

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 Chartered Society of Physiotherapy – SNSL(Org) 01 /
Tystiolaeth gan Cymdeithas Siartredig Ffisiotherapi – SNSL(Org) 01



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Dear Committee Members

Re: Safe Nurse Staffing Levels (Wales) Bill – Briefing from the CSP to inform scrutiny of the member in charge of the Bill

Introduction

The Chartered Society of Physiotherapy (CSP) welcomes the opportunity to provide a briefing to inform the scrutiny of the member in charge of the Bill. The profession will also be providing a further written contribution in response to the committee's terms of reference.

As highlighted in our response to the member in charge of the Bill, the CSP and our members are wholly committed to supporting the drive to improve the quality of care and outcomes for patients, and understand the spirit of the proposed Bill. However, we cannot support an approach to legislation that does not address staffing in a multidisciplinary way, does not focus on quality outcomes for patients, and risks a focus on numbers of nurses in isolation from the plethora of other factors that impact on patient outcomes and benefit.

Comments from the CSP

1. The CSP notes that the Bill seeks to address the issue of 'minimum' staffing levels and has been renamed the 'Safe' Nurse Staffing Levels (Wales) Bill. Also, that the Bill includes specific provision that any ratio is upwardly

adjustable and must not be used as an upper limit by the health service body to which such a ratio applies. However, the profession considers that ambiguity still remains around the intended meaning of 'safe', with this exacerbating the risk that the legislation will be misinterpreted and misapplied.

This is heightened by the interchangeable use of both words within the Bill. 'Safe' and 'minimum' are used without clarity of intention. Safe is used as the heading for Section 2 and is used at Section 2 - insert Section 10a sub-section (1) paragraph (a). Minimum is used at Section 2 – insert Section 10A sub-section (1) paragraph (b), while Section 2 - insert Section 10A sub-section (5) paragraphs (b), (c) and (e) all refer to 'minimum ratios'. This latter term also leads to concern that a specific patient : nurse staff ratio will be defined, or be presumed to exist that can be applied to different patient care/service delivery contexts, regardless of variables relating to patient acuity, environment and wider staffing issues (including those relating to skill mix and the multi-disciplinary team).

2. The Society remains concerned that a 'minimum' staffing level does not necessarily mean a 'safe' staffing level. As there is no guarantee that implementing a set level of staffing achieves the delivery of safe care, there is a risk of the Bill misleading the public and failing to support a cohesive approach to staffing levels across services in ways that will contribute to safe and effective patient care. The CSP considers that any guidance from the Welsh Ministers should be fully transparent about the evidence-base for the positive correlation between staffing levels and quality of patient care.
3. The Society notes in the explanatory memorandum the assertion that the ratios should be maintained in adult in-patient wards in acute hospitals as this is where the majority of evidence exists. The profession wishes to reference very recent work undertaken by National Institute for Health and Care Excellence whose extensive review of the literature highlighted an explicit lack of evidence relating to nurse staffing levels linked to patient outcomes. (Detail in sections 2 and 3, document accessible via; <http://www.nice.org.uk/Guidance/SG1>)

The Society is also concerned about the transferability of the limited observational studies that exist from outside of the UK to requirements for Wales.

The CSP continues to question how it can be possible to provide an overarching minimum staffing level when the level of care required by individuals or groups of patients (e.g. within a particular patient group, stage of a care pathway, or a care environment) may vary from hour to hour, day to day or from week to week. The intended longer-term of the legislation in terms of the patient care settings to which it should apply is also unclear, with it only being indicated in Section 2 – insert Section 10A sub-section (1) paragraph (b) that it is intended to relate specifically to staffing levels in adult inpatient wards in acute hospitals.

Recognising the absence of robust evidence, the profession is further concerned about the suggestion of wider application of the minimum ratios to

other settings and circumstances. It is essential that consideration of staffing levels in any area of service delivery takes account of the multiple variables that impact on quality of patient care and outcomes. These variables relate to the three broad areas of patient acuity, service environment, and staffing factors (including those pertaining to skill mix and the integrated contributions of the multi-disciplinary team).

