwy Glerc) Sian Thomas (Ymchwilydd) Philippa Watkins (Ymchwilydd) Gwyn Griffiths (Cynghorydd Cyfreithiol) Enrico Carpanini (Cynghorydd Cyfreithiol)

Trawsgrifiad
Gweld trawsgrifiad o'r cyfarfod.

1 Cyflwyniadau, ymddiheuriadau a dirprwyon

1.1 Ni chafwyd unrhyw ymddiheuriadau.
1.2 Dirprwyodd Peter Black ar ran Kirsty Williams AC ar gyfer yr eitemau'n ymwneud â'r Bil Lefelau Diogel Staff Nyrsio (Cymru).

2 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 2

2.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

3 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 3

3.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.
3.2 Cytunodd Rory Farrelly i ddarparu gwybodaeth ychwanegol i'r Pwyllgor ynghylch cynllun recriwtio diweddar Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg i lenwi'r 140 swyddi nyrsio gwag yn y Bwrdd Iechyd. Cytunodd Rory Farrelly hefyd i egluro'r dyddiadau cau perthnasol ar gyfer ceisiadau a nifer y ceisiadau a ddaeth i law.

4 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 4

4.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

5 Y Bil Lefelau Diogel Staff Nyrsio (Cymru): sesiwn dystiolaeth 5

5.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

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

6.1 Derbyniwyd y cynnig.

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

7.1 Trafododd y Pwyllgor y dystiolaeth a ddaeth i law.

7.2 Mae'r Pwyllgor wedi cytuno i ofyn am wybodaeth ychwanegol am y trefniadau sydd ar waith yn yr Alban i sicrhau lefelau diogel staff nyrsio heb ddeddfwriaeth.

8 Y Bil Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru): paratoi ar gyfer gwaith craffu

8.1 Nododd y Pwyllgor benderfyniad y Pwyllgor Busnes mewn egwyddor i gyfeirio'r Bil at y Pwyllgor Iechyd a Gofal Cymdeithasol ar gyfer gwaith craffu Cyfnod 1 a Chyfnod 2 a chytunodd i ysgrifennu at y Pwyllgor Busnes i ddweud nad oedd unrhyw bryderon sylweddol ynghylch yr amserlen arfaethedig.

8.2 Cytunodd y Pwyllgor i ysgrifennu at randdeiliaid i ddweud bod y Bil yn cael ei gyflwyno.

9 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: sesiwn dystiolaeth 1

9.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

10 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: sesiwn dystiolaeth 2

10.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

11 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: sesiwn dystiolaeth 3

11.1 Ymatebodd y tystion i gwestiynau gan yr Aelodau.

11.2 Cytunodd y tystion i ddarparu gwybodaeth ychwanegol i'r Pwyllgor ynghylch:

- amlinelliad o'r costau'n gysylltiedig â chodi'r targed ar gyfer nifer y lleoedd ar gyrsiau hyfforddi meddygon teulu o 136 i o leiaf 200 (fel yr argymhellir gan y Gymdeithas Feddygol Brydeinig) neu i nifer y teimlent y byddai'n realistig; a
- dadansoddiad o'r ardaloedd a lleoliadau yng Nghymru lle nad yw lleoedd hyfforddi wedi'u llenwi dros y 3 blynedd diwethaf.

12 Papurau i'w nodi

12.0a Nododd y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 31 Ionawr.

12.1 Memorandwm Cydsyniad Deddfwriaethol: Y Bil Arloesi Meddygol: gohebiaeth gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol.

12.1a Nododd y Pwyllgor yr ohebiaeth.

12.2 Gohebiaeth gan y Pwyllgor Deisebau: P-04-600 Deiseb i achub y gwasanaeth meddygon teulu yng Nghymru

12.2a Nododd y Pwyllgor yr ohebiaeth.

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

13.1 Derbyniwyd y cynnig.

14 Ymchwiliad i'r gweithlu Meddygon Teulu yng Nghymru: ystyried y dystiolaeth a ddaeth i law

14.1 Ystyriodd y Pwyllgor y dystiolaeth a ddaeth i law.

Coleg Nyrsio Brenhinol
Cymru
Royal College of Nursing
Wales

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Tina Donnelly CBE, TD, DL, CCMI, MSc (ECON), BSc (Hons), RGN, RM, RNT, RCNT, Dip N, PGCE
Director, RCN Wales

Telephone [redacted]
Fax
Email [redacted]

3 February 2015

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

Dear David Rees

Inquiry into GP Workforce in Wales

We understand that the Health & Social Care committee is currently undertaking an Inquiry into the GP workforce in Wales specifically examining;

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

There can be no doubt that some regions of Wales are really struggling to recruit sufficient numbers of GPs and this is an important area of policy for the Committee to address.

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Accessible primary care services are vital, both to the improving the health of the public and ensuring the effective operation of secondary care services (including emergency care). GP surgeries are at the heart of the primary care system and their sustainability is essential.

The RCN are sure Committee members are well aware that GP surgeries must work closely with Community Pharmacy, Colleagues in Secondary Health Care and the Community Nursing Service, in order to deliver effective care to the patient. However they may be less aware that even a 'traditional' GP surgery is an effective multi-disciplinary team led by the GP and including practice nurses and health care support workers and increasingly pharmacists.

Practice Nurses undertake a huge range of tasks, addressing public health, travel health, the management of long-term conditions and cervical cytology. Registered nurses can undertake a two year postgraduate course to become Nurse Practitioners and would be senior nurses within the practice responsible for nurse led clinics, minor illness, triage, supplementary or independent prescribing.

The Welsh Government published its plan for a primary care service in Wales up to March 2018 and the Ministerial states clearly:

At a time of such pressures we have to use the clinical skills and abilities of all members of the primary care team to their maximum. No GP should routinely be undertaking any activity which could, just as appropriately be undertaken by an advanced practice nurse, a clinical pharmacist or an advanced practitioner paramedic. No advance practice nurse should routinely be undertaking activities which could be, equally successfully, be undertaken by a healthcare support worker.

This approach means that considering GP recruitment – and assuring potential future GPs of a modern and effective working environment needs to be considered as part of a wider professional workforce plan.

The Royal College of Nursing believes that in some areas it will be suitable for the Welsh Government to develop primary care centres/surgeries which employ salaried GP and nurse practitioners. There is considerable evidence that advanced nurse practitioners benefit patient care and at the same time support the GP in providing a more effective service. Nurses who can independently prescribe can speed up

Continued.....

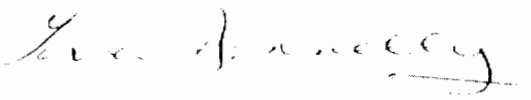
patient care considerably and also strengthen the clinical accountability for prescription. Based in general practice specialist nurses and nurse consultants should be able to lead diagnostic clinics with the ability to admit directly to hospitals

The Committee may be particularly interested in the primary care projects currently being developed in ABMU to support GPs including a Chronic Conditions Nurse, a Continence Service and development of training for practice nurses and a course for advanced nurse practitioners.

I hope this information and perspective is useful to the Committee in its deliberations on the GP workforce and I look forward to results of your Inquiry in the hope it will stimulate a wider discussion on mechanisms for improving primary care.

Kind regards

Yours sincerely



TINA DONNELLY
DIRECTOR, RCN WALES

Eitem 7.2

Kirsty Williams AC

David Rees AC,
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol
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Ebost: kirsty.williams@cymru.gov.uk
Ffôn: 0300 200 7277
5 Chwefror 2015

Annwyl Gadeirydd,

Bil Lefelau Diogel Staff Nyrsio (Cymru)

Diolch i chi am eich gohebiaeth ar 22 Ionawr, ac am y cyfle i gyflwyno tystiolaeth i'r Pwyllgor Iechyd a Gofal Cymdeithasol ynghylch Bil Lefelau Diogel Staff Nyrsio (Cymru) yn eich cyfarfod ar 15 Ionawr.

