

Safe Nurse Staffing Levels (Wales) Bill

Summary of consultation responses

Two formal written consultations were undertaken to inform the development of the Bill. An [initial consultation](#) on the proposed content of the Bill was held in May and June 2014. A [second consultation](#), on the draft Bill, was undertaken between July and September 2014.

Initial consultation on the proposed content of the Bill

A total of 29 written submissions were received from a range of respondents including Local Health Boards, Community Health Councils, trade unions and professional bodies/groups, individuals, and the Older People's Commissioner. A full list of respondents is included as Annex A.

Consultation questions

1. What are your views on the effectiveness of the current arrangements for planning and ensuring safe nurse staffing levels in the Welsh NHS?

A number of respondents described a lack of consistent, transparent approach to determining and maintaining safe staffing levels, and suggested that the current arrangements are ineffective and 'leave too much to chance'. Some respondents pointed to Health Boards not meeting Chief Nursing Officer (CNO) guidance as evidence of this. The Chartered Society of Physiotherapy emphasised the need to understand why this guidance hasn't been met – 'without an understanding of the reasons why it may not be reasonable to expect the law to address the 'problem'.'

Some evidence suggested that staffing is driven by finance, rather than quality or need.

Regrettably across Health Boards the current and historic financial climate takes precedence over best practice and professional guidance when setting safe nurse staffing levels. Historical funded establishment figures exist in areas where the change in clinical services and levels of acuity are unrecognisable to those that existed when the levels were set. (MNS10 All Wales Senior Nurse Advisory Group (AWSNAG) for Mental Health Nursing)

Poorly-managed sickness absence, and an over-reliance on agency or bank staff was also highlighted.

Written evidence from Health Board representatives, including a submission from Nurse Directors, described work that has recently been undertaken with the CNO's office in relation to staffing levels, including the development of an acuity/dependency tool for acute settings. This 'robust work', it was suggested, needs to be bedded into practice before new measures are introduced.

2. Do you support the use of mandatory minimum nurse staffing ratios, including registered nurse to patient ratios and registered nurse to nursing support worker ratios? Please explain your answer.

Action to address safe staffing was widely felt to be a priority. It was acknowledged that staffing ratios are a complex issue.

All responses supported the need for safe and appropriate staffing, but it was noted that minimum staffing levels do not necessarily equate to safe staffing levels. There was also some concern that minimum levels could become the norm rather than a baseline. While a number of respondents agreed with the proposal to mandate nurse to patient and skill mix ratios, there was a strong note of caution that flexibility must be retained as this is key to meeting patient need. Some respondents specified that use of an acuity/dependency tool alongside the ratios would help ensure an appropriate level of staffing (at different times and on different wards). The importance of professional judgment in assessing patient need was also strongly emphasised.

Some evidence referred to legally enforceable ratios being in place elsewhere (such as childcare, education and airlines for example). It was highlighted that enforceable staffing levels would be of benefit to both patients and nursing staff.

This proposed bill is very important for the protection of patients and also staff caring for patients. I think this will provide the ward based staff with support and a solid basis upon which to challenge unacceptable care / demands placed on them by higher level managers. (MNS4 L. Crowther)

Evidence also described the importance of an appropriate skill mix ratio. Again, it was suggested that the appropriate mix may vary, and that professional judgment was needed to determine the required combination of nursing staff.

Some respondents highlighted that some roles (particularly ward managers/sisters but also, for example, student nurses) should be supernumerary and not included in the 'minimum' ratios.

The draft NICE guidance on safe staffing was highlighted in some responses as providing an appropriate model to support safe staffing.

It was suggested that, if minimum ratios were introduced, this would require careful, phased implementation as well as adequate funding. Health Boards may

need time to develop their nursing workforce, otherwise there could be a significantly increased cost because of the need to utilise temporary (agency/bank) staff to make up the numbers.

Some evidence suggested the need for a more holistic approach to ensuring safe, quality care, involving the whole healthcare team – ‘it is not just the domain of nursing staff.’ This was strongly echoed by the Chartered Society of Physiotherapy (CSP), which is opposed to the setting of mandatory minimum nurse staffing levels. The CSP's concerns largely centred around the lack of consideration given to other health professions in the proposed legislation, and the possible adverse effects on these staff of implementing staffing requirements/protections that apply only to nurses. It also emphasised that minimum levels do not equate to safe or quality care, and questioned what evidence base supports the need for the bill.

