

# Senedd Cross-Party Group on Nursing & Midwifery

## Topic: Fresh Air in Care

Minutes of the meeting held on 21 May 2024 6pm – 7.30pm

### Attendance in person

Jenny Rathbone, MS (**Chair**); Mabon ap Gwynfor MS; Sam Rowland MS

Tracey Gauci, Consultant Practitioner Infection Control, Hywel Dda University Health Board

Prof Dr Carolyn Wallace, Director of the Wales School for Social Prescribing Research (WSSPR)

Nicky Hughes, Associate Director of Employment Relations, RCN Wales

Sandy Harding, Associate Director of Nursing Professional Practice, RCN Wales

Lisa Turnbull, Policy, Parliamentary and Public Affairs Manager, RCN Wales

Rebecca Eedy, Midwife at Aneurin Bevan University Health Board, RCM Wales

Lynn Jones, Powys Senior Lead Maternity Clinical Informaticist, RCM Wales

Aysima Harper, Policy, Parliamentary and Public Affairs Assistant, RCN Wales

Sion Trewyn, Policy, Parliamentary & Public Affairs Officer, RCN Wales

### Attendance online

Steve Watson, Vice Chair RCN Wales Board; Ryland Doyle, Office of Mike Hedges MS

Suzanne Hardacre, Director of Midwifery, Gynaecology and Integrated Sexual Health, CTM UHB

Chris Davies, Parkrun & 5k Your Way Ambassador for Wales; Nick Unwin, RCN Wales

### Apologies

Llyr Gruffydd, MS; Jane Dodds MS; Natasha Asghar MS; Peredur Owen Griffiths MS

Helen Whyley, Director of RCN Wales, Julie Richards, Director of RCM Wales

## Meeting Notes

**Jenny Rathbone** introduced the guest speakers; Tracey Gauci, Consultant Practitioner Infection Control at Hywel Dda University Health Board and Prof Dr Carolyn Wallace, Director of the Wales School for Social Prescribing Research (WSSPR).

## Importance of ventilation in the health care environment

**Tracey Gauci** opened the discussion with the following points:

Florence Nightingale was the first healthcare professional to research and present evidence of the impact of poor ventilation on spreading infection and best methods to reduce the risk. 'Nightingale windows' open from the top allowing air circulation without a draft at patient bed level. This type of window minimises risk of patient falls and vermin entering the environment.

Despite this history, ventilation not a priority until COVID-19. Prior to COVID-19 focus on reducing energy consumption; healthcare architecture such as sealing windows prevented good air circulation.

Adequate air ventilation is 6 complete air changes in an hour; current average air ventilation on non-specialist wards (i.e. not intensive care) 2 or 3 air changes an hour; increases risk of airborne infection.

High CO2 levels known to reduce concentration, impacting memory recall and information processing **creating a cognitive risk for healthcare professional** making safety critical decisions.

“Corridor care” - more patients than intended added to bays and wards increases risk of airborne infection.

Huge variation and lack of consistency across the NHS estate and within Health Boards as to how ventilation is assessed or addressed. Professional and technical guidance/standards all exist - but do the board employ the personnel to assess and advise? How is this prioritised? A complete refurbishment of the estate requires extraordinary amount of capital investment, but **many actions could be taken to assess and minimise risk.**

2008 Welsh Health Circular recommended each health board develop a specialist negative pressure suite to allow for isolation of airborne infection. E.g. high consequence infectious diseases such as tuberculosis. Still not achieved across Wales; investment required is about £0.5m per room.

There are alternatives, not as effective but better than nothing. These include:

- Semi -permanent ‘pods’ which can be built around/into a ‘bay’.
- Pop-up tents that can surround a bed (space needed to deploy this).

**Impact of climate change** – increased temperatures in the summer mean that patients and staff suffer from heat and air quality declines. Fans (often personal to patients and staff) brought onto the wards can create their own issues because they are not cleaned or unclear who is responsible for cleaning them. Simply banning them is counterproductive.

Some health boards have invested in mobile air conditioning units. They are preferable to fans as they purify and circulate air, as well as address comfort by reducing heat. As long as there is a policy on cleaning these (and PAT testing etc) these are a sensible way forward.

## Discussion

The following points and issues were raised:

COVID-19 has provided more research about the risks of airborne infection and busted some myths.

- the risk of singing in a choir is less than sitting at desk with colleagues. When singing or speaking larger droplets from the mouth are likely fall to the floor. Smaller droplets from just breathing are more likely to be carried across the room horizontally. Preventative measure such as masks and opening windows are more useful in an office environment.
- Portable desk CO2 monitors are useful for healthcare staff (in hospitals/ GP surgeries and care homes) because they promote awareness of risk and discussion of action (e.g.

opening window/ moving to new room,). Less useful for patients who less likely to be able to take any action so these devices simply cause concern.