Gofynasoch yn eich gohebiaeth a allwn i roi amlinelliad i'r Pwyllgor o ba rai o'r dangosyddion a amlinellir yn adran 3(5) o'r Bil a oedd yn deillio o ganllawiau'r CNO, canllawiau NICE a pha rai a oedd wedi'u cynnwys o ganlyniad i'r ymatebion i'ch ymgynghoriad chi ar y Bil. Mae hyn wedi'i nodi yn y tabl isod:

Dangosydd	Ffynhonnell
(a) cyfraddau marwolaethau	▪ Ystod eang o ymchwil academaidd (y cyfeirir at lawer ohoni yn y Memorandwm Esboniadol) ▪ Ymatebion i'r ymgynghoriad
(b) cyfraddau ailddderbyn	▪ Ymchwil academaidd[1] ▪ Ymatebion i'r ymgynghoriad, gan gynnwys ymateb gan y Grŵp Cynghori Arbenigol Cenedlaethol ar gyfer Diabetes ▪ Canllaw staffio diogel NICE - Resource impact commentary
(c) heintiau a gafwyd yn yr ysbyty	▪ Dangosyddion ansawdd gofal y CNO[2] ▪ Canllaw staffio diogel NICE - Resource impact commentary

[1] **Er enghraifft, *RN Staffing Affects Patient Outcomes After Discharge* (Health Services Research Journal, Ebrill 2011)**
[2] **Mae nifer o Ddangosyddion Ansawdd Gofal wedi'u nodi yn nogfen y CNO, Adult Acute Nursing Acuity & Dependency Tool Governance Framework (mae'r ddogfen yn dweud bod y dangosyddion hyn yn gysylltiedig â materion staffio ymhlith nyrsys).**

	▪ Ymatebion i'r ymgynghoriad ▪ Cynllun peilot 'ward ag adnoddau perffaith' (Aneurin Bevan)
(d) camgymeriadau wrth roi meddyginiaethau	▪ Dangosyddion ansawdd gofal y CNO ▪ Canllaw staffio diogel NICE ▪ Ymatebion i'r ymgynghoriad
(e) nifer a difrifoldeb y cwympiadau	▪ Dangosyddion ansawdd gofal y CNO ▪ Canllaw staffio diogel NICE
(f) nifer a difrifoldeb wlserau pwyso a gafwyd yn yr ysbyty	▪ Dangosyddion ansawdd gofal y CNO ▪ Canllaw staffio diogel NICE ▪ Ymatebion i'r ymgynghoriad
(g) boddhad y cleifion a'r cyhoedd â'r gwasanaethau	▪ Dangosyddion ansawdd gofal y CNO ▪ Canllaw staffio diogel NICE ▪ Ymatebion i'r ymgynghoriad ▪ Cynllun peilot 'ward gydag adnoddau perffaith'
(h) lefelau goramser a salwch ymhlith nyrsys	▪ Canllaw staffio diogel NICE ▪ Ymatebion i'r ymgynghoriad ▪ Cynllun peilot 'ward gydag adnoddau perffaith'
(i) y defnydd o nyrsys dros dro (asiantaeth a chronfa)	▪ Canllaw staffio diogel NICE ▪ Ymatebion i'r ymgynghoriad ▪ Cynllun peilot 'ward gydag adnoddau perffaith'

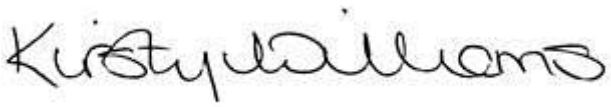
Yn eich gohebiaeth gofynasoch hefyd pam nad yw rhai o'r dangosyddion nyrsio diogel sydd i'w gweld yng nghanllawiau NICE wedi'u cynnwys yn adran 3(5) o'r Bil.

Y dangosyddion o eiddo NICE sydd heb eu cynnwys ar wyneb y Bil yw egwyliau wedi'u colli a chydymffurfio â hyfforddiant gorfodol, ond does dim byd i atal y dangosyddion hyn rhag cael eu defnyddio hefyd i fesur effaith y Bil os bydd Llywodraeth Cymru o'r farn bod hynny'n briodol. Yn wir, mae'r Bil yn dweud nad yw'r rhestr o ddangosyddion nyrsio diogel yn gynhwysfawr.

I fod yn glir, mae'r mwyafrif o'r dangosyddion a nodwyd gan NICE wedi'u cynnwys yn y rhestr yn y Bil (cwympiadau; wlserau pwysau; camgymeriadau wrth roi meddyginiaethau; goramser ymhlith nyrsys; defnyddio nyrsys dros dro). Mae dangosydd nyrsio diogel NICE 'Digonolrwydd diwallu anghenion gofal nyrsio'r cleifion' yn cyfeirio at brofiadau'r cleifion o ofal (mae NICE yn awgrymu y gallai hyn gael ei fesur drwy gyfrwng arolygon ymysg cleifion). Mae'r Bil yn cynnwys boddhad cleifion a'r cyhoedd â gwasanaethau fel dangosydd. Mae canllawiau NICE hefyd yn cynnwys nifer y nyrsys sydd wedi'i gynllunio, sy'n angenrheidiol ac sydd ar gael ar gyfer pob shifft fel dangosydd. Bydd darpariaethau Bil Lefelau Diogel Staff Nyrsio (Cymru) yn golygu bod rhaid i'r wybodaeth hon gael ei chofnodi a'i monitro.

Yn olaf, gofynasoch a allwn i ddarparu ymatebion ysgrifenedig i'r cwestiynau a restrwyd yn Atodiad A i'ch gohebiaeth. Rwyf wedi manylu ar yr atebion i'r cwestiynau hyn yn Atodiad A i'r ohebiaeth hon.

Yn gywir



Kirsty Williams
Aelod Cynulliad Brycheiniog a Sir Faesyfed

Atodiad A

1. **A all y Bil fel y'i drafftiwyd gyflawni amcanion y polisi yn realistig [yn arbennig o ystyried na chaiff y cymarebau gofynnol eu nodi yn y Bil]?**

Gall.

Bydd y Bil hwn yn darparu sail statudol ar gyfer cynllunio a chyflawni lefelau diogel o ran staff nyrsio ledled y GIG yng Nghymru, gan gynnwys cyflawni **cymarebau gofynnol a chanllawiau perthynol ar gyfer lleoliadau i oedolion o gleifion mewnol aciwt. Byddai'r ddeddfwriaeth hon yn gwarantu** canlyniadau ac yn diogelu'r canlyniadau i gleifion, lle nad yw canllawiau ar eu pen eu hunain wedi llwyddo. Byddai'r Bil yn sicrhau bod lefelau diogel o ofal nyrsio'n cael eu cyflawni, yn gyson felly, ar draws holl ysbytai Cymru.

Ond nid yw hynny'n golygu diddymu canllawiau'n llwyr.

Nid set o dargedau anhyblyg, wedi'i phennu ar wyneb y Bil, yw'r angen. Mae pryderon wedi'u mynegi ynghylch dull o'r fath a hynny yn y Cynulliad ac mewn ymateb i'm hymgynghori innau ynglŷn â'r Bil.

Yr hyn y mae ei angen, yn hytrach, yw set statudol o egwyddorion, a'r rheiny'n sail i ganllawiau ac yn gorfodi'r canllawiau i gael eu cyflawni (gan gynnwys cymarebau gofynnol, ond heb fod yn gyfyngedig i gymarebau gofynnol). Mae'r egwyddorion hyn wedi'u hadlewyrchu mewn dwy ddyletswydd glir yn yr adran 10A(1)(a) a (b) newydd, a fydd yn gallu cael eu gorfodi yn unol ag egwyddorion y gyfraith weinyddol; mae yna bob rheswm dros gredu y byddan nhw'n effeithiol i sicrhau bod lefelau staffio'n cael lle teilwng ymysg yr ystyriaethau eraill sy'n angenrheidiol er mwyn dylanwadu ar benderfyniadau ar bolisïau a gweithrediadau mewn cyrff yn y gwasanaeth iechyd.