Cwm Taf University Health Board raised a concern that mandating staff numbers may be too inflexible an approach:

As demographic changes, advances in technology and future workforce planning requirements cannot be completely predicted, it is likely that legislating for workforce numbers could be a barrier to a more flexible approach which could be more responsive in meeting the needs of local populations both now and in the future. (MNS14 Cwm Taf UHB)

3. To what further settings should minimum nurse staffing ratios apply and why?

A key theme under this heading was that safe staffing levels must be ensured in all healthcare settings. The proposed bill's focus on acute areas may be too narrow, and there was a common concern that resources could be diverted away from areas where mandatory ratios do not apply in order to meet the requirements for acute ward settings, what some evidence described as ‘robbing Peter to pay Paul’.

Evidence highlighted the wide range of settings/services that would benefit from improved staffing levels, for example, mental health and learning disabilities. There was a strong focus on the importance of ensuring adequate staffing in community settings, with some evidence suggesting this should be an equal priority.

The numbers of community nurses are stated to have reduced by 30% over recent years so rather than focus simply on the hospital setting; wouldn't it be prudent to look at nursing levels across all patient care rather than creating a two tier system?

Indeed, might there be a tendency to discharge patients from hospital early if the minimum staffing levels cannot be achieved thus pushing the problem onto the primary sector? (MNS15, Gillian Evans)

4. What factors should be considered to ensure that staffing levels adapt to meet local need?

Evidence highlighted that patient acuity is the main factor which may change from shift to shift, and supported the use of acuity/dependency tools and professional judgment to ensure an appropriate level of staffing.

The staffing of hospital wards should be based around the needs of its patients and they must be able to be flexible around the ever-changing needs of their patients. When difficult decisions need to be made, ward managers need to have the power to respond and alter their staff balance accordingly. (MNS26 Older People's Commissioner)

In some responses, the NICE guidance on safe staffing was welcomed as a helpful tool.

It was noted that staffing requirements will vary between Health Boards, and will need to take account of demographics, population health, disease trends and the balance of acute and community service provision in an area.

Within Health Boards and hospitals, the hospital environment itself (ward layout for example) can impact on staffing needs – 'no one size fits all'. Staff skills and competencies also need to be considered, and it was noted that nurse staffing should be considered in the context of the whole multi-disciplinary healthcare team.

It was also pointed out that recruitment may be difficult in some areas resulting in a genuine shortage of staff. It was suggested that robust workforce planning strategies are needed.

5. Are the current arrangements for recording, monitoring and reporting nurse staffing levels in NHS Wales adequate and appropriate for the purposes of this Bill? If not, how might these need to be strengthened?

The Health Boards/Nurse Directors' submissions described use of e-rostering systems in some areas (it was not clear from the written evidence how widespread

use of these is), which can be used for monitoring purposes and identifying additional staffing need.

Other evidence suggested the current arrangements may be lacking in transparency and accuracy, and may not adequately capture nurse staffing data (for example, information on nursing grades, clinical information regarding acuity and activity, or complete bed usage may not be recorded). It was suggested that there is no direct link between the workforce data currently collected (which may largely be looked at for 'financial management' purposes) and quality of care or outcomes for patients.

It was also suggested that current methods are burdensome on nurses, and that there is a need for a clearer, simpler and more accurate system. Some suggested an all-Wales system may be required.

Some evidence suggested that nursing ratios should be prioritised as a performance measure, to be scrutinised at Chief Executive/Board level.

There is good evidence that Board level management can become disconnected from front-line service delivery and nursing ratios, (if properly implemented) could strengthen intra-organisational transparency. (MNS17 Hywel Dda Community Health Council)

The Health Boards/Nurse Directors' evidence stated that there is potential for safe staffing to become a Welsh Government tier 1 priority, which would support effective monitoring/reporting and could be implemented faster than legislation.

6. Should reports on staffing levels be publicly available?

Evidence broadly welcomed the publication of information on staffing levels, but there was a clear view that simply publishing numbers would not in itself aid public understanding, and there would be a need to ensure that the published data is meaningful and provides sufficient context/explanation.

