Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar Ddeddf Lefelau Staff Nyrsio (Cymru) 2016: craffu ar ôl deddfu.

This response was submitted to the Health and Social Care Committee consultation on the Nurse Staffing Levels (Wales) Act 2016: post-legislative scrutiny.

NS09: Ymateb gan: | Response from: Mind Cymru

Mind Cymru's response to the Health and Social Care Committee's Inquiry into the Nurse Staffing Levels (Wales) Act 2016

About Mind Cymru

We're Mind Cymru, the mental health charity. We work nationally and locally.

Nationally, we campaign to raise awareness, promote understanding and drive change. We're also the first point of call for information and advice, providing mental health information to people in Wales over a million times every year. Locally, in communities across Wales, independent local Minds provide life-changing face-to-face support to more than 25,000 people each year.

Together, we won't give up until everyone experiencing a mental health problem gets support and respect.

Overview:

We welcome the Health and Social Care Committee's inquiry into the Nurse Staffing Levels (Wales) Act 2016. The legislation has been a key step in developing the rights of patients in Wales.

The issue it aims to solve is a pressing one. We know that patients in hospitals with a higher patient to nurse ratio see around a 26% higher mortality rate compared to better staffed wards, as well as higher rates of staff burnout and lower staff retention[1]. The Act has clearly driven major changes to healthcare in Wales and is leading across Europe in its ambition.

It has had clear benefits, notably in the increased onus placed on Health Boards to find a way to meet the requirements of the legislation, and a transparency about what they might need to meet

[1] https://pubmed.ncbi.nlm.nih.gov/17064706/.

their targets. The Royal College of Nursing has highlighted that in preparation for the extension of Section 25B of the Act to paediatric wards in October 2021, every Health Board recruited more paediatric nurses[2]. They also proposed additional funding and resources would be needed. These changes by Health Boards to comply with the legislation have no doubt improved patient experiences on paediatric wards, as there are simply more staff with more time to care for them appropriately.

However, the Act has been incomplete in its scope, as mental health care is still yet to be included in its remit. A timelines is needed for the extension of Section 25B of the Nurse Staffing Levels (Wales) Act 2016 to mental health inpatient wards.

A duty to calculate and maintain safe staffing levels in inpatient settings would fundamentally improve the state of mental health care in Wales. While Section 25B of the Act outlines that the ideal nurse staffing level is "the number of nurses appropriate to provide care to patients that meets **all reasonable requirements** in that situation"[3], we know that this is often not the case in mental health facilities.

Mental health nursing is the second biggest field of pre-registration nursing, with increasing investment from the Welsh government[4], but the same set of issues keep reappearing, and patients are not receiving the level of care they deserve. Areas flagged by Healthcare Inspectorate Wales (HIW) for improvement can be traced back to staffing, amongst other issues. For example, the recent case at Hafan-y-Coed in Cardiff and the Vale flagged the need for staff to complete their training sufficiently to deliver restrictive practices in a humane and careful way[5]. However, with time and stress pressures, training that is vital to the job is not as comprehensively completed as it should be. This trickles down to the quality of care and can put patients and staff at risk of harm.

Mental health nursing is an extremely sensitive, important role. Someone being treated on a mental health ward are likely to be vulnerable. As part of their care, they must be guaranteed:

- Person-centred and trauma-informed care;
- A safe and caring therapeutic environment;
- And their rights respected in their care.

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[2] https://www.rcn.org.uk/professional-development/publications/Mental-health-nursing-English-uk-pub-010-913
[3] https://www.legislation.gov.uk/anaw/2016/5/contents/enacted
[4] https://www.rcn.org.uk/professional-development/publications/Mental-health-nursing-English-uk-pub-010-913
[5] https://www.hiw.org.uk/immediate-improvement-required-keep-patients-safe-following-inspection-mental-health-unit-llandough

These elements, and others, can only be delivered adequately and safely if there are enough staff in position to be able to care for patients in the right way, for the right length of time. Beyond the nursing level itself, the provision in the Act to "make arrangements for the purpose of informing patients of the nurse staffing level" gives the patient more agency over their care and protects the right to a specific quality of treatment.

Extending Section 25B of the Act will not completely revolutionise inpatient care and solve every issue identified by HIW inspection and monitoring reports. However, staff are the greatest asset to the Welsh NHS. They provide selfless care to those who need it during the most difficult times of their lives. What the extension will do is establish a duty of care that a patient can expect and staff can aspire towards. It is a simple change that would benefit many people across Wales, whatever age.