Rwy'n ymwybodol hefyd y gallai rhagnodi lefelau staffio ar wyneb y Bil lesteirio datblygiadau yn y gwasanaeth yn y dyfodol. Bydd gosod y cymarebau (a dulliau ar gyfer pennu lefelau staffio priodol i nyrsys yn lleol) mewn canllawiau statudol, yn hytrach nag ar wyneb y Bil, yn sicrhau bod gan GIG Cymru yr hyblygrwydd i ymateb i newidiadau wrth ddarparu gwasanaethau ac wrth roi gofal. Mae'n haws i ganllawiau gael eu cadw'n gyfoes na deddfwriaeth, a gall canllawiau ymateb yn well i ddatblygiadau perthnasol, megis datblygiadau mewn technoleg. Mae hefyd yn bwysig nodi mai arbenigwyr perthnasol yn y maes fydd yn pennu'r cymarebau a'r dulliau, sydd i'w nodi yn y canllawiau, ac y cân nhw eu seilio ar dystiolaeth.

2. **A yw'n ddilys defnyddio tystiolaeth ryngwladol yn uniongyrchol mewn perthynas â chymarebau staffio gofynnol yng Nghymru o ystyried y gwahaniaethau yn y systemau gofal iechyd?**

I fod yn glir: mae'r Bil hwn wedi'i seilio ar y sefyllfa sy'n hysbys yng Nghymru ac yn y Deyrnas Unedig, ac ar y gronfa o dystiolaeth sydd eisoes yn bod yma i helpu i'w roi ar waith. Mae'r gronfa dystiolaeth hon yn amlygu:

- problemau o ran staff nyrsio mewn meysydd aciwt;
- bod swyddi nyrsio wedi'u torri er mwyn arbed arian; a hefyd
- y berthynas rhwng lefelau staff nyrsio a'r canlyniadau i'r cleifion.

Mae'r gronfa dystiolaeth hefyd yn tanlinellu bod gwaith wedi'i wneud eisoes, yn y Deyrnas Unedig, i ddatblygu dulliau a chanllawiau a fydd yn helpu i roi'r cymarebau gofynnol ar waith mewn lleoliadau aciwt, ond nad oes unrhyw ofynion mewn deddfwriaeth ar hyn o bryd i ategu'r canllawiau hyn.

Gan hynny, y cyfan y mae'r dystiolaeth ryngwladol yn ei wneud yw rhoi rhagor o enghreifftiau a gwersi. Mae'n dangos bod cymarebau wedi'u rhoi ar waith yn effeithiol mewn rhai rhannau o'r byd yn barod (er enghraifft Califfornia, Victoria (Awstralia), Japan), ac yn rhoi gwybodaeth am y llwyddiant a'r effeithiau a gafwyd wrth roi deddfwriaeth ar waith ynghylch cymarebau nyrsys.

Mae'n dangos hefyd (drwy'r astudiaeth Ewropeaidd fawr yn 2014 a gyhoeddwyd yn The Lancet) fod yr un berthynas sylfaenol yn bodoli rhwng lefelau staff nyrsio a chyfraddau marwolaethau, ni waeth beth fo'r gwahaniaethau rhwng gwledydd gwahanol o ran strwythurau a chyllid y gwasanaethau iechyd. Ystadegyn syfrdanol yw bod yna gynnydd o 7 y cant yn y tebygrwydd y bydd claf mewnol yn marw o fewn 30 diwrnod ar ôl cael ei dderbyn i'r ysbyty am bob un claf ychwanegol y mae nyrs yn gyfrifol amdano.

3. Pam nad oes diffiniad o 'ysbyty acíwt' yn y Bil o ystyried nad oes diffiniad y gellir ei ddefnyddio'n gyffredinol?

Mae adran 2 o'r Bil a fydd yn mewnosod adran 10A (5) (d) yn Neddf y Gwasanaeth Iechyd Gwladol (Cymru) 2006 yn darparu ar gyfer y canllawiau y mae'n rhaid i Weinidogion Cymru eu dyroddi er mwyn diffinio'r termau, neu er mwyn cynnwys darpariaeth sydd i'w defnyddio wrth ddiffinio'r termau yn yr adran 10A (1) (b) newydd. Bydd hyn yn cynnwys diffiniad o 'ysbyty aciwt'.

Gellir nodi hefyd fod y term 'ysbyty aciwt' yn cael ei ddefnyddio'n gyffredin yn y sector iechyd. Wrth ddrafftio deddfwriaeth, rwy'n credu ei bod yn bwysig defnyddio ymadroddion sy'n canu cloch ymysg y brif gynulleidfa darged (sef y sector gofal iechyd yn yr achos hwn). Mae'n werth nodi bod y CNO a NICE yn diffinio wardiau aciwt i oedolion fel wardiau meddygol a llawfeddygol sy'n darparu gofal dros nos i oedolion o gleifion mewn "ysbytai aciwt" (dylid derbyn nad yw hyn yn cynnwys gwasanaethau gofal critigol, gwasanaethau mamolaeth na gwasanaethau iechyd meddwl).

Gellir gwahaniaethu hefyd rhwng ysbytai acíwt ac ysbytai cymunedol, sydd at ei gilydd yn cynnig cyfle i adsefydlu ar ôl cyfnod o ofal acíwt. Ni fydd y cymarebau'n gymwys i ysbytai cymunedol (yn yr un modd, nid yw canllawiau NICE dyddiedig mis Gorffennaf 2014 yn gymwys i ysbytai cymunedol).

Mae peidio â diffinio'r term 'ysbyty acíwt' ar wyneb y Bil hefyd yn darparu mwy o hyblygrwydd ar gyfer cynildeb ac addasiadau yn y dyfodol yng ngoleuni profiad. Bydd y gallu i ddiffinio ac i newid diffiniadau mewn canllawiau yn galluogi Gweinidogion Cymru i ymateb yn gyflym ac yn hyblyg i newidiadau wrth i wasanaethau a gofal gael eu darparu yn y GIG yng Nghymru.

Fe allen ni roi diffiniad o “ysbyty aciwt” a chadw hyblygrwydd drwy roi pŵer i Weinidogion Cymru ei ddiwygio drwy is-ddeddfwriaeth os aiff y diffiniad yn hen: ond mae’n ymddangos ei bod yn gallach gadael i’r cyrff gofal iechyd ddefnyddio term y diwydiant fel y mae’n cael ei ddeall o dro i dro, yn unol â chanllawiau.

4. **Pam mae diffiniad y termau mewn perthynas â'r cymarebau wedi'u neilltuo ar gyfer y canllawiau a pha ystyriaeth a roddwyd i gynnwys rhai diffiniadau allweddol yn y Bil?**

Mae i nifer o’r termau sydd wedi’u defnyddio yn yr adran 10A (1) (b) newydd ddiffiniad eisoes. Er enghraifft, mae i ‘registered’ yng nghyd-destun nyrs ddiffiniad yn barod yn rhinwedd adran 5 o Ddeddf Dehongli 1978 ac Atodlen 1 iddi.

Am fod darpariaethau’r Bil yn mewnosod darpariaethau yn Neddf y Gwasanaeth Iechyd Gwladol (Cymru) 2006, lle bo’n briodol fe fydd e hefyd yn codi diffiniadau sydd eisoes yn bod yn y Ddeddf honno. Er enghraifft, mae ‘patient’ wedi’i ddiffinio eisoes gan adran 206.

Fe fydd angen diffinio termau eraill, megis ‘gweithiwr cymorth gofal iechyd’ ac ‘ysbyty acíwt’. Ystyriwyd cynnwys y termau hyn naill ai ar wyneb y Bil neu mewn rheoliadau ond bernid nad oedd hynny’n briodol (am y rhesymau sydd wedi’u rhoi yn fy ymateb i gwestiwn 3 uchod).

5. **O ystyried bod y diffiniad o 'corff y gwasanaeth iechyd' fel y'i nodir yn y Bil yn cynnwys Gweinidogion Cymru, mae'r Bil fel y'i drafftiwyd yn ei gwneud yn bosibl i Weinidogion Cymru gyhoeddi canllawiau iddynt hwy eu hunain. Ai dyma'r bwriad, ac os felly, pam?**

O dan Ddeddf y Gwasanaeth Iechyd Gwladol (Cymru) 2006, Gweinidogion Cymru sy’n gyfrifol am ddarparu gwasanaethau nyrsio. Cyfarwyddir y Byrddau Iechyd Lleol i arfer swyddogaethau ar eu rhan a rhoddir swyddogaethau i Ymddiriedolaethau GIG yn unol â’r gorchmynion a’u sefydlodd. Pe na bai yna Fyrddau Iechyd Lleol neu Ymddiriedolaethau GIG am unrhyw reswm, Gweinidogion Cymru fyddai’n ysgwyddo’r swyddogaeth hon felly.