The Chartered Society of Physiotherapy (CSP) were more sceptical:

Publishing staffing levels with an accompanying statement of an apparent 'safe' or 'minimum' level carries risk. The CSP does not consider it helpful to give the public the impression that a particular level equates to safe care as this is far too simplistic and does not take into account the wide range of factors that should be considered when determining 'safe', 'effective' care. (MNS18 CSP)

The Nurse Directors, Hywel Dda and Betsi Cadwaladr Health Boards suggested that, rather than blanket publishing of numbers, information relating to occasions where safe staffing might have been compromised, and the associated outcome, may be of greater value.

There was some support for information to be published in a number of different ways, for example from noticeboard displays at ward level to more detailed information being included in Health Board annual reports.

7. What action should be taken to address non-compliance with minimum nurse staffing requirements – are the existing monitoring/intervention processes appropriate?

Some evidence suggested that existing processes may be inadequate or inappropriate for the purposes of the bill, and there was a clear view that Health Boards should be held more accountable for safe staffing. The complexity of this issue was highlighted by some respondents.

This is a very complex area to achieve. If there is a deliberate intention for any health Board to not prioritise safe staffing then appropriate action and sanctions should be applied, if this area was a Tier 1 target then this might be possible. (...) What would be more meaningful is the need for assurance that Health Boards are considering ways to ensure that safety is a priority at all times. (MNS9 Hywel Dda University Health Board)

A range of interventions were suggested in evidence, including financial penalties. Some evidence emphasised the focus of any action taken should be on improvement, rather than punishment.

It was suggested that some kind of robust, national policing or compliance control may be needed, and that there may be a significant cost associated with this.

It was also noted that tolerances should be built in to the ratios, as there would inevitably be times that, despite best efforts, minimum levels may not be met.

8. Should there be a requirement in the legislation for protected time for staff training and development to be built into nurse staffing ratios?

A key theme in responses was the importance of education and continuing professional development. The Chartered Society of Physiotherapy echoed this, but

had concern about one health profession's training being protected but not another's.

It was noted that lifelong learning is a professional requirement for nurses, but that this wasn't necessarily facilitated by the NHS. Evidence described how staff are often unable to be released for training (even where this is compulsory training) because of low staffing levels. Some respondents described a significant element of good will, and report staff attending training during their days off.

Some evidence specified that the proposed legislation should ensure protected time off for staff training and development. There was a concern that, without this protection, adhering to required minimum levels could make it even more difficult for staff to be released.

It was noted that a requirement for protected time for staff training and development may carry an additional and significant cost.

The Nurse Directors/Health Boards refer to the soon-to-be-introduced system of revalidation for nurses which, they suggested, would support continuing professional development and drive this agenda forward.

9. Are existing provisions for NHS staff and patients to raise concerns about the NHS in Wales sufficient? If not, please provide further detail.

10. Are there specific protections that should be included within this Bill?

A small number of respondents suggested that existing provisions for staff and or patients to raise concerns are not sufficient, or may be too complex and act as a deterrent. The Royal College of Nursing (RCN) indicated that some of its members had been actively discouraged from raising concerns about unsafe staffing.

There was a broader view that the correct mechanisms exist, but that there may be a wider cultural problem in that staff don't feel supported to raise concerns, that they may be fearful of repercussions, and that complaints/concerns may not receive appropriate priority – some evidence describes lengthy delays in Health Boards responding to complaints for example. It was suggested that supporting people to use the current mechanisms would be preferable to further mechanisms being developed.

The All Wales Senior Nurse Advisory Group (AWSNAG) for Mental Health Nursing suggested that the remit of health watchdogs/inspectionates could be strengthened in relation to safe staffing.

A small number of responses suggested that the bill should include specific protection for staff and patients in raising concerns.

11. How, and at what point, should the impact of this legislation be evaluated?

There was no real consensus in evidence as to an appropriate timescale for evaluation, although there was a view that monitoring should be ongoing, with more formal evaluation at particular points (the most common suggestions here were every six months, annually or within five years).

Unison Cymru suggested that the impact of the bill should be evaluated twice a year – once during summer and once during the winter period – to take account of the impact of seasonal pressures on staffing requirements.

Cwm Taf University Health Board highlighted that, as the issues involved are complex, evaluation is likely to be a protracted process.