Mental health inpatient settings:

We know that 1 in 50 people in Wales has a severe mental and enduring mental illness (SMI), such as schizophrenia or bipolar disorder[6]. The occurrence of these conditions is increasing in Wales. The Wales Governance Centre has indicated that the proportion of people with SMI increased from 11.7% immediately pre-pandemic to 28.1% by April 2020[7].

For some people with SMI, the best option for their treatment is to enter an inpatient ward. Most will be informal patients, but some will be formal, likely detained under the Mental Health Act.

When someone enters a mental health inpatient setting, it is likely to be when they are at their most vulnerable and are in a place of intense emotional distress. The staff they meet on their journey through care will play a vital role in achieving their outcomes.

Inpatient care in Wales has changed over the last decade. There are fewer people in mental health hospitals (in 2009 there were 1733, yet in 2019 there were 1291[8]); fewer admissions (an overall drop

[6] https://www.nhsconfed.org/publications/welsh-nhs-confederations-health-and-wellbeing-alliance-mental-health-sub-group
[7] https://www.cardiff.ac.uk/news/view/2534728-share-of-people-in-wales-experiencing-severe-mental-health-issues-more-than-doubled-during-pandemic,-report-finds#:~:text=The%20share%20of%20people%20in,to%20the%20pre%2Dpandemic%20period.
[8] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health/Psychiatric-Census/patientsinmentalhealthhospitalsandunitsinwaleswithamentalillness

from 10,824 2010-11 to 7639 2020-21); and fewer average daily beds (fallen from 1857 in 2011-12 to 1291 in 2021-22[9]).

This data could indicate a number of causes, from better community focused care, such as through Community Mental Health Teams (CMHTs), to a reduction in demand. However, despite the positive progress this data suggests, HIW frequently reports issues that can be traced to staffing levels on mental health wards.

Some patients have faced abuse or neglect, whether this is intentional or not. In HIW's 2020-21 annual monitoring report for mental health and learning disability facilities, it noted that there were 151 complaints, including 20 of alleged abuse or neglect from staff[10]. There were also 42 staff concerns raised, ranging from infrastructure to the care environment and staffing[11]. These figures were increasing on recent years.

We can see that patients' voices are not as readily listened to as they would be if there was a legislative right to a safe staffing level. The 2023 HIW review into discharge arrangements at Cwm Taf Morgannwg UHB highlighted the "clear risks" to patient safety that required the involvement of concerns from patient relatives or carers and staff whistleblowers to rectify[12]. Staff at Cwm Taf facilities were "striving to deliver services to patients in very challenging circumstances, often exacerbated by issues with workforce capacity and resource constraints"[13]. This poor ratio of patients to nurses greatly impacted the wellbeing and morale of the workforce, which likely impacted the quality of the care they could provide.

The introduction of an extended Nurse Staffing Levels (Wales) Act would help Health Boards take steps to improve this, which would, in turn, enable better quality care for patients.

A key example for how this could work lies in the experience of Cardiff and the Vale UHB in 2019 and 2020. Where 25A places an overarching responsibility on Health Boards and trusts to have "regard"

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[9] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Activity/NHS-Beds/nhsbeds-by-specialty

[10] https://www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-1

[11] Notably, this is more commonly seen in independent healthcare providers. 86 of the 151 complaints were about said facilities. While there were 3 complaints of alleged abuse or neglect in NHS settings, there were 17 for independent facilities. There were also 27 staff concerns raised for independent hospitals versus 15 for NHS.

[12] https://www.walesonline.co.uk/news/wales-news/significant-risks-patients-being-discharged-26401932

[13] https://www.walesonline.co.uk/news/wales-news/significant-risks-patients-being-discharged-26401932

to providing sufficient nurses, to "allow time to care for patients sensitively"[14], Section 25B is a "duty to calculate and take steps to maintain nurse staffing levels". 25A already applies to mental health wards. 25B does not. Cardiff and the Vale reported themselves as non-compliant for both years after facing problems with their recruitment and retention[15]. As a result, in 2021, the Mental Health Clinical Board management team was asked to address gaps in nurse staffing and financial allocation.

The Executive Director of Nursing for the Health Board worked hard to ensure compliance, raising the issue with the Health Board on several occasions. The legislation acted as a lever to improve patient safety, whereby the Executive Director could raise the issue at relevant meetings as something fundamental to the running of their mental health inpatient settings. There is no clear reason why this could not work in a similar way for the extension of Section 25B. This increase emphasis can only be a good thing for patient outcomes.