Gellir nodi hefyd fod dwy ran i’r ddyletswydd newydd yn yr adran 10A (1) newydd. Dim ond i’r ddyletswydd fwy penodol yn yr adran 10A (1) (b) newydd y bydd y canllawiau’n gymwys. Does dim rheswm pam na ddylai Gweinidogion Cymru roi sylw i’r ddyletswydd fwy cyffredinol (yn adran 10A(1)(a)) wrth arfer swyddogaethau. Dim ond os byddan nhw’n uniongyrchol gyfrifol am leoliadau sy’n dod o fewn y diffiniad o ward i oedolion o gleifion mewnol aciwt y bydd Gweinidogion Cymru’n dod o dan y canllawiau. Os daw Gweinidogion Cymru’n uniongyrchol gyfrifol am leoliadau o’r fath, does dim rheswm pam na ddylai lleoliadau o’r fath ddod o dan y canllawiau yr un fath â chyrff eraill yn y gwasanaeth iechyd.

Nid yw’n anarferol o gwbl i weinidog neu awdurdod cyhoeddus arall fod yn gyfrifol am ddyroddi canllawiau ynghylch sut mae swyddogaethau’r awdurdod ei hun yn cael eu harfer. Y diben yn hyn o beth yw rhoi cyhoeddusrwydd ac awdurdod cyfreithiol i’r egwyddorion sy’n pennu sut y caiff y swyddogaethau hynny eu harfer.

6. **Pam mae gwahaniaeth rhwng y ddyletswydd i gynnal lefelau diogel staff nyrsio (sy'n datgan ei bod yn ofynnol i gyrff gydymffurfio) a'r gofynion adrodd cyfatebol (sy'n datgan bod yn rhaid i gyrff adrodd ar sut y gwnaethant geisio cydymffurfio)?**

Diben y gofyniad ynglŷn â chyflwyno adroddiadau yw sicrhau gwybodaeth er mwyn hyrwyddo'r amcan statudol o lefelau diogel staff nyrsio.

Cydnabyddir y gall fod adegau pan na fydd modd i gyrff yn y gwasanaeth iechyd gydymffurfio â'r ddyletswydd.

Bwriad deddfwriaethol y Bil yw cyflwyno'r dyletswyddau newydd fel cydrannau allweddol a gorfodadwy yn y broses benderfynu broffesiynol, ac nid gosod targedau anhyblyg.

Bydd un gofyniad o ran adroddiadau, lle bydd rhaid i'r byrddau iechyd lleol ddangos eu bod wedi anelu at gydymffurfio â'r ddyletswydd, yn casglu gwybodaeth lawer mwy defnyddiol (yn enwedig os methwyd â chydymffurfio) na dyletswydd sy'n gwneud dim mwy na gofyn i'r cyrff yn y gwasanaeth iechyd fanylu ar eu cydymffurfiaeth.

7. **Pam mae pŵer Gweinidogion Cymru i gyhoeddi canllawiau wedi'i gyfyngu i'r ddyletswydd mewn cysylltiad â chymarebau gofynnol, ac felly nid yw'n berthnasol i'r ddyletswydd ehangach i gyrff y gwasanaeth iechyd roi sylw i bwysigrwydd lefelau diogel staff nyrsio wrth arfer eu holl swyddogaethau?**

Mae hanfod y ddyletswydd fel y mae wedi'i nodi yn yr adran 10A(1)(a) newydd yn glir a does dim angen canllawiau i'w ategu.

Egwyddor y Bil hwn yw darparu sail statudol ar gyfer cyflawni'r canllawiau *presennol* ynglŷn â nyrsio mewn lleoliadau i oedolion o gleifion mewnol aciwt, a chymarebau gofynnol perthynol.

Er hynny, mae'r CNO a NICE yn gweithio tuag at ymestyn dulliau a chanllawiau i leoliadau eraill. Mae cyfnod nesaf gwaith y CNO yn canolbwyntio ar nyrsys ardal ac ymwelwyr iechyd, a lleoliadau i gleifion mewnol iechyd meddwl i ddechrau. Yn ystod 2015, mae NICE yn bwriadu cyhoeddi canllawiau ar gyfer lleoliadau mamolaeth, adrannau damweiniau a brys a lleoliadau i gleifion mewnol iechyd meddwl.

Disgwylir y bydd Llywodraeth Cymru'n cymryd y gwaith hwn i ystyriaeth, ac felly mae'r Bil yn cynnwys darpariaethau i ymestyn adran 10A(1)(b) i leoliadau a gwasanaethau eraill, pan fydd y dystiolaeth i ategu hynny wedi'i datblygu. Bydd hynny'n sicrhau mai'r cymarebau gofynnol sy'n fwyaf priodol i'r lleoliadau hynny fydd unrhyw gymarebau gofynnol a ddatblygir.

8. **A yw'n fwriad bod cyrff y gwasanaeth iechyd yng Nghymru yn cydymffurfio â'u dyletswyddau o ran cymarebau staffio gofynnol cyn i Lywodraeth Cymru gyhoeddi'r canllawiau perthnasol?**

Nac ydy.

Mae'r ffaith bod yr adran 10A(1)(b) newydd yn cynnwys cyfeiriad pendant at y canllawiau statudol yn dangos nad yw'r ddyletswydd i fod yn gymwys os nad oes canllawiau.

Byddwn yn rhag-weld y byddai canllawiau Llywodraeth Cymru'n cael eu dyroddi i gyd-fynd â'r Cydsyniad Brenhinol ac â dod â'r Ddeddf i rym. Byddwn yn rhag-weld y byddai Gweinidogion Cymru'n dymuno paratoi'n briodol i gyflawni dyletswyddau statudol newydd sydd yn yr arfaeth, fel y maen nhw'n gwneud yn gyffredin yn achos y ddeddfwriaeth sy'n cael ei chyflwyno gan Lywodraeth Cymru.

A bwrw bod egwyddorion cyffredinol y Bil yn cael eu cymeradwyo, byddwn yn edrych ymlaen at drafod amserlen ar gyfer gweithredu ac amserlen ar gyfer y cyfnod cyn i'r Ddeddf gychwyn gyda Llywodraeth Cymru.

I fod yn glir, dwy ddim yn credu bod y gofyniad ynglŷn â dyroddi canllawiau yn un beichus, o gofio bod canllawiau a dulliau cynllunio gweithlu y Prif Swyddog Nyrsio eisoes ar gael ar sail anstatudol. Yn yr un modd, dylai cyrff yn y gwasanaeth iechyd fod yn cydymffurfio â chanllawiau'r Prif Swyddog Nyrsio yn barod, ac felly nid gofyniad 'newydd' iddyn nhw mo hwn. A dweud y gwir, mae'r Byrddau Iechyd Lleol wedi cael cyllid ychwanegol i recriwtio nyrsys ychwanegol i fodloni'r canllawiau, ac maen nhw'n cyllidebu ar gyfer hynny yn eu cynlluniau tair-blynedd.

9. **A gynhaliwyd asesiad o'r gost o ymestyn cymarebau staffio gofynnol i leoliadau ychwanegol?**

I gyd-fynd ag unrhyw gynigion i ymestyn y Bil i rannau eraill o staff y GIG, byddai angen cronfa dystiolaeth gadarn, ac asesiad effaith wedi'i gostio a byddai angen i'r Cynulliad graffau ar y cynigion hefyd. Gan nad yw'r gronfa dystiolaeth gadarn honno ar gael yng Nghymru ar hyn o bryd, does dim asesiad manwl wedi'i wneud ar hyn o bryd o gost ymestyn deddfwriaeth ar lefel staffio ddiogel i leoliadau eraill.

Mae gwaith yn cael ei wneud ar hyn o bryd gan y Prif Swyddog Nyrsio yng Nghymru a chan NICE yn Lloegr i ddatblygu dulliau a chanllawiau ar gyfer lleoliadau ychwanegol. Byddwn yn disgwyl i'r gwaith hwn gyfrannu at y gronfa dystiolaeth ar gyfer ymestyn cymarebau gofynnol a chanllawiau i leoliadau eraill.