Similar to question 14 (what factors should be measured to determine the cost-benefit analysis of this legislation), a range of indicators were suggested including:

- length of stay;
- number of adverse incidents;
- complaints;
- patient satisfaction;
- staff satisfaction;
- staff sickness absence (particularly for conditions such as work-related stress);
- HIW inspections;
- Number of ‘rule 28s’ (this involves cases where coroners are required to report circumstances in which further deaths could occur if action is not taken to prevent them).

12. What unintended consequences could arise as a result of this legislation and what steps could be taken to deal with these consequences?

The main concerns here related to a) diversion of resources from other areas, b) issues around flexibility and c) the potential impact on workforce.

A significant concern was that, were minimum staffing levels to be mandated in certain areas, this could result in resources being diverted away from other 'unprotected' environments to meet the staffing levels required by the legislation.

There was a concern that other staff groups/professions may be adversely affected if the NHS has to put additional resource into the nursing workforce in order to meet legal requirements.

The potential danger of some services being lost (reduced or closed) if resources were diverted to meet legal requirements in nursing was highlighted.

There was some concern about minimum levels being 'misinterpreted' as a marker of safe staffing, and that the minimum could become the target rather than the baseline. It was again emphasised that there must be flexibility to increase capacity where the need arises.

There was also a concern that the legislation could become outdated, and would not keep pace with changing models of health and social care.

Evidence highlighted a concern about workforce, and whether sufficient numbers of nurses were being trained to meet future requirements. It was suggested there may be a need for a recruitment and training expansion.

There was a related concern that the bill would result in a significant increase in the use of temporary (agency/bank) staff, particularly in the short term.

Some evidence emphasised the need to protect working hours, i.e. nursing staff must not be required to work additional or longer shifts to meet the requirements.

It was also highlighted that the bill must ensure staff have time to nurse patients – not take on board other roles. 'Generally nurses just want to nurse patients and have the freedom to do just that safely.' The Nurse Directors echoed this view, and described how a broadening of nurses roles could impact on direct clinical care.

The RCN made the point that Nurse Directors have a difficult role in balancing corporate and clinical governance responsibilities and must be supported. 'They

must never be made to compromise their professional judgment about safe staffing because of financial pressures within LHBs'.

The Nurse Directors' submission provided the following note of caution:

Careful consideration needs to be given to whether the actions to mitigate the unintended consequences then make the legislation so cumbersome as to negate the intention. Using other means of ensuring safe staffing levels are implemented falling short of using a legal instrument should be considered. (MNS18 Nurse Directors)

13. What would the impact or costs be in terms of: raising staffing levels; and additional administration and regulation as a result of this legislation and how can any impacts be mitigated?

Some evidence suggested that the costs associated with implementing the proposals are likely to be considerable, and will relate not just to increased expenditure on staffing but also monitoring, compliance and protected time for training if these proposals are taken forward as suggested in the consultation.

Evidence highlighted the difficulty in assessing what the likely costs would be, and suggested the need for a formal baseline analysis of current staffing levels.

There was some concern as to where the money would come from, and what services may be reduced or lost. Unison Cymru emphasised that this must not happen, and that increased expenditure on staffing should be seen as an investment in staff that will reap economic benefits in long term.

The RCN suggested that there may be significant resource already available in the system, including in relation to unfilled vacancies, use of agency/bank nurses, sickness absence, reduced litigation, and via realignment of clinical budgets.

There was some agreement that improved care, as a result of improved staffing levels, may result in cost savings but that these would only be realised in the longer term. It was also noted that expenditure on temporary (agency/bank) staff should reduce if the proposals are implemented.

14. What factors should be measured to determine the cost-benefit analysis of this legislation should it become law?

Similar to the response to question 11 (how, and at what point, should the impact of this legislation be evaluated?), a range of indicators were suggested including:

- mortality and morbidity rates;
- infection rates;
- length of stay;
- readmission rates;
- incident reporting;
- episodes of avoidable harm;
- Fundamentals of Care audit improvement;
- patient satisfaction/feedback;
- complaints;
- litigation;
- staff satisfaction;
- health and wellbeing of staff;
- staff retention.

The British Geriatrics Society described a lack of good quality economic evidence as to the cost/benefit of introducing such a measure.

What evidence exists suggests may be potential savings by reducing risk of adverse events but inconclusive. The BGS considers it a matter of urgency that robust economic research and analysis is undertaken to examine the costs and benefits associated with improved registered nurse staffing. (MNS12 British Geriatrics Society)

Second consultation on the draft Bill

A total of 27 written submissions were received from a range of stakeholders, many of whom had also responded to the first consultation. A full list of respondents is included as Annex B.

