About Chest Heart & Stroke Scotland (CHSS)

CHSS provides a range of support services and advice to people living with heart and chest conditions, or living with the impact of a stroke. These include the provision of Stroke Nurses in 6 Health Boards, and Rehabilitation Support services where we work closely with Allied Health Professionals including speech and language therapists, physiotherapists, and occupational therapists. In addition, we provide training and on-line CPD resources to health professionals and social care staff.

Do you think the Bill will achieve its policy objectives?

1. We support the Bill's policy objective to strengthen workforce planning in order to ensure the provision of safe and high quality care and improved outcomes for service users. The inclusion of overarching guiding principles for health and care staffing and planning are welcome, particularly where they explicitly put service users at the centre.

2. There are clearly also other challenges though outwith the remit of the Bill, not least the ongoing difficulties in recruiting and retaining staff across both the health and social care sectors, which are likely to be exacerbated by Brexit.

3. With the survival rates for conditions such as heart attack and stroke continuing to improve, there are increasing numbers of people requiring long-term health services and care within their homes and communities. Combined with the trend towards increasing early discharge from hospitals, the pressure on these areas is growing.

4. Execution of the requirements of the Bill will therefore require flexibility if its policy objectives are to be met. The reference in the Policy Memorandum to the importance of facilitating multi-disciplinary and multi-agency working is particularly important, and we believe the shift in this direction is essential to providing person-centred care.

5. We have concerns too though that the Bill may inadvertently create barriers to this shift, as explained below.

What are the key strengths of:

Part 2 of the Bill (Staffing in the NHS)
6. Within the duty on Health Boards to follow common staffing methods, the inclusion of the requirement to take into account the needs of patients and their views is key if people are to be put at the centre of health and social care delivery. We note the intention that the legislation will enable development of further workforce planning tools.

**Part 3 of the Bill (Staffing in care services)**

7. We particularly welcome section 7 which requires care providers to ensure that their staff can undertake appropriate training for their work. Many people receiving care will be living with the effects of a stroke, or lung or heart disease, and it is important that the staff supporting them (most of whom will be non-specialists) understand the impact on the people they care for. This enables them to provide the best possible care, for example by understanding the sometimes ‘hidden’ disabilities after stroke such as cognitive or communication difficulties (aphasia).

8. CHSS is a key provider of free CPD online training for non-specialist health and social care staff including ‘STARS’ (Stroke Training and Awareness Resources), Heart-e (Heart Education Awareness Resource and Training through e-learning), and a new resource about lung conditions called Resp-e (to be launched later in this year). All the information provided is reliable, researched, best practice or evidence based, and the resources were developed in partnership with experts.

**What are the key weaknesses of:**

**Part 2 of the Bill (Staffing in the NHS)**

9. By putting the only existing common staffing methods on a statutory footing (ie those primarily for nurses), the legislation may inadvertently undermine the intentions of the guiding principles set out in Section 1. There remains the risk that maintaining numbers of specific workforce groups is prioritised, rather than identifying the right mix of professional skills which are needed. This could in turn reinforce the current emphasis on funding acute care at the expense of community care.

10. We note the Policy Memorandum’s statement that the legislation is not intended to set or prescribe minimum staffing levels, but instead support flexibility and the ability to re-design and innovate across multi-disciplinary settings. But the existing staff level tools and professional judgement tools which will now be prescribed by legislation took between 3-7 years to develop and implement. It will therefore be some considerable time before we see similar tools in place for the allied health professions for example – and in the meantime there remains the challenge of possible bias towards focusing on workforce numbers of nurses particularly.

11. Community healthcare and rehabilitation – where many AHPs operate – is likely to be a more complex area too for determining workforce tools. We know from people living with our conditions that there are already significant issues around accessing therapy,
with long waiting times, sometimes limited service, and lack of specialists. This lack of access is a health inequality issue – those who can afford it are often paying for private therapy to fill the gaps in NHS provision.

12. Treatment by physiotherapists, occupational therapists, and speech and language therapists, can be essential to the people we represent. The treatment they provide enables the best possible outcome for example for someone after a stroke hoping to make the fullest possible recovery, limit any lasting disability, and return to their lives. For people undertaking cardiac or pulmonary rehabilitation, access to physiotherapy is again an essential component of what are clinically proven to be highly effective programmes, and which reduce subsequent hospital admissions or GP visits.

Part 3 of the Bill

What differences might the Bill make? [eg unintended consequences, take account of integration, etc]

13. Whilst the Bill makes reference to taking into account patients' views, needs, and dignity, overall it is not clear how people are at the centre of the workforce planning. Instead, the Bill is largely about planning for specific groups of the NHS and care workforce, which as described above may be to the detriment of the care that people need given the multi-disciplinary reality of their support requirements.

14. The Policy Memorandum makes brief reference to the Bill complying with human rights and supporting a rights-based approach, but it has clearly not been built around the premise of the right to health.