10. **Mae'r Bil yn darparu ar gyfer cymarebau i fod yn gymwys i wardiau ar gyfer oedolion sy'n gleifion mewnol mewn ysbytai acíwt. Ai'ch bwriad felly yw y dylent fod yn gymwys i wardiau mamolaeth ar gyfer cleifion mewnol; wardiau iechyd meddwl ar gyfer cleifion mewnol o fewn ysbytai acíwt; wardiau gofal critigol ar gyfer cleifion mewnol; wardiau arbenigol ar gyfer cleifion mewnol? Os na, pam na chaiff hyn ei nodi yn y Bil?**

Diffiniad y CNO a NICE o leoliadau aciwt i oedolion yw eu bod yn wardiau meddygol a llawfeddygol sy'n darparu gofal dros nos i oedolion o gleifion mewn ysbytai aciwt, a ddylai gael ei gymryd fel pe na bai'n cynnwys gwasanaethau gofal critigol, gwasanaethau mamolaeth, a gwasanaethau iechyd meddwl. Byddwn yn rhag-weld y byddai'r canllawiau statudol sy'n ofynnol o dan y Bil hwn yn cynnwys diffiniad, er mwyn cynnig eglurder.

Mae'n debyg y bydd gan ofal critigol, mamolaeth, iechyd meddwl a meysydd arbenigol eraill ofynion gwahanol iawn o ran y lefelau staffio, y cymysgedd sgiliau a'r setiau sgiliau angenrheidiol. Mae'r gronfa dystiolaeth a fyddai'n helpu i roi'r Bil hwn ar waith yn ymwneud â wardiau meddygol a llawfeddygol cyffredinol i oedolion mewn ysbytai acíwt.

11. Pam mae angen deddfwriaeth yng Nghymru o ystyried bod Lloegr a Gogledd Iwerddon wedi sicrhau cymarebau is rhwng nyrsys a chleifion na Chymru heb ddefnyddio deddfwriaeth?

Mae ffigurau a gyhoeddwyd gan yr RCN[3] wedi dangos bod gan Gymru fwy o gleifion am bob nyrs, ar gyfartaledd, na Lloegr, Gogledd Iwerddon a'r Alban, ond roedd y data wedi'i seilio ar ymchwil ar gyflogaeth a wnaed yn 2009. Heb ffigurau cyfoes tebyg, nid yw'n hysbys a yw'r darlun yn dal yr un fath.

Hefyd, yr hyn nad yw'r ffigurau hyn yn ei ddangos yw faint o amrywio sydd yna ym mhob gwlad. Yn Lloegr, er enghraifft, mae gwaith diweddar gan Francis a Keogh yn dangos yn glir y gall lefelau'r staff nyrsio fod gryn dipyn yn waeth mewn rhai ardaloedd na'i gilydd.

Nod y Bil hwn yw sicrhau lefelau priodol a diogel o staff nyrsio yn gyson ar draws holl ysbytai Cymru.

12. A oes digon o gapasiti o ran staff nyrsio i ddarparu'r hyn y mae'r ddeddfwriaeth hon am ei chyflawni? Os na, faint o amser yr amcangyfrifir y byddai'n ei gymryd i ddatblygu'r capasiti hwnnw?

Drwy osod lefelau staff nyrsio diogel ar sail statudol, mae'r Bil yn anelu at gryfhau atebolrwydd dros ddiogelwch, ansawdd ac effeithiolrwydd wrth gynllunio a rheoli'r gweithlu.

Mae adroddiad yn 2013 gan Gyngor Rhyngwladol y Nyrsys yn disgrifio sut mae sawl gwlad wedi bod yn troi at gymarebau gorfodol fel strategaeth i wella amodau gwaith ac i'w gwneud yn haws i nyrsys ailddechrau ymarfer:

> "Shortly after the implementation of mandated ratios in Victoria, Australia - five thousand unemployed nurses applied to return to work and fill vacant posts in the health services" (Kingma 2006 p.225). Further, research commissioned by the Australian Nursing Federation (ANF) found that "more than half of Victoria's nurses

[3] **Y Coleg Nyrsio Brenhinol, *Guidance on safe nurse staffing levels in the UK*, 2010**

would resign, retire early or reduce their hours if mandated, minimum nurse:patient ratios were abolished" (ANF 2004 p.1).

Yn yr un modd, bernir bod y ddeddfwriaeth ar gymarebau yng Nghaliffornia wedi cyrraedd ei nodau o leihau llwyth gwaith nyrsys a gwella'r sefyllfa o ran recriwtio a chadw nyrsys, yn ogystal â chreu effaith gadarnhaol ar ansawdd y gofal. (Linda Aiken et al 2010).

Dadleuwyd hefyd nad yw 'prinder' nyrsys o reidrwydd yn brinder o unigolion sydd â chymwysterau nyrsio: yn hytrach mae'n brinder nyrsys sy'n fodlon gweithio o dan yr amodau presennol. Dywedwyd mai cynlluniau gweithlu a dulliau dyrannu annigonol, diffyg staff newydd yn sgil cyfyngiadau adnoddau, polisïau gwael ar recriwtio, cadw ac 'ailddechrau' a defnydd aneffeithiol ar yr adnoddau sydd ar gael drwy gymysgedd a defnydd sgiliau amhriodol, strwythurau gwael y cymhellion a chymorth gyrfa annigonol yw prif achosion prinderau nyrsys.[4] Bydd y Bil yn helpu i fynd i'r afael â'r materion hyn.

13. Pa asesiad sydd wedi'i wneud o effaith bosibl y Bil ar weithwyr cymorth gofal iechyd os bydd angen llai ohonynt ar wardiau acíwt ar gyfer oedolion o ganlyniad i'r Bil?

Mae gan weithwyr cymorth gofal iechyd ran hanfodol i'w chwarae wrth gefnogi nyrsys.

Yn hytrach na bwriadu lleihau cyfanswm y gweithwyr cymorth gofal iechyd, drwy osod lefelau staff nyrsio ar sail statudol, mae'r Bil yn anelu at gryfhau atebolrwydd dros ddiogelwch, ansawdd ac effeithiolrwydd wrth gynllunio a rheoli'r gweithlu (gan gynnwys cynlluniau gweithlu ar gyfer gweithwyr cymorth gofal iechyd).

Mae'r Bil yn rhoi hwb i ddefnyddio dulliau gweithredu aciwtedd a barn broffesiynol i bennu cymysgedd sgiliau angenrheidiol y staff nyrsio ar wardiau (uwchlaw'r lefel ofynnol). Bydd hyn yn sicrhau na fydd yr un aelod o'r staff yn ymgymryd â thasgau nad oes ganddo gymwysterau priodol i'w cyflawni, a bod adnoddau staff yn cael eu defnyddio yn y modd mwyaf effeithiol, yn unol ag egwyddorion gofal iechyd darbodus.

14. A ydych yn hyderus bod y darpariaethau presennol ar gyfer staff a / neu gleifion o ran codi pryderon yn ddigonol?

Ydw. Bydd y Bil yn darparu sail statudol i'r staff a'r cleifion gael herio lefelau staffio gwael a hynny mewn cyrff yn y gwasanaeth iechyd ac yn y llysoedd drwy gyfrwng adolygiad barnwrol.

Fe fues i'n ystyried a ddylai amddiffyniad penodol i gleifion a staff a fyddai'n codi pryderon gael ei gynnwys yn y Bil, gan ofyn y cwestiwn yn fy ymgynghoriad cyntaf. Awgrymodd nifer fach o ymatebwyr y dylai'r Bil gynnwys amddiffyniad penodol, ond roedd yna farn ehangach fod y dulliau cywir eisoes yn bod.

Fel y gŵyr y Pwyllgor, mae gwaith i gryfhau'r trefniadau ar gyfer cwynion wedi dechrau yn sgil adolygiad Keith Evans o bryderon yn y GIG yng Nghymru yn 2009.

[4] **Buchan, J ac Aiken, L, Solving nursing shortages: a common priority, 2008**

15. A ydych wedi ystyried y gallai'r gofyniad yn y Bil i hysbysu cleifion am nifer y staff nyrsio sydd ar ddyletswydd a'u rolau hefyd gynnwys gofyniad i nodi gwybodaeth am y dulliau presennol i gleifion a staff herio achosion o dorri'r canllawiau?