Support for the Bill

The vast majority of respondents welcomed the aims of the Bill and its changed focus to 'safe' rather than 'minimum' nurse staffing levels. There were some notes of caution or concerns around specific provisions. These are highlighted in the pages following, along with any suggested alterations to wording.

Only the Chartered Society of Physiotherapy were directly opposed to the introduction of a safe nurse staffing levels bill, for the reason that it 'does not address staffing in a multidisciplinary way'. A small number of responses (from three NHS organisations) questioned whether the Bill is the correct or only mechanism by which improved nurse staffing levels could be achieved.

Challenges

The main challenges to successful implementation of the Bill, as identified in responses, were cost, availability of nursing workforce and the unintended consequence of wards being closed in order to comply with required staffing levels.

The concern about ward closures was raised by a number of respondents (SNSL 6, 12, 16, 17, 22); this includes two of the Health Boards who responded to the consultation.

These Health Boards were also among those who raised concern about the financial implications. Betsi Cadwaladr University Health Board described the cost implications as 'potentially huge', highlighting legacy budgetary deficits which would need addressing, including to comply with the required protections for supernumerary status, headroom, cover for maternity leave and continuing professional development.

A number of respondents were concerned whether there would be a sufficient number of nurses to meet the demands of the Bill (SNSL 6, 12, 18, 21, 22, 27). A growing shortage of registered nurses, proportion of senior nursing staff at

retirement age, length of training time, and the practice of recruiting from overseas to fill gaps were highlighted. The potential impact on staffing in other areas was also mentioned. Care Forum Wales for example, stated that the Bill may result in increased movement of nurses from the independent sector, which would ‘exacerbate the current crisis in nursing homes’.

Comments on specific provisions

<p>2 Safe nurse staffing levels</p> <p>(1) In Part 1 of the National Health Service (Wales) Act 2006 (promotion and provision of the health service in Wales) after section 10 (provision of services otherwise than by Welsh Ministers) insert—</p> <p style="text-align: center;"><i>“Safe nurse staffing levels</i></p> <p>10A Duty to maintain safe nurse staffing levels</p> <p>(1) Each health service body in Wales must in exercising its functions –</p>	<p>The Socialist Health Association requests clarity on the application of the Bill to different settings, specifically whether the Bill applies to NHS facilities operating in Wales; all healthcare facilities (public and private) operating in Wales; or all healthcare services commissioned by NHS Wales, including from England.</p>
<p>(a) have regard to the importance of ensuring that nurses are deployed in sufficient numbers to enable the provision of safe nursing care, allowing time to care for patients sensitively, efficiently and effectively; and</p>	
<p>(b) take all reasonable steps to maintain minimum nurse : patient ratios and minimum nurse : healthcare support workers ratios in adult inpatient wards in acute hospitals (in accordance with guidance under this section).</p>	<p>There remained some concern over use of the word minimum. The Chartered Society of Physiotherapy stated that the words safe and minimum appear to be used interchangeably throughout the Bill ‘without clarity of intention’.</p> <p>It was suggested that the word ‘recommended’ be used instead of, or as well as ‘minimum’ (Professor</p>

	<p>Dame Clark). The RCN suggested that ‘safe nurse:patient ratios’ be used instead.</p> <p>The RCN also suggested the need to make it clear where nurse means registered nurse.</p> <p>Some evidence requested more clarification in the Bill as to what constitutes ‘reasonable steps’ (SNSL 25). The Royal College of Physicians suggested that the wording ‘all reasonable steps’ be changed to ‘all steps’ or ‘all possible steps’.</p> <p>The importance of appropriate skill mix was again emphasised, and the differentiation between nurse:patient and nurse:healthcare support worker ratios was welcomed. The importance of the role played by healthcare support workers in supporting nurses was highlighted; some evidence referred to examples of Health Boards downgrading support worker posts to pay for more registered nurses (SNSL 9).</p> <p>It was widely emphasised that setting staffing levels is only one element, and needs to be triangulated with use of acuity/workforce planning tools and professional judgment.</p>
<p>(2) In this section “health service body” has the same meaning as in section 7.</p>	
<p>(3) The Welsh Ministers may by regulations make provision for the duty under subsection (1)(b) to extend to additional settings within the National Health Service in Wales.</p>	<p>Some responses suggested that the Bill’s initial focus on adult acute settings was correct and evidence-based (SNSL 4, 19).</p> <p>The provision to extend to additional settings was generally welcomed, with community settings particularly highlighted. There was some concern that, as currently drafted, ‘additional settings within the National Health Service in Wales’ may not include care homes or other settings, such as people’s homes,</p>

