HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM Audit Scotland on behalf of the Auditor General for Scotland

1. The Auditor General welcomes the opportunity to provide the Health and Sport Committee with their views to support its scrutiny of the Health and Care (Staffing) (Scotland) Bill.

Background

2. The Auditor General published a report *NHS Workforce Planning, the clinical workforce in secondary care* in July 2017, available [here](#). This was the first part of a two-part audit on NHS workforce planning. It focused on overall workforce planning arrangements, in particular clinical staff working in secondary care, such as in hospitals. The 2017 report included findings and recommendations that are relevant to the Committee's consideration of the Health and Care (Staffing) (Scotland) Bill.

3. The report raised concerns about sustaining the current staffing levels in the NHS. Vacancies for certain consultant and nursing positions remain high and are proving difficult to fill. In addition, upcoming retirements risk increasing vacancy levels in parts of the NHS where the age profile of the staff is older. We found that while demand for health and social care is expected to rise, neither the Scottish Government or NHS boards had adequately projected how this will affect the skills and workforce numbers needed in the long term.

4. Our NHS workforce planning report made recommendations relating to the NHS workforce. It did not consider the wider workforce planning of the social care sector. The call for views seeks comment for Part 2 and Part 3 of the Bill. These cover staffing in the NHS and staffing in care services respectively. While some of the thematic comments in this response around supply and demand factors may equally apply to the care services workforce, our specific audit work related to the NHS workforce. As such, this response refers mainly to Part 2 of the Bill.

General comments

5. The NHS workforce planning report contained two recommendations that related directly to safe staffing levels:
   - The Scottish Government should demonstrate how policy initiatives, such as safe staffing levels and elective centres, are expected to affect staffing requirements in NHS boards
• NHS Boards should fully cost the workforce changes needed to meet policy directives, such as the shift to community-based care, proposed elective centres, safe staffing levels and more regional working.

6. These recommendations relate to how safe staffing policy may affect the required staffing levels and any additional costs incurred in meeting these. Part 2 of the bill does not refer to this specifically, but the Bill's Financial Memorandum anticipates no significant additional costs from the need to change staffing levels because of the Bill. It states there may be opportunities to reduce supplementary staffing costs through better use of existing staff resources (para 23). The Bill's Policy Memorandum states that the “Bill's provisions are not expected to have any additional financial impact on Health Boards, given the current requirement for Health Boards to apply current staffing tools when determining staffing requirements.” (para 171)

7. While we cannot know whether the Bill will increase or reduce the current staffing levels and costs at this stage, we note the following risks that the Bill could result in additional staffing costs:

• The Scottish Government and NHS Boards have already been looking to reduce supplementary staffing costs, but these costs continue to rise. As we reported, in December 2015, the Scottish Government launched the Managed Agency Staff Network (MASNet). It aimed to reduce agency spending and improve the arrangements NHS boards have for managing, monitoring and reviewing agency staff needs. Nursing agency costs have risen from £4.2 million in 2011/12 to £24.5 million in 2016/17, in real terms. Since our audit, the 2017/18 figures have been published showing nursing agency costs have fallen slightly to £23.6 million. Given there is a current requirement to apply staffing tools to determine numbers, it is unclear to what extent better use of existing staff resources will reduce these agency costs, or how this will be achieved.

• We highlight in our report that agency costs are putting pressure on NHS Boards' pay budgets and that workforce projections are not reflecting demand pressures. We also report NHS staff survey information which shows that around a third of staff surveyed felt there were not enough staff to do their job properly. Since then, in November 2017, the Scottish Government published its analysis of responses to the public consultation on safe staffing. Insufficient funding to cover any additional staffing requirements identified was the most frequently-commented on issue by some margin and was raised at discussion groups and by individual and organisational respondents.
Specific comments on Part 2 of the Bill

8. We welcome the overall intent of the Bill to explicitly set out the duty to ensure appropriate staffing levels. The Bill’s Policy Memorandum is clear that NHS Boards already have a responsibility to ensure appropriate staffing levels (para 44) and that the Bill is making this an explicit statutory duty. We would raise the following considerations for the Committee based on our audit of the NHS workforce.

The risk that increasing vacancies in the nursing and medical professions will affect service provision and agency costs

9. Section 121B sets out the duty to follow a common staffing method, using staffing level tools and professional judgement tools for certain types of healthcare. Section 121C within Part 2 of the Bill sets out the types of health care, locations and employees that the application of the common staffing method will apply to. This is exclusively nurses and midwives except for medical practitioners in emergency care provision.

10. The Bill notes that NHS Boards should take into account current staffing levels and vacancies. But it is unclear what measures NHS Boards should take, should vacancies continue to rise. Our 2017 report highlighted that increasing demand for services, paired with staff recruitment difficulties, risks increasing vacancies in the NHS. The National Health and Social Care workforce plan part 1 estimates that around 2,600 additional nurses and midwives will be needed by 2021/22 to meet demand. The plan acknowledges that between 2017 and 2020 the number of existing students entering the workforce will not be enough to meet demand. We reported that the estimate of the number of additional nurses and midwives needed by 2021/22 may be an underestimate. The Scottish Government has not fully incorporated future demand for healthcare and the impact of retirements from an ageing workforce.

11. The increase in demand or lack of nursing and medical workforce supply for types of health care specified in section 121C could result in increased vacancies. The Bill does not consider the impact of this or how a NHS Board should respond. If staffing levels were regarded unsafe, the NHS Board may choose to use agency staff, with an additional cost, or risk being unable to provide certain services to the public. It is unclear how the Bill may extend to other workforce groups, and how this will affect multi-professional workforce planning

12. The Bill only applies to a set number of types of health care and associated employees, namely those set out in Section 121C of the Bill. It
is not clear how this will affect the mix of skills and professions used in these areas to deliver healthcare.

13. Part of dealing with workload pressures is ensuring that the workforce has the correct balance (skills mix) between doctors, nurses