Bydd angen i'r canllawiau statudol y mae'r Bil yn gofyn amdanyn nhw gydbwyso angen cleifion a gofalwyr am wybodaeth â'r baich gweinyddol posibl wrth ddarparu'r wybodaeth honno.

Serch hynny, gellir nodi y bernir eisoes mai'r arfer gorau yw dangos lluniau ar lefel y ward i ddangos y gadwyn hysbysu (cydnabuwyd hyn yn gynnar yn ymgyrch y 1000 o Fywydau).

16. A yw'r cynllun peilot 'ward gydag adnoddau perffaith' wedi darparu tystiolaeth y byddai cyflwyno lefelau diogel o staff nyrsio yn cyfrannu at ostyngiadau sylweddol mewn costau staff banc ac asiantaeth, o ystyried bod costau staff banc wedi gostwng yn sylweddol ar draws wardiau'r cynllun peilot a'r wardiau rheoli?

Dangosodd y cynllun peilot 'ward gydag adnoddau perffaith' yn Aneurin Bevan yn 2012 ostyngiad o fwy na 60% yng nghostau staff asiantaeth a staff cronfa. Gwelwyd ychydig o ostyngiad hefyd yng nghyfanswm costau rhedeg y wardiau hyn tra oedd y cynllun peilot ar waith. Serch hynny, canfyddiad allweddol y cynllun peilot yn fy marn i oedd yr effaith gadarnhaol ar ansawdd ac ar ddiogelwch cleifion. Roedd y wardiau'n gallu datblygu siwrnai ddi-fwlch i'r cleifion, roedd profiadau cadarnhaol i'r cleifion yn cael eu hadlewyrchu mewn arolygon ymhlith y cleifion, ac roedd hanfodion safonau gofal yn cael eu hymgorffori yn y wardiau. Cafwyd cynnydd hefyd ym moddhad y staff.

17. A allech roi eglurhad pellach o fwriad y cyfeiriad at 'bob blwyddyn ariannol' yn y ddarpariaeth cychwyn a geir yn adran 4 o'r Bil?

Mae'r cyfeiriad at 'bob blwyddyn ariannol' wedi'i gynnwys er mwyn ei gwneud yn glir (i gyrff yn y gwasanaeth iechyd) mai dim ond o 1 Ebrill yn y flwyddyn ar ôl i'r Cydsyniad Brenhinol gael ei roi y daw'r dyletswyddau newydd sy'n cael eu gosod gan y Ddeddf yn effeithiol. Felly, pe bai'r Cydsyniad Brenhinol yn cael ei roi ar 1 Medi 2015, er enghraifft, dim ond o 1 Ebrill 2016 ymlaen y byddai'r dyletswyddau newydd sy'n cael eu gosod gan y Ddeddf yn dechrau bod yn effeithiol. Yn yr un modd, pe bai'r Cydsyniad Brenhinol yn cael ei roi ar 1 Ionawr 2016, byddai'r dyletswyddau newydd sy'n cael eu gosod gan y Ddeddf yn dod yn effeithiol o 1 Ebrill 2016 ymlaen.

Gan hynny, byddai'r gofynion ynglŷn â'r adroddiad blynyddol yn cynnwys blwyddyn ariannol gyfan, yn hytrach na rhan o flwyddyn. Y bwriad y tu ôl i'r ddarpariaeth hon yw ei gwneud yn haws i gyrff yn y gwasanaeth iechyd ddefnyddio'r strwythurau sydd eisoes ar gael i lunio'r adroddiadau hyn yr un pryd ag y maen nhw wrthi'n llunio adroddiadau eraill.

Byddai'r adran 10A (10) newydd yn caniatáu i adroddiad sy'n ofynnol o dan y Bil hwn gael ei gynnwys fel rhan o adroddiad ehangach.

18. Nid ymddengys y gall y ddyletswydd i gynnal y cymarebau gofynnol1 fod yn effeithiol hyd nes y caiff canllawiau2 Gweinidogion Cymru eu cyhoeddi. A ddylai adran 4 o'r Bil ymdrin â hyn?

Gweler fy ymateb i gwestiwn 8.

Eitem 7.3

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

Llywodraeth Cymru
Welsh Government

David Rees AM
Chair, Health and Social Care Committee
National Assembly for Wales

3 February 2015

Dear David,

I am writing to draw your attention to a Legislative Consent Memorandum which I laid before the Assembly on Friday 30 January. It is not normal practice for Ministers to write directly in this way, but for the reasons set out below I think it appropriate in this instance. A copy of the Memorandum is attached.

The Serious Crime Bill, currently before Parliament completed Committee stage in the House of Commons on 22 January, having been introduced in the Lords.

The Assembly has previously passed two Legislative Consent Motions in respect of amendments to this Bill, firstly in respect of an extension of the offence of child cruelty (at Report stage in the Lords), and secondly in respect of coercive or controlling behaviour (at Committee stage in the Commons).

A number of amendments were tabled by the UK Government on 8 January which required careful consideration as to whether they give rise to the need for the legislative consent of the National Assembly for Wales. Among these was an amendment creating an offence of sexual communication with a child, and the Memorandum I have laid sets out the reasons why this provision falls within the legislative competence of the Assembly.

I note that Business Committee has agreed this morning that the Memorandum will be considered in Plenary on 10 February. Given the late stage of the Bill in Parliament, timescales are exceptionally short. I wanted to ensure that you were made aware as early as possible.

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I am also copying this letter to the Chair of the Children, Young People and Education Committee and to Elin Jones AM, Kirsty Williams AM, and Darren Millar AM as Party Spokespeople.

Best wishes

Mark Drakeford.

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

SUPPLEMENTARY LEGISLATIVE CONSENT MEMORANDUM
(Memorandum No.3)

SERIOUS CRIME BILL

1. This Legislative Consent Memorandum is laid under Standing Order ("SO") 29.2. SO29 prescribes that a Legislative Consent Memorandum must be laid, and a Legislative Consent Motion may be tabled, before the National Assembly for Wales if a UK Parliamentary Bill makes provision in relation to Wales for a purpose that falls within, or modifies the legislative competence of the National Assembly.

2. The Serious Crime Bill ("the Bill") was introduced in the House of Lords on 5 June 2014. The Bill can be found at:

   http://services.parliament.uk/bills/2014-15/seriouscrime.html

Summary of the Bill and its Policy Objectives

3. The Bill is sponsored by the Home Office. The UK Government's principal policy objective for the Bill is to ensure that law enforcement agencies have effective legal powers to deal with the threat from serious and organised crime.

4. The Bill is in six Parts:

   - Part 1 makes provision in respect of the recovery of property derived from the proceeds of crime.

   - Part 2 makes amendments to the Computer Misuses Act 1990.

   - Part 3 provides for a new offence of participating in the activities of an organised crime group and strengthens the arrangements for protecting the public from serious crime and gang-related activity provided for in Part 1 of the Serious Crime Act 2007 and Part 4 of the Policing and Crime Act 2009 respectively.

   - Part 4 provides for the seizure and forfeiture of substances used as drug-cutting agents.

   - Part 5 amends the law in relation to the offences of child cruelty and female genital mutilation, provides for female genital mutilation protection orders and creates a new offence of possession of "paedophile manuals".

   - Part 6 provides for or extends extra-territorial jurisdiction in respect of the offences in sections 5 (preparation of terrorist acts) and 6 (training for terrorism) of the Terrorism Act 2006 and confers Parliamentary approval (as required by section 8 of the European Union Act 2011) for

two draft Council Decisions under Article 352 of the Treaty of the Functioning of the European Union. Part 6 also contains minor and consequential amendments to other enactments and general provisions, including provisions about territorial application and commencement.

Provisions in the Bill for which consent is sought

5. The consent of the Assembly is sought for the amendments tabled by Karen Bradley, Minister for Modern Slavery and Organised Crime, in the UK Parliament on 8 January 2015, which introduce new provision relating to 'Sexual Communication with a Child'. Details of the amendment can be found in the Notices of Amendments tabled in Public Bill Committee; this list was tabled in Parliament on 8 January 2015.