	<p>where nursing care is provided.</p> <p>There was a suggestion that the Bill should include provision to extend to other healthcare professionals, as well as other settings (SNSL 14).</p>
<p>(4) The Welsh Ministers must issue guidance to health service bodies in Wales about compliance with the duty under subsection (1); and health service bodies must have regard to the guidance.</p>	
<p>(5) The guidance –</p>	
<p>(a) must specify methods by which health service bodies may comply with the duty under subsection (1) (including methods of the kinds described in subsection (6), to the extent that the Welsh Ministers consider it practicable;</p>	<p>The British Medical Association (BMA) suggested that the guidance may need to define what is meant by a ‘safe staffing level’, including reference to skill mix.</p> <p>The Royal College of Physicians supported the use of a ‘red flag’ system when assessing whether available nursing staff meet patients’ needs over a 24 hour period.</p>
<p>(b) must specify minimum recommended nurse : patient ratios for the purposes of subsection (1)(b) (which individual health service bodies may adjust so as to increase the minimum numbers of nurses for their hospitals);</p>	<p>See earlier comments under (1)(b)</p>
<p>(c) must specify minimum recommended nurse : healthcare support worker ratios for the purposes of subsection (1) (b) (which individual health service bodies may adjust so as to increase the minimum numbers of nurses for their hospitals);</p>	<p>See earlier comments under (1)(b)</p>

<p>(d) must define, or include provision to be used in defining, the terms used in subsection (1)(b);</p>	
<p>(e) must include provision for ensuring that the recommended minimum ratios are not applied as an upper limit in practice;</p>	<p>The potential for minimum ratios to be interpreted as a norm/target level was a significant concern raised by a number of respondents. The provision to ensure that this does not happen was welcomed, but there was some concern about how this would work in practice/how it would be monitored (SNSL 19).</p>
<p>(f) must be designed to ensure that the requirements of the duty under subsection (1) are met on a shift-by-shift basis;</p>	
<p>(g) must include provision about the publication to patients, to the extent that Welsh Ministers consider it appropriate, of the numbers, roles and responsibilities of nursing staff on duty; and</p>	<p>There was support for making staffing data publicly available, though no clear view as to the manner in which this should be done. The BMA is unconvinced that the current arrangements for recording, monitoring and reporting are adequate. Hywel Dda University Health Board raised a concern about data alone not providing an accurate picture, and this may undermine public confidence in a service.</p>
<p>(h) must include provision which in the opinion of the Welsh Ministers provides the protections mentioned in subsection (7).</p>	
<p>(6) The methods mentioned in subsection (5)(a) are methods that in the opinion of the Welsh Ministers –</p>	
<p>(a) involve the use of validated acuity tools and dependency workforce planning tools, which are capable of being applied to calculations by reference to individual nursing shifts;</p>	<p>Use of such tools was largely welcomed. Professor Dame Clark suggested that the word ‘dependency’ should be omitted, as this is often loosely used and not clearly understood. She also highlighted the need to include the concept/term ‘evidence-based’, and</p>