The impact of the pandemic:

Staff in mental health facilities across Wales did their best to deliver a caring, therapeutic environment for patients during the pandemic. Managers were "very proud and complimentary"[16] about their work. Staff found ways to innovate in the use of video calling and delivering activities to improve quality of life despite restrictions. This came despite Section 17 leave being limited, family and friend visits being affected, and outbreaks of the virus being fairly common on wards. Beyond the needs of the patients, staff were frequently on the front lines, at risk of contracting the virus themselves, and were finding their own ways through the crisis. The clear issues with recruitment the pandemic highlighted do not undermine their hard work an sacrifice during that time.

Staffing levels were only maintained at the time through costly "frequent and considerable use of temporary agency staff"[17]. With staff affected by the virus, this became more common. HIW further noted that some settings were carrying a number of registered nurse and support worker vacancies, and in these settings, staffing had been further compromised at times when permanent staff were absent from work because they had symptoms of coronavirus or were required to self-isolate. They

[14] https://www.legislation.gov.uk/anaw/2016/5/contents/enacted
[15] https://www.rcn.org.uk/Professional-Development/publications/progress-and-challenge-in-delivering-safe-and-effective-care-2022-uk-pub-010-279
[16] https://www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-1
[17] https://www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-1

identified that a number of providers needed to take action to recruit permanent staff in order to maintain required staffing levels and skill mix to ensure safe and effective care.

For patients, establishing a developed relationship with the staff responsible for their treatment is key to them achieving a positive outcome. Their care will involve trusting and feeling secure, something that poor continuity due to staff changeover can negatively affect. Plus, a high turnover can lead to an increased risk of poor medication management or treatment in line with their care and treatment plans.

Developing the workforce:

The concerns surrounding Tawel Fan Ward at Ysbyty Glan Clwyd in 2013, which led to its closure, included significant concerns raised by staff and family members about patient care. The Ockenden Tawel Fan Report[18] highlighted the impact on patient care stemming from, amongst other things, a lack of adequate staffing and a lack of skills in the workforce.

Put simply, the size of the mental health workforce is inadequate for the demand that is there. For example, over the previous decade, the total number of mental health consultant nurses has not risen above ten and is currently at 7.2 (full time equivalent)[19]. The number of Mental Health Consultant Nurses working in other settings has decreased from 5 to 2.9[20].

The Welsh government's 2019-22 Delivery Plan for the Together for Mental Health Strategy aimed for a workforce plan for mental health services. The 2022 HEIW and SCW multi-professional workforce plan for mental health services is a positive step, but we still see many roles left unfilled in the workforce. We would hope to see these gaps addressed with an extension of the Nurse Staffing Levels (Wales) Act, to take a proactive approach to building a resilient and the right workforce. We realise that these steps will take some time to see a change in the delivery of services as new nurses will need to be trained and recruited, but we feel a clear timeline would encourage proactivity and positive progress.

Patient safety:

The role of a mental health nurse is extremely specific. They have legal responsibilities regarding the lawful detaining of individuals and must be registered with the Nursing and Midwifery Council specifically as a 'mental health nurse'. Registered nurses whose field of practice entry is adult or

[18] https://bcuhb.nhs.wales/news/updates-and-developments/updates/archived-updates/tawel-fan/tawel-fan/
[19] https://www.rcn.org.uk/professional-development/publications/Mental-health-nursing-English-uk-pub-010-913
[20] https://www.rcn.org.uk/professional-development/publications/Mental-health-nursing-English-uk-pub-010-913

child nursing cannot restrain or detain patients, even if they work on a mental health ward. The need to have relevant nurses in every setting is key for patient safety.

These roles are particularly important with restraint, for example. This can be an immensely triggering experience for someone with a history of trauma. Besides being used only when proportionate and as a last resort, it must be undertaken by staff who know what they are doing. But we know this is often not the case. A key recent example was seen in the HIW report from earlier this year about Hafan-y-Coed unit at Llandough Hospital. Without sufficient staffing levels, those working on mental health wards are often put under immense time pressure that can limit the amount of training they are able to complete.

In April 2023, HIW issued a report following an inspection of the Pine and Ash Wards within the unit, raising concerns that staff had participated in incidents of restraint without the required levels of training. Overall completion of the Strategies and Interventions for Managing Aggression (SIMA) training required for utilising restraint was only 51% on Ash Ward and 70% on Pine Ward[21].

There have been 10 incidents of restraint on Ash Ward within the last six months (before January 2023) and 4 involved staff with incomplete SIMA training. Aligning with the work above, HIW noted that several of the Datix reports were incomplete and did not mention the staff involved, so the true figure could be higher. Also, the Health Board's Prevention and Management of Violent and Aggressive Situations and Psychiatric Emergencies Procedure was out of date by around 7 years. This would indicate that staff and patients are not fully protected and safeguarded against injury. The wider care at the hospital was deemed to be of a high quality, but staffing has been reported as being an issue previously. It is not unlikely that the training insufficiency is linked to this, at least to some degree.