6. The amendment was agreed to in Committee on 20 January and is included as Clause 67 in the Bill as amended in Public Bill Committee. This Clause provides for a new offence where an adult communicates with a child under 16 for the purpose of obtaining sexual gratification and the communication is sexual or intended to encourage a sexual response. The offence would be triable either way with a maximum penalty (on conviction on indictment) of two years' imprisonment.

7. It is the view of the Welsh Government that new Clause 67 falls within the legislative competence of the National Assembly for Wales in so far as it relates to "protection and well-being of children (including adoption and fostering) and of young adults" (paragraph 15) under Part 1 of Schedule 7 to the Government of Wales Act 2006.

8. The provisions outlined above apply in relation to Wales.

9. The provisions outlined above do not include powers for Welsh Ministers to make subordinate legislation.

Advantages of utilising this Bill rather than Assembly legislation

10. It is the view of the Welsh Government that it is appropriate to deal with these provisions in this UK Bill as it represents the most practicable and proportionate legislative vehicle to enable these provisions to apply in relation to Wales. The inter-connected nature of the relevant Welsh and English administrative systems mean that it is most effective and appropriate for provisions for both to be taken forward at the same time in the same legislative instrument. This will enable the non-devolved partners of the Police and Courts to provide effective partnership and support in delivering a stronger child protection framework. We consider therefore that making provision for an offence which applies across England and Wales helps ensure a co-ordinated approach to the issue as senders and recipients of communications could be located in either country

Financial implications

11. There are no financial implications for the Welsh Government.

Mark Drakeford AM
Minister for Health and Social Services
January 2015

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

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref : SF/MD/312/15

David Rees AC
Cadeirydd y Pwyllgor Iechyd a Gofal Cymdeithasol
Cynulliad Cenedlaethol Cymru
Tŷ Hywel
Bae Caerdydd
Caerdydd
CF99 1NA

3 Chwefror 2015

Cyllid iechyd a diwygio

Rwy'n cyfeirio at eich llythyr dyddiedig 10 Rhagfyr sy'n gofyn am ragor o wybodaeth a fyddai'n eich helpu chi i wneud penderfyniad ynghylch a ddylid ymgymryd â darn o waith i ddiwygio iechyd cyn diwedd y Cynulliad hwn ai peidio. Er mwyn helpu i lywio ystyriaethau eich Pwyllgor o argymhellion y Pwyllgor Cyllid, rydych wedi gofyn am ragor o wybodaeth, a amlinellir isod.

Cyllid presennol
Cadarnhad ynghylch a oes cynlluniau wedi'u cadarnhau ar gyfer y cyllid ychwanegol ar gyfer 2014-15 a 2015-16, i gael ei ddefnyddio i ddiwygio gwasanaethau iechyd, neu i gynnal y lefelau gwasanaeth presennol yn unig

Mae'r adroddiad annibynnol a gyhoeddwyd gan Ymddiriedolaeth Nuffield ym mis Mehefin 2014 yn nodi'n glir yr heriau ariannol sy'n wynebu'r GIG yn y dyfodol. Roedd yr adroddiad hwn yn rhoi'r brif dystiolaeth gefnogol ar gyfer y cyllid ychwanegol i'w ddarparu i'r GIG. Un o brif gasgliadau'r adroddiad oedd bod y GIG yng Nghymru yn fforddiadwy yn y dyfodol os yw'n derbyn cyfran o incwm cenedlaethol ac yn parhau i sicrhau'r arbedion o ran cynhyrchiant ac effeithlonrwydd a gafwyd yn y gorffennol. Bydd y camau gweithredu ar gynhyrchiant ac effeithlonrwydd yn parhau, gyda mwy o effeithlonrwydd posibl yn digwydd yn sgil canoli gwasanaethau arbenigol iawn. Byddai hyn yn golygu darparu mwy o ofal yn y gymuned sy'n agos at gartrefi pobl, atal pobl rhag cael eu derbyn i ysbyty am driniaethau arferol, rhagor o integreiddio â gwasanaethau cymdeithasol, a datblygu agenda o ofal iechyd darbodus ar draws yr holl wasanaethau a ddarperir gennym.

O ganlyniad, defnyddir y cyllid ychwanegol a gyhoeddwyd yn y gyllideb ddrafft, ochr yn ochr â'r gyllideb gofal iechyd yn ei chyfanrwydd, i barhau i ddarparu'r gwasanaethau diogel o ansawdd uchel a ddisgwylir gan ein cleifion. Ar yr hun pryd, bydd hyn yn sicrhau bod y gyllideb gyfan yn cael ei defnyddio mewn modd sy'n cyfrannu at ail-lunio a diwygio'r ffordd rydym yn darparu ein gwasanaethau iechyd er mwyn sicrhau ein bod mewn sefyllfa fwy cynaliadwy.

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Mae'r canllawiau cynllunio newydd, a gyhoeddwyd ar 31 Hydref 2014, yn nodi'n glir ein disgwyliadau o ran y newidiadau rydym yn gobeithio eu gweld. Bydd hyd a lled y diwygiadau a'r newidiadau y mae sefydliadau'r GIG yn bwriadu eu gwneud yn amlwg o fewn eu cynlluniau integredig tair blynedd a gyflwynir erbyn 30 Ionawr 2015. Er mwyn cael cydsyniad Llywodraeth Cymru bydd angen iddynt ddangos yn glir sut y bydd diwygiadau o'r fath yn cyfrannu at ddiwallu amcanion polisi a galluogi parhad o ran darparu gwasanaethau cynaliadwy.

Cadarnhad o ddosbarthiad, a gynlluniwyd neu a gytunwyd, y cyllid ychwanegol o £200 miliwn sydd ar gael ar gyfer byrddau ac ymddiriedolaethau iechyd unigol yn 2014-15, cyn gynted ag y penderfynir ar y ffigurau hyn, gan gynnwys sut y cyfrifwyd y dyraniadau

Roedd yn ofynnol i bob sefydliad GIG gyflwyno cynlluniau gwasanaeth ar ddechrau'r flwyddyn ariannol yn unol â'r canllawiau cynllunio newydd a'r gofynion ynddynt. Er bod rhai sefydliadau heb lwyddo i gwblhau'r cynlluniau tair blynedd cytbwys yn foddhaol ac yn unol â'r gofynion, gofynnwyd iddynt sicrhau eu bod o leiaf yn cyflwyno cynlluniau cadarn wedi'u cymeradwyo gan y bwrdd am flwyddyn.

Mae'n bwysig fod sefydliadau'n parhau i fod yn atebol i ddarparu hyn yn erbyn yr ymrwymiadau cynllunio gwreiddiol a gymeradwywyd gan eu byrddau. O ganlyniad, dyrannwyd y £200 ychwanegol yn unol â'r gofynion adnodd gwreiddiol a amlinellir yn eu cynlluniau.

Mae angen cyfran o'r £200m i dalu am y dyfarniad cyflog, a gaiff ei ddosbarthu ar wahân. Dyrannwyd y £175 miliwn sy'n weddill fel a ganlyn:

Sefydliad	**Dyraniad Ychwanegol o**
	£m
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg	26.100
Bwrdd Iechyd Aneurin Bevan	26.700
Bwrdd Iechyd Betsi Cadwaladr	35.000
Bwrdd Iechyd Caerdydd a'r Fro	15.500
Bwrdd Iechyd Cwm Taf	8.000
Bwrdd Iechyd Hywel Dda	38.700
Bwrdd Iechyd Powys	25.000
Cyfanswm	**175.000**

Cadarnhad o'r cyllid ychwanegol sydd ar gael i fyrddau ac ymddiriedolaethau iechyd unigol yn 2015-16, gan gynnwys sut y cyfrifwyd y dyraniadau hyn, pan fyddant ar gael

Rwyf eisoes wedi rhoi gwybod i'r pwyllgor y byddai dyraniadau ychwanegol yn 2015-16 yn seiliedig ar fformiwla dyrannu adnodd a ddiweddarwyd. Bydd angen rhoi'r £200m a ddyrannwyd yn 2014-15 i waelodlinau sefydliadau'r GIG ar y sail hon.