	suggests the phrase ‘evidence-based and validated workforce planning tools’ be used instead of acuity and dependency tools.
(b) allow for the exercise of professional judgement within the planning process;	This was highlighted as being of key importance in ensuring flexibility and an appropriate level of staffing in response to demands on a ward. There was some concern that the focus on/setting of minimum staffing levels may lower the value of or reduce recognition of professional judgment (SNSL 19, 20, 22).
(c) make provision for the required nursing skill-mix needed to reflect patient care needs and local contexts; and	There was a suggestion that greater clarity/definition is needed about what is meant by ‘local contexts’ (SNSL 21).
(d) reflect or apply standards, guidelines and national frameworks produced or adopted by professional nursing organisations.	
(7) The protections mentioned in subsection (5)(h) are protections for –	
(a) the supernumerary status of persons performing the functions of Lead Sister, Charge Nurse, Senior Midwife and Community Team Leader (or such offices as in the opinion of the Welsh Ministers have replaced any of those offices);	<p>This was welcomed, although Hywel Dda and Betsi Cadwaladr Health Boards highlighted this may involve a funding commitment. Hywel Dda’s preferred term would be ‘supervisory’. Whilst supporting the need for certain roles to be supernumerary, the Royal College of Physicians pointed out that these staff must still develop/maintain clinical skills, and there is a need to ensure that senior expertise is not lost from the clinical area. Other evidence (SNSL 27) also suggested that senior staff should still be able to provide assistance, for example, with wound dressings or drug rounds where needed.</p> <p>The RCN suggested that ‘Ward Sister’ would be more appropriate than ‘Lead Sister’, pointing out that Lead</p>

	<p>Sisters may not be ward-based, may cover a number of clinical areas and may already have supernumerary status.</p> <p>Other specific comments included:</p> <p>This should be extended to include newly appointed staff (SNSL 16, 17).</p> <p>The reference to Community Team Leader suggests that this Bill may currently apply to community settings and does not therefore aid clarity (SNSL 26).</p>
(b) induction periods for temporary or student staff;	<p>Montgomeryshire and Brecknock and Radnor Community Health Councils suggested this should also specify 'newly appointed staff'.</p>
(c) time to undertake or participate in continuing professional development, including mentorship and supervision roles; and	<p>There was broad support for this. Specific comments included:</p> <p>The Community Health Councils (CHCs) suggested this should also specify 'statutory/mandatory training'.</p> <p>Protected time for nurses to comply with the 'revalidation' process (being introduced by the Nursing and Midwifery Council) should be explicit in any legislation related to nurse staffing levels (SNSL 20).</p> <p>All frontline staff should receive mandatory human rights, dignified care and dementia care training (SNSL 11).</p>
(d) planned and unplanned leave.	<p>The Older People's Commissioner asked whether this would include suspended staff, as this would need to be taken into account when workforce/rota planning.</p>
(8) Before issuing guidance the Welsh Ministers must consult – (a) such persons as appear to them likely to be affected by the guidance;	<p>The Chartered Society of Physiotherapy suggested that the Bill's Explanatory Memorandum should set out in more detail with whom the Welsh Government will be required to consult, noting that other professions are</p>

<p>(b) such organisations as appear to them to represent the interests of persons likely to be affected by the guidance; and</p> <p>(c) such other persons as they consider appropriate.</p>	<p>likely to be affected by the legislation.</p>
<p>(9) The duty under subsection (1), and action to prevent recurrence of any failure to comply with it, must be monitored in accordance with any document issued by Welsh Ministers setting out processes in place to monitor progress (such as the NHS Delivery Framework); but this subsection is without prejudice to the health service bodies' responsibility for compliance.</p>	<p>Some responses suggested that this area may need to be strengthened, and that there is a lack of clarity as to how compliance will be measured and what action will be taken as a result.</p> <p>Montgomeryshire CHC proposed that hospitals failing to comply with the minimum nurse staffing levels should be publicly censured and given a precise timescale to demonstrate that they have successfully taken action to achieve and sustain safe nurse staffing levels.</p> <p>Brecknok and Radnor CHC proposed that non-compliance should attract a fine of at least £50,000, to be levied against the budget allocation for that body's executive director team/corporate board function.</p>
<p>(10) Each health service body in Wales must publish an annual report (whether or not as part of a wider report) which—</p> <p>(a) gives details of the methods by which the health service body has aimed to comply with its duty under subsection (1) in respect of that year;</p> <p>(b) gives details of the methods by which the health service body aims to comply with its duty under subsection (1) in respect of the following year;</p>	<p>There were fewer specific comments about this. It was highlighted that any such report must be accessible to and understandable by the wider public (SNSL 10).</p>