HIW noted in their annual monitoring report that the emphasis on e-learning that was developed during the pandemic has been a positive step, but has faced challenges, notably that not all essential training can be delivered remotely. Safe de-escalation techniques, for example, cannot be delivered as effectively remotely, and lack of training can pose significant risks. This was noted as an area of improvement. For wards with insufficient staff numbers, enabling set education time in person can be difficult.

[21] https://www.hiw.org.uk/immediate-improvement-required-keep-patients-safe-following-inspection-mental-health-unit-llandough

However, and encouragingly, the unit has committed to improving training and, importantly, ensure *"all incidents of restraint are recorded in detail on Datix and are reviewed **on a regular basis** by the senior nurse. An audit will be undertaken to evaluate the quality of details provided on Datix."* [22] This will ensure further detailed information about the use of restraint, that will enable further work to identify particular staffing pinch points, such as overuse on particular groups of people. The Senior Nurse for Adult Mental Health has taken responsibility for this work and was due to report back to HIW in March 2023. We await updates on further progress.

The Welsh government's recently published *Reducing Restrictive Practices Framework*[23] aims to improve the guidance around the use of restraint for the benefit of patient and staff human rights, wellbeing and safety. It seeks to put measure in place *"so that when situations arise where restrictive practice are used as a last resort, to prevent harm to the individual or others, there is prior planning and training in place to secure the safety of all concerned."* Better staffing levels will be a fundamental aspect to the success of this document. Importantly, *"restrictive practices should **never** be used to compensate for staff shortages or other resource difficulties"*.

The key issue with this guidance is that it is non-statutory, as of yet. Health Boards are not legally bound to abide by every aspect of it, despite it being likely that they will strive to do so where possible out of an ambition to work safely and effectively. While the guidance discourages the use of restraint in instances of staff shortages to manage patients, making it statutory would put the onus back on Health Boards to ensure they are doing everything in their power to protect patients during their stay in an inpatient setting.

Beyond the use of restraint, there are other risks to patient safety caused in part by insufficient staffing:

- HIW has noted several providers had incorrect and inconsistent practice around ligature risk assessments. They noted examples where action had not been taken to reduce risks. They wrote to the Chief Executive of NHS Wales to raise their concerns[24]. This was due to lack of the ability to monitor the ward environment effectively.
- Seclusion care is often deficient across Welsh Health Boards. 1 of 8 of the inspection visits undertaken by HIW in the year 2020-21 identified poor practice. Examples include a patient being cared for in a seclusion suite on an empty ward. Staffing requirements were unclear

[22] https://www.hiw.org.uk/immediate-improvement-required-keep-patients-safe-following-inspection-mental-health-unit-llandough
[23] https://www.gov.wales/reducing-restrictive-practices-framework
[24] https://www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-1

and the patient's care and treatment plan did not contain enough detail to guarantee adequate care. The use of CCTV to monitor the patient when undertaking personal care is another example indicative of an environment where poor staffing has triggered[25].

Again, it is important to recognise that not all incidents of patient safety will be resolved by the extension of Section 25B of the Act. What this step will do, however, is ensure the numbers of staff are there to provide patients with more dedicated time to their care. It can be assumed that staff will have more time to complete training; incorrect ligature assessments can be identified with more care; and patients will be protected against the use of restrictive practice as a side effect of limited staffing capacity. Other steps, such as improving the quality of care and treatment planning and investing in the mental health estate will also improve the state of mental health inpatient settings in Wales.

Recommendations:

The clear next step for the implementation of any mental health reforms to the Nurse Staffing Levels (Wales) Act is to do so in partnership with the upcoming replacement mental health strategy.

1. The Welsh government should set out a timeline for the extension of Section 25B of the Nurse Staffing Levels (Wales) Act 2016 for mental health inpatient settings.
2. The Welsh government should incorporate this extension as a key element of their replacement mental health strategy, as a key part of their plan for inpatient care.
3. The Welsh government should continue to invest in mental health nursing and developing the mental health workforce to meet demand through means testing and engagement with partners such as HEIW and HIW.
4. The Welsh government should make the Reducing Restrictive Practices Framework guidance statutory, to protect patient safety and rights in line with safe staffing ambitions.

[25] https://www.hiw.org.uk/mental-health-hospitals-learning-disability-hospitals-and-mental-health-act-monitoring-annual-1