Health (Tobacco, Nicotine etc. and Care)(Scotland) Bill

North Ayrshire Health & Social Care Partnership

NVPs AND SMOKING IN HOSPITAL GROUNDS

1. Do you support the Bill’s provisions in relation to NVPs?

NAHSCP and NHSAA are fully supportive of this measure – cigarettes and NVPs are not sold on NHS Ayrshire & Arran premises regardless of age of staff or in vending machines. North Ayrshire Council’s Policy on smoking expresses concerns that e-cigarettes will potentially undermine the ban on smoking in public places, therefore, the council has decided that e-cigarettes and NVPs will be subject to the same restrictions as tobacco based products.

2. Do you support the proposal to ban smoking in hospital grounds?

NHS Ayrshire and Arran have banned smoking on hospital grounds other than in the mental health in-patient setting where there are gazebo type smoking shelters for in-patient’s use in designated areas. Under current legislation such areas are currently exempt although there is an aspiration in NHS Ayrshire and Arran for mental health in-patient hospitals to move to being smoke free as of 2016 and there is a specific working group already in place supporting this.

In Arrol Park, one outside gazebo is available but it is only used in exceptional circumstances, e.g., someone under constant observation or at risk of absconding. Also if there was a safety risk e.g., too dark to go outside the grounds. Every individual who smokes is risk assessed and if the risk is minimal, they would smoke outside the grounds as everyone else on site is required to do.

Support measures to assist people to stop smoking are available and staff should be encouraged to utilise these if felt appropriate. These are referenced in the council’s policy on smoking and the council is prepared to be flexible in supporting staff to access these.

Members of the public are aware there is currently no legislation that allows for any charges/prosecution of individuals who continue to smoke in hospital grounds and the measure in this Bill would be welcomed.

Support via nicotine replacement therapy and smoking cessation advice is crucial in supporting individuals who smoke who are admitted to hospital and there must be pro-active and immediate support available 24/7 365 days a year to minimise discomfort/distress.

3. Is there anything you would add/remove/change in the Bill with regards to NVPs or smoking in hospital grounds?

It has been suggested a ‘distance from the building’ measure may be re-introduced for no smoking purposes, this would be viewed as a backwards step as it risks the focus on any measures to address smoking on NHS premises.
to become a matter of perspective of distance; it would be a more effective
classic action to enforce a total ban on NHS premises.

**DUTY OF CANDOUR AND WILFUL NEGLECT**

In our written response to the consultation, which ended in December, we expressed
a view that we were unconvinced that introducing a legislative duty was required. It
was, and remains our view, that our professions, within joint services, fully embrace
the duty of candour which is embedded in their current Codes of Conduct.

In addition, for nurses, midwives and medical staff the clear duty of candour has been re-emphasised by the publication of ‘Guidance on the Professional Duty of
Candour’, earlier this month (July 2015). The guidance was a joint MNC/GMC
publication with the support of the other professional regulators.

With regard to the explicit provisions, as laid out in the Bill, we have concerns over a
number of the requirements.

**Part 2: Section 21(4)**

There is no clarity around ‘A responsible person’ – additionally, if ‘a responsible
person’ was the clinician involved in an adverse event they must seek another
registered health professional to provide an opinion on harm (as laid out in Section
3). This seems to be at odds with the desired outcome that all professions exercise a
duty of candour, in that the decision on harm is being taken outwith their sphere of
influence/control. This is further complicated by the definition contained in section
25(a) to (f), where ‘a responsible person’ appears to mean an organisation.

We are unclear on the dichotomies in Section 21(1) a, b, c. The false subdivisions
‘health’, ‘care’ and ‘social services’ do not appear to take any cognisance of
integrated services, delivered within the Health and Social Care Partnerships. The
failure to place the legislation into a contemporary integrated services approach is a
recurrent theme.

Section 21 (2)(b) is of concern – effectively this puts a ‘registered health
professional’ as the arbiter of harm, no matter where or by whom care is being
delivered. Additionally this appears to consider the opinion of a registered health
profession to be of more value than that of a registered social care professional,
effectively healthcare professionals undertake the ‘policing’ role of all services,
including ‘care’ services.

Section 21(4) (d). The section does not appear to take due regard to contemporary
healthcare provision. In many areas across Scotland urgent and/or life saving care,
as laid out in (i) and (ii), is provided by healthcare professionals other than medical
practitioners e.g. Advanced Nurse Practitioners, Emergency Nurse Practitioners,
Paramedics etc. The requirement for intervention to be by a medical practitioner is
unnecessarily restrictive in its application, additionally if interpreted as written this
would mean, in the absence of a medical practitioner taking action then any harm
would be outwith the scope of the legislation.
Section 22 appears to be contrary to the requirements set out by the NMC/GMC in their guidance document or duty of candour, that the individual practitioner should have the duty of candour placed ‘personally’ upon them rather than on a separate ‘responsible person’. The introduction of a third person (the responsible person) appears to distance the individual from exercising the professional duty of candour.

Section 24(1) lacks synergy with the emerging integration of health and social care. The requirement to produce ‘end of financial year’ reports fails to take cognisance of the different financial reporting periods of health and local authority parent organisations. This will be additionally complicated for some organisations where all social work services are not included in their health and social care partnerships (e.g. where children’s services remain separate).

Section 24(5) and the additional requirements of 24 (6) and 24 (7) will create a ‘dis-integrated’ approach to reporting and service delivery. The outlined approach is directly contrary to the principles and ethos of the Public Bodies (Joint Working) (Scotland) Act 2014, which seeks to ensure joint seamless service provision rather than disjointed separation of both provision and reporting. These sections represent an unnecessary, non-value added bureaucracy.

Section 25(a) to (f) specifically excludes an ‘individual’ as being a ‘responsible person’; this seems contrary to the requirements early in the Bill (Section 22) which necessitates the actions of an individual.

**Part 3**

In general we are in agreement with the provisions set out in this section of the Bill however there may be unintended consequences of some aspects that would require clarification before fully endorsing the Bill provisions.

Section 27(1) (6), (3) (6) and 29(3) (6). The interpretation of these provisions has the potential to include staffing levels for wards and/or community teams, potentially nursing, care and/or residential homes.

An example might be where a mandated workforce tool notes the requirement for 30 nurses; however the ward has only been funded for 28 nurses on a continuous basis – assuming the workload tool is designed to ensure safe staffing levels, anything below this level would be considered unsafe and therefore ‘neglectful’. Would an organisation be in breach of “a relevant duty of care” given that the shortage of staff is of a chronic nature and therefore care is not being provided to the required standard (as determined by the workforce tool), or would there need to be evidence of a specific failure in care?

In addition, if there is found to be wilful neglect by reason of insufficient staff numbers who is to be held accountable for the neglect – in the case of the NHS is it the Chief Executive, the responsible Director or another e.g. the Senior Charge Nurse or Clinical Nurse Manager? The same question of responsibility is equally applicable in a nursing, care or residential home.
Part 3, Section 26(5) introduces the definition of adult services to mean services provided to a person aged 18 or over. As this is the only reference to age, we assume that the preceding section, under Part 3, apply to children and adults. It is our view that it is inconceivable to provide a lesser degree of protection to children than we afford to adults.

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