Architects of new hospital building generally educated in air circulation issues and the need for mechanical ventilation.

Consultant level infection prevention control nurses in each health board is critical – and important for these roles to provide advice, training guidance to the care home sector.

### **Suggested Follow-up Questions for MS**

- Does your UHB have a negative pressure suite, or pop-up tents for treating airborne infections?
- Does your health board have a plan for assessing and improving air quality in non-specialist wards? Mobile air conditioning units part of this plan?
- Do staff (in hospitals/ care homes and GP surgeries) have access to a CO2 monitor?
- Does your health board have an Infection Prevention Control Consultant Nurse? What support for the care home sector?

### **Fresh Air and social prescribing.**

**Carolyn Wallace** made the following points:

‘Social prescribing’ can be described as community referral – using the community infrastructure and support to enable people to better manage their own health and wellbeing. For example, someone experiencing loneliness or bereavement strategies to combat isolation beneficial.

Considerable evidence that mental health can be improved by contact with nature. Both mild and severe mental health conditions. Contact with nature reduces cognitive fatigue and negative thoughts. Important this is alongside clinical treatment and not a replacement.

Social prescribing is undertaken by GPs and other health professional e.g. midwives and health visitors. Evidence that non-health professionals taking on this role can reduce stigma and increase accessibility.

- ‘green’ social prescribing is nature based e.g. gardening or walks, ‘blue’ social prescribing is water based for example, swimming.

Significant report on social prescribing published in 2021 by Public Health Wales/University of South Wales.<sup>1</sup> Provided a wealth of evidence and led to the National Framework on social prescribing<sup>2</sup>. It showed huge variation in use of social prescribing – e.g. Rhondda Cynon Taff had highest number of referrals, Cardiff the least.

There is a social prescribing course and qualification undertaken by a wide variety of professionals. Variability in salary received by practitioners – at the time of the report between £17k & £35k.

### **Discussion**

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<sup>1</sup> [phw.nhs.wales/publications/publications1/understanding-social-prescribing-in-wales-a-mixed-methods-study-a-final-report/](https://phw.nhs.wales/publications/publications1/understanding-social-prescribing-in-wales-a-mixed-methods-study-a-final-report/)

<sup>2</sup> <https://www.gov.wales/national-framework-social-prescribing-html#:~:text=The%20NFfSP%20sets%20out%20to,delivery%20regardless%20of%20the%20setting.>

- People with wide variety of conditions can be supported by social prescribing; cardiovascular, respiratory, mental health, social isolation etc
- Evidence that social prescribing works better when based in the community rather than being 'medicalised'. Chris Davies from Park Run supported this with example of promoting Park Run in Newport. Originally, they tried to partner with GP surgeries but the information Park Run supplying often perceived as an 'extra burden' by busy GP surgeries; when they partnered with community organisations MIND and MACMILLAN, the number of referrals increased and those partnerships have proved very successful.
- 'Social Prescribing' perhaps not the best term but it is recognized internationally.
- Carolyn Wallace gave example of integrated social prescribing in Singapore where it is part of the hospital discharge plan.
- Sam Rowlands noted that Singapore was one of the few countries that had mandatory outdoor residential education as part of its curriculum.
- Mabon ap Gwynfor asked about examples of social prescribing linked to housing improvements, such as safety rails, ramps or mould removal. Carolyn Wallace was not aware of any such examples in Wales but suggested it was worth investigating as strong evidence of links between poor or unsuitable housing and poor health and wellbeing.

### Suggested Follow-up Questions for MS

- Does your constituency office have links to a social prescribing practitioner so you can refer constituents who might benefit?
- What social prescribing schemes are supported by your local authority/health board?
- Can outdoor based social prescribing be supported by improving benches, public toilets, dropped curbs etc? What are barriers to outdoor enjoyment?

### Closing Remarks:

Steve Watson **RCN Wales Vice Chair Board** emphasised importance of infection prevention and Control Consultant Nurse role and called for WG long term capital investment plan to improve NHS estate. Wales has resources to educate the next generation about importance of fresh air.

Nicky Hughes **Associate Director of Employment Relations, RCN Wales** thanked the guest speakers for their contributions, and the importance of patient and staff safety as hospital staff struggled in the current crisis of Corridor Care.

**Jenny Rathbone** thanked all attendees particularly the two speakers.

**Action:** Making health care buildings fit for the future could be consideration for the Health Committee, as well as scrutiny of ventilation in the NHS estate

Need to increase social prescribing and share RCT best practice. Social prescribing in Rotherham showed a **21% reduction in inpatients admissions**. **Action:** Consider IMD on social prescribing.

**The next Cross-Party meeting scheduled for Autumn 2024. Date and topic TBA.**