<p>(c) records the number of occasions on which the duty under subsection (1)(b) may have been contravened, and the action taken to prevent recurrence; and</p> <p>(d) includes a detailed plan to prevent recurrence of any other failure to comply with the duty under subsection (1) or to take account of guidance issued under subsection (5).”</p>	
<p>3 Review</p> <p>(1) The Welsh Ministers must review the operation and effectiveness of this Act.</p> <p>(2) The first review must be carried out as soon as practicable after the end of the period of one year beginning with the date on which this Act comes into force.</p> <p>(3) Subsequent reviews must be carried out at intervals of not more than 2 years.</p> <p>(4) A review must consider the extent to which this Act has achieved the purpose specified in section 1.</p>	<p>This was seen as essential by some. Montgomeryshire/Brecknock and Radnor CHCs suggested that more detail as to how such a review will be carried out is needed.</p>
<p>(5) The Welsh Ministers must publish a report of the results of each review which gives details of the impact of this Act; in particular, Welsh Ministers must include details of the impact on a range of matters which appear to the them to constitute indicators of safe nursing including –</p>	<p>This was welcomed by some. Specific comments included:</p> <p>Montgomeryshire/Brecknock and Radnor CHCs suggested that the wording should be amended to ‘including, but not exclusively’.</p> <p>The Older People’s Commissioner suggested that indicators linked to the amount of time protected for training and context of that training, also the number</p>

<ul style="list-style-type: none"> (a) mortality rates; (b) readmission rates; (c) hospital-acquired infections; (d) medication administration errors; (e) number and severity of falls; (f) patient and public satisfaction with services; (g) nursing overtime and sickness levels; (h) use of temporary nursing; and (i) number and cost of legal proceedings brought against the National Health Service in Wales. 	<p>and severity of pressure sores should also be included.</p> <p>Professor Dame Clark suggested that ‘temporary nursing’ is not the appropriate term, but that if it has to be used, ‘agency and bank nursing’ should be included in brackets afterwards.</p>
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Annex A: Responses received to the initial consultation on the proposed content of the Bill

- MNS1 F. Marsh (individual)
- MNS2 H.E. Burton (individual)
- MNS3 P. Murphy (individual)
- MNS4 L. Crowther (individual)
- MNS5 Dr D. Barton (individual)
- MNS6 J. Blake (individual)
- MNS7 anonymous (individual)
- MNS8 Unison Cymru
- MNS9 Hywel Dda University Health Board
- MNS10 All Wales Senior Nurse Advisory Group for Mental Health Nursing
- MNS11 Royal College of General Practitioners
- MNS12 British Geriatrics Society
- MNS13 Royal College Of Physicians
- MNS14 Cwm Taf University Health Board
- MNS15 G. Evans (individual)
- MNS16 J. Lewis (individual)
- MNS17 Hywel Dda Community Health Council
- MNS18 Nurse Directors Wales
- MNS19 Chartered Society of Physiotherapy
- MNS20 Betsi Cadwaladr University Health Board
- MNS21 additional response from British Geriatrics Society
- MNS22 Royal College of Nursing

MNS23 British Medical Association Wales

MNS24 A. Jamal (individual)

MNS25 North Wales Community Health Council

MNS26 Older People's Commissioner

MNS27 Welsh NHS Confederation

MNS28 Cwm Taf Community Health Council

MNS29 anonymous (individual)

Annex B: Responses received to the second consultation on the draft Bill

SNSL 1	H. Jones (individual)
SNSL 2	J. Ellis (individual)
SNSL 3	J. Underwood (individual)
SNSL 4	Professor Dame June Clark (individual)
SNSL 5	H. Burton (individual)
SNSL 6	J. Henry (individual)
SNSL 7	Diabetes National Specialist Advisory Group
SNSL 8	J. Collier (individual)
SNSL 9	UNISON Cymru
SNSL 10	Older People's Commissioner
SNSL 11	Age Cymru
SNSL 12	Hywel Dda University Health Board
SNSL 13	A. Rogers (individual)
SNSL 14	Socialist Health Association
SNSL15	Royal College of Physicians
SNSL16	Montgomeryshire Community Health Council
SNSL 17	Brecknock and Radnor Community Health Council
SNSL 18	Care Forum Wales
SNSL 19	Welsh NHS Confederation
SNSL 20	Velindre NHS Trust
SNSL 21	Chartered Society of Physiotherapy

- SNSL 22 Betsi Cadwaladr University Health Board
- SNSL 23 British Medical Association Cymru
- SNSL 24 A. Tanner (individual)
- SNSL 25 Royal College of Nursing
- SNSL 26 Abertawe Bro Morgannwg University Health Board
- SNSL 27 R. Mitchell (individual)