HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM MARIE CURIE

Introduction

1. Marie Curie provides care and support for people living with a terminal illness and their families and carers. We provide support through our two hospices in Glasgow and Edinburgh, as well as our community nursing services across 31 local authority areas, and our volunteer led services. We also provide nationwide support through our information and support service including our national helpline. Last year we provided care for 8,601 people living with a terminal illness, as well as their families and carers across Scotland.

2. Marie Curie is partially funded by statutory partners. Our services are commissioned through health and social care partnerships and procured through NHS Boards. We currently employ around 200 registered nurses and 270 healthcare assistants across our hospices and nursing services, including health and personal care assistants working on our Fast Track services in Scotland. We also employ 20 allied health professionals including social workers, and 3 consultants across our hospices in Edinburgh and Glasgow. Our multidisciplinary team delivering care come from a range of different specialities and this includes, but is not limited to, clinicians, nurses, healthcare assistants, allied health professionals and social care workers.

3. We welcome the Health and Care (Staffing) (Scotland) Bill and the focus on improving outcomes for people. Our response to this consultation will relate to areas of interest to Marie Curie. We will also touch on concerns surrounding health and care staffing in Scotland and highlight work to address these to ensure a sustainable workforce capable of meeting future needs and outcomes.

Palliative Care and the future workforce

4. Palliative care is the type of care for people living with a terminal illness where a cure is no longer possible. The goal of palliative care is to help the patient and everyone affected by their illness to achieve the best quality of life. It aims to treat or manage pain and other physical symptoms and helps with psychological, social and spiritual needs.

5. 45,000 people who die each year would benefit from some form of palliative care. Yet a quarter of those people do not receive the care they need. The population in Scotland is ageing and with it more and more people will need palliative care and support services. By 2041, that could be another 6,000-7,000 people dying of terminal illness every year. We need to make sure these extra people are supported.
6. We welcome the Scottish Government’s vision in the Strategic Framework for Action on Palliative and End of Life Care that by 2021, everyone in Scotland who needs palliative care will have access to it. We also welcome the commitment in the Health and Social Care Delivery Plan that by 2021 the availability of care options will be improved by doubling the palliative and end of life provision in the community.

7. We support the development of the Health and Care (Staffing) (Scotland) Bill to help provide high quality care and improved outcomes, by helping to ensure appropriate staffing for health and care services. However, this alone will not solve the impending future demand crisis. Serious consideration also needs to be given to future-proofing the workforce to ensure that it can effectively care for the increasing number of people that will need palliative care. Palliative care should be prioritised when training new health and care staff, and careers within the community and social care setting are both valued and promoted as desirable workforce options.

**Policy objectives and guiding principles**

8. We welcome the policy objectives as set out in the policy memorandum that accompanies the Bill. The development of this legislation shows a commitment to, and ambition for, getting staffing right in health and care settings in Scotland. We welcome the focus on using evidence-based approaches to inform decision making around staffing requirements and agree that this will form the basis to enable safe and high-quality care.

9. We agree that organisations need to have up-to-date information on the numbers of people they employ to carry out different tasks, what skills that workforce has, where there are gaps and what skills and staff will be needed to deliver future services and priorities. We further believe that these priorities need to look beyond organisational objectives and support the changing demographic in Scotland discussed above. With the shift of care from the acute to the community, the Bill should support consideration of service redesign and service delivery models within organisations. This has been outlined as one of the policy intentions of the Bill within the documentation.

10. However, we believe more needs to be done to facilitate and support this within statutory organisations. We advocate the need to undertake workforce planning as a whole system approach, rather than as individual organisations. It is becoming increasingly evident that people need the right staff with the right skills in the right place at the right time. That means that there needs to be multiple services and a mix of different types of people delivering it. Scotland needs individuals, communities, voluntary and statutory organisations, health and social care staff – and different levels of staff within that. We would like to see more emphasis on organisations to work together to ensure that people get the right support. Only then will we see improved outcomes for people. Currently health and social care integration is still in its infancy, but we have concerns around how effective this is currently working across the country.
11. We are encouraged that there is significant emphasis on service users’ health and care needs, but also cognisance of the need for professional judgement in relation to each service. We believe that a person-centred approach is vital in the design and delivery of health and care services and ensuring people receive the right care at the right time. We would further like to see more enabling, participatory and inclusionary language used within the Bill to reflect this. The Bill currently focuses on ‘taking account’ of views and needs, rather than engaging with people on their needs and views.

12. We also believe that professional judgement is key to the delivery of health and care service delivery. One size does not fit all, and we welcome the approach taken by the Bill to provide a statutory basis for the provision of staffing in health and social care, but not prescribe what that needs to look like for every service and every location. Local decision-making and flexibility are key, provided that these decisions are informed by those using and delivering services.

13. Ensuring staff safety and wellbeing is also paramount to ensuring that safe and high-quality care can be delivered. While the provisions in the Bill focus on an open and honest culture for all staff and provide a platform for people to raise concerns about staffing levels, we believe that further work is needed across the health and care sector to ensure that staff are valued, recognised, and have the time needed to provide care and support.