In addition, there is no reference to staffing levels that can help to ensure effective quality of care for patients. Wrapped up in the term 'effective', the profession would see care that is delivered with compassion, in partnership with patients to ensure that it is delivered in line with their individual needs and preferences, based on the best available evidence, and with due consideration to optimising outcomes for patients and optimising use of resources. This will include consideration of how staffing levels and configurations across the multi-disciplinary team can reduce individuals' need for hospital admission, their length of stay, and re-admission.

4. The CSP notes from the explanatory memorandum that the Bill seeks to address the risk that the legislation will have the consequence of service providers diverting resources from other areas and staffing groups in order to comply with mandated nurse staffing levels. However, given that section 2 – insert Section 10A sub-section (1) paragraph (a) relates only to nursing, the CSP considers there is still the risk that reductions will be made to staffing in other groups (such as Allied Health Professions (AHPs)), or that some services to patients will be terminated to meet the new, legally enforced nurse staffing levels requirements. The profession therefore remain strongly concerned that the legislation would have a perverse impact. The negative implications of the legislation could well be to reduce the safety, quality and effectiveness of care; lessen patient access to services that will have long-term benefits for their health and well-being; and compromise the delivery of cost-effective, affordable services in response to changing population and patient needs.

The CSP is convinced that the need for patients to have services that are 'safe' and 'effective' requires 'appropriate' levels of staffing across the whole workforce including medical, nursing, AHPs such as physiotherapy and others. Staffing levels of the other staff groups do impact on high quality patient care. Addressing staffing needs within one profession is therefore insufficient for safeguarding and optimising the effectiveness of care for patients in totality.

5. The CSP notes in Section 2 – insert Section 10A sub-section (6) paragraph (a) a reference to the use of validated workforce planning tools, which are capable of being applied to calculations by reference to individual nursing shifts. We would urge that a focus on nurse input and tasks risks compromising the required focus on patient outcomes and benefit. Furthermore, we are aware that the recent NICE work on safe staffing in acute wards in acute hospitals failed to identify robust evidence on the effectiveness of defined approaches or toolkits to determine nursing staff requirements and skill mix. The value of this requirement within the Bill is therefore questionable.

6. We would also urge that an appropriate distinction in terminology is achieved between use of staffing level ratios and workforce planning activities, when these obviously reflect different aspects of services in terms of resourcing, design and delivery. The use of terms interchangeably is likely to cause confusion.
7. The CSP notes in section 2 – insert Section 10A sub section (6) paragraph (c) a reference to provision for the required nursing skill mix needed to reflect patient care needs and local circumstances. Greater clarity and definition is needed on what constitutes ‘local circumstances’ and a greater emphasis on ensuring that expectations reflect the significance of local factors relating to patient acuity, service environment and wider staffing issues.
8. The CSP welcomes, in section 2 – insert Section 10A sub-section (7) paragraph (c) the reference to time to undertake or participate in continuing professional development, including mentorship and supervision roles. However, once again, the CSP highlights that it is essential that these needs are recognised across the whole workforce, including for AHPs and support workers, with the risks of a focus on nurse staffing requirements mitigated.
9. The “range of matters” in section 3 sub-section (5) paragraphs (a) to (i) are noted to primarily relate to failures of care rather than positive aspects of quality of care and patient outcomes and as previously highlighted the evidence base for monitoring and reporting such elements requires further consideration.

Concluding comments

In conclusion, whilst supporting attention to enhance the quality of care and outcomes for patients, the CSP considers a more rounded and multi-factorial method is necessary to achieve safe and effective care delivered by appropriate staffing. The Society continues to hold the view that a number or ratio is not an indicator of good quality care delivered with compassion.

The profession is content for this evidence to be made available publicly.

About the CSP and Physiotherapy

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK’s 52,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,300 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self-management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways. With a focus on quality and productivity, physiotherapy puts meeting patient and population needs, optimising clinical outcomes and the patient experience at the centre of all it does.