Fel rhan o lythyr Dyrannu Refeniw Byrddau Iechyd Lleol 2015-16, a gyhoeddwyd ym mis Rhagfyr 2014 , dyrannwyd £200 miliwn yn ychwanegol, fel a ganlyn:

	Cyfran Darged Anghenion Uniongyrchol - Rhagfyr 2014	**Dyraniadau Ychwanegol - 2014**
	%	**£m**
Prifysgol Abertawe Bro Morgannwg	17.908%	35.815
Aneurin Bevan	19.132%	38.264
Prifysgol Betsi Cadwaladr	21.257%	42.515
Prifysgol Caerdydd a'r Fro	14.395%	28.789
Cwm Taf	11.112%	22.225
Hywel Dda	12.128%	24.255
Powys	4.069%	8.137
Cyfanswm / Cyfartaledd	**100.000%**	**200.000**

Bydd derbyn cynlluniau gwasanaeth integredig tymor canolig sefydliadau'r GIG cyn dechrau y flwyddyn ariannol nesaf yn darparu'r dystiolaeth bellach sy'n ofynnol i lywio'r gwaith o ddosbarthu unrhyw ddyraniadau ychwanegol o'r gronfa wrth gefn fach sydd gan yr AIGC. Bydd hyn yn ategu'r hyblygrwydd ariannol ychwanegol y gellir gofyn amdano a'i ddarparu dan y drefn newydd a gyflwynwyd yn dilyn Deddf GIG Cymru (Cyllid) 2014.

Amlinelliad o sut y bydd y cyllid ychwanegol o £70 miliwn a gyhoeddwyd gan Weinidog Cyllid a Busnes y Llywodraeth yn dilyn Datganiad yr Hydref Llywodraeth y DU, yn cael ei dargedu i "gefnogi'r GIG yng Nghymru i ymgymryd â'r gwaith diwygio, a'r newid sydd ei angen i sicrhau cynaliadwyedd hirdymor y gwasanaeth iechyd yng Nghymru", fel y nodwyd yn ei datganiad ysgrifenedig ar 3 Rhagfyr

Fel y soniais yn y nodyn a anfonwyd atoch ar 28 Ionawr, cyhoeddais ddatganiad ysgrifenedig a'i anfon at holl Aelodau'r Cynulliad ar y diwrnod hwnnw. Roedd y datganiad yn amlinellu sut y byddai'r cyllid ychwanegol gan Lywodraeth Cymru i'r GIG yn cael ei fuddsoddi.

Crynodeb o'r dyddiadau allweddol yn amserlen 2015 ar gyfer cytuno ar gynlluniau tair blynedd, gan ddechrau gyda'r dyddiad cau ar gyfer cyflwyno cynlluniau yn Ionawr 2015.

Roedd Fframwaith Cynllunio'r GIG a gyhoeddwyd 31 Hydref 2014 yn cynnwys yr amserlen ganlynol ar gyfer Cymeradwyo'r Cynllun.

Gweithredu	**Amserlen**	**LIC**	**GIG**
Byrddau'r GIG yn cymeradwyo fersiwn 'Drafft Terfynol' o'r cynlluniau integredig tymor canolig	Ionawr 2015		✓
Sefydliadau'r GIG yn cyflwyno cynlluniau 'Drafft Terfynol' a gymeradwywyd gan y Bwrdd i LIC	31 Ionawr 2015		✓
Proses graffu LIC	Chwefror – Mawrth 2015	✓	
Byrddau'n ymateb i adborth o'r broses graffu ac yn diwygio'r Cynlluniau yn unol â hynny. Y Byrddau wedyn yn cymeradwyo'r fersiynau terfynol	Cyn 31 Mawrth 2015		✓

Cyllid a chynaliadwyedd hirdymor yn y dyfodol

Amlinelliad o ganlyniadau ychwanegol, os o gwbl, sydd i'w cyflawni gyda'r cyllid ychwanegol yn 2014-15 a 2015-16

Fel y cyfeiriwyd ato uchod, bydd y cyllid ychwanegol yn galluogi'r GIG i barhau i ddarparu'r gwasanaethau a'r canlyniadau positif a ddisgwylir gan ein cleifion, ac ar yr un pryd yn ail-lunio a diwygio ein gwasanaethau. Mae/Bydd y canlyniadau gofynnol o ran y ddarpariaeth a'r camau angenrheidiol i'w cyflawni yn cael eu nodi'n glir yng Nghynlluniau Integredig Tymor Canolig tair blynedd sefydliadau'r GIG.

Amlinelliad o'r trefniadau sydd wedi'u gwneud neu a fydd yn cael eu gwneud i fonitro canlyniadau'r buddsoddiad hwn

Mae gennym sawl cyfrwng ar gyfer monitro a goruchwylio perfformiad sefydliadau'r GIG er mwyn sicrhau eu bod yn cyflawni yn erbyn y disgwyliadau ac yn parhau ar y trywydd i gyflawni yn erbyn y cynlluniau gwasanaeth a gymeradwywyd.

Mae'r rhain yn cynnwys:

- Cyfarfodydd misol o Brif Weithredwyr lle bydd craffu ar y ddarpariaeth a'r perfformiad ariannol.

:

- Cynhelir cyfarfodydd o'r Tîm Gweithredol ar y Cyd bob chwe mis â phob BILI ac Ymddiriedolaeth. Bydd aelodau o Dîm y Cyfarwyddwyr Gweithredol a'r Prif Weithredwr a Thîm Gweithredol y BILI neu Ymddiriedolaeth unigol yn bresennol yn y cyfarfodydd hyn.

- Cynhelir cyfarfod o'r Bwrdd Cyflawni Integredig yn fisol a'i gadeirio gan Gyfarwyddwr y Rhaglen Gyflawni neu Ddirprwy Brif Weithredwr GIG Cymru. Mae'r cyfarfod hwn yn monitro cynnydd perfformiad BILI / Ymddiriedolaethau yn erbyn gofynion cyflawni Ansawdd a Diogelwch Llywodraeth Cymru.

- Cynhelir cyfarfodydd Ansawdd a Chyflawni yn fisol, er y gallant fod yn llai aml pan ystyrir fod y sefydliadau'n cyflawni o ran perfformiad ac ansawdd.

- Cyflwyniad manwl o ffurflenni monitro ariannol misol. Caiff perfformiad ariannol ei adolygu'n fanwl a gofynnir am esboniadau am unrhyw amrywiadau adweithiol o'r cynllun.

Yn ogystal â hyn, mae gennym hefyd drefniadau o ran cynnydd ac ymyrryd a ddatblygwyd mewn cytundeb ag AGIC a Swyddfa Archwilio Cymru, lle rhennir gwybodaeth am berfformiad a chynnydd gan sefydliadau'r GIG..

Amlinelliad o unrhyw gynlluniau a sefydlwyd gan Lywodraeth Cymru i asesu a yw gwasanaethau yn cael eu diwygio fel y bwriadwyd, a hefyd y lefelau cyllid sy'n angenrheidiol ar gyfer y gwasanaeth iechyd ar ôl 2015-16, er mwyn sicrhau bod darparu gwasanaethau yn parhau i fod yn gynaliadwy.

Un o'n prif ddulliau o archwilio a yw gwasanaethau'n cael eu diwygio yw drwy'r cynlluniau tymor canolig. Asesir a yw gwasanaethau'n cael eu diwygio drwy adolygu, craffu a chymeradwyo'n ffurfiol y Cynlluniau Integredig Tymor Canolig. Yna bydd perfformiad a darpariaeth y diwygiadau hynny i'r gwasanaethau'n cael eu rheoli drwy'r prif drefniadau rheoli perfformiad y manylir arnynt uchod.

Mae'r lefelau cyllid sy'n ofynnol ar gyfer y gwasanaeth iechyd y tu hwnt i 2015-16 yn amlwg yn fater i Lywodraeth Cymru ei ystyried yng nghyd-destun y setliad o San Steffan. Cyhoeddwyd adroddiad Ymddiriedolaeth Nuffield "Degawd o Galedi yng Nghymru?" ym mis Mehefin 2014 ac mae'n asesiad annibynnol allweddol o'r heriau a'r gofynion ariannu.

Yn gywir,
Mark.

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

Mae cyfyngiadau ar y ddogfen hon

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