14. We do not feel that provision 1 (1) (b) (v) set out in the guiding principles for health and care staffing is the best way to ensure that this happens. Under current proposals, we recognise that there are duties for health boards to provide staff with information on the methodology used and to encourage staff to submit views on the use of the methodology. However, we believe that there should be mechanisms for a more proactive consultative process to consider health and care staff views on existing service provision and staffing levels, and that these views are used to inform the use of any staffing methodology. There can often also be a lack of understanding within organisations of the roles that people are undertaking and often unrealistic expectations over what frontline staff can do within given timeframes. This can lead to people not receiving the care and support that they need.

15. For example, nine out of ten paid carers report facing limited time for care visits, with almost half of carers reporting they worked longer than their contracted hours to allow them to support people properly. One out of five feel that they haven’t received adequate mandatory training, adding that many thought that cutbacks and intensifying workload are having a negative impact on the people they provide care for. We believe that the experiences of those delivering care and support should be integral to decisions around staffing. Staff views should inform any professional judgement in a locality.
16. Further, as an organisation that delivers health and care services, commissioned under the scope of the Bill through statutory organisations, we are open and transparent around the support we provide in each locality and service. However, we do not routinely share staff establishment tools with service users and we are unsure of the added value this would bring. It would be useful to see how the Scottish Government thinks this would work in practice.

Areas of consideration for palliative care services

17. Under the Health and Care (Staffing) (Scotland) Bill, our services are contained within the planning and securing the provision of health and care services from another person under a contract, agreement or arrangement. While the Bill does not directly apply duties to our hospices or nursing services, it is our understanding that the commissioning authority will have a duty to consider staffing arrangements in that service before commissioning services. We must therefore have regard to the guiding principles of the Bill and be able to demonstrate appropriate staffing arrangements in place to our commissioners.

18. Tools developed for NHS contexts can not necessarily be applied to other types of settings, such as hospices and our care at home services. We welcome the principles of the Bill that focus on service users’ health and care needs, but also contain recognition of the need for professional judgement in relation to each service. We expect to demonstrate to commissioning authorities that Marie Curie currently has a workforce staffing tool that is appropriate to the services that we deliver, which is reinforced through the professional judgement of our staff.

19. However, in relation to our hospices, we have concerns that the common staffing method and types of healthcare contained within that, under part 2 of the Bill, do not necessarily apply to the hospice setting. We have further concerns on how each commissioning authority may choose to interpret the common staffing method, and how that applies to hospices, differently in their areas. We do not expect to be subject to different staffing models depending on the location of our hospices. In relation to our nursing service, which would be described as a care at home service, we deliver services in 31 health and social care partnership areas. Again, we do not expect to be subject to different staffing models depending on commissioning area.

20. Our services are currently regulated by Healthcare Improvement Scotland and the Care Inspectorate. We are inspected against the Health and Social Care Standards. Domain 7, Workforce management and support, includes considerations of how we recruit and manage staff, including appropriate staffing levels, ensuring the skills mix match the services’ requirements, and consideration of resourcing and capacity constraints to ensure that safe, effective and person-centred care is at the core. We would expect satisfactory inspection reports to satisfy commissioner requirements over safe staffing
levels and skills within our services. We would like to see further consideration of this contained within guidance for statutory organisations, with links to regulatory frameworks and requirements on commissioned services. If there is to be consideration of developing specialist tools for palliative care services would be happy to work with Scottish Government to develop this guidance.

21. We also have concerns regarding the recruitment and retention of staff, as highlighted earlier in this response. Key factors relating to workforce can be outside of the control of NHS Boards and care providers. This can have negative impacts on health and care services, including organisations’ capacity to recruit to safe staffing levels, and can lead to supplementary and ancillary staffing. This can have negative implications on organisational resource, as this staffing increases the overall cost of a service.

22. This is clearly a complex issue and while it impacts on the effectiveness of the Bill, is not wholly within the Bill to solve. We believe that there needs to be serious consideration of future-proofing the workforce now to ensure that it can effectively care for the increasing number of people that will need palliative care. We believe this is particularly important in relation to social care staff. This needs to be regarded as part of a whole-system approach and needs to be considered within the scope of the Bill and its accompanying guidance, including the Bill’s financial memorandum. We believe the considerations need to include the following:
   - Mechanisms to promote and give value to health and social care roles and that staff that fulfil those roles.
   - Additional resources made available to organisations to enable them to invest in their workforce
   - A focus on developing new models of care that both deliver high quality and effective compassionate care for people and improve working conditions and support for staff
   - Sustainable five-year service level agreements and contracts between the third sector and statutory partners to allow organisations to develop robust services, including investing in staff and focusing on service delivery, and
   - Culture change, including public promotion of working in health and social care, including recognition and awareness of community care and the third sector role in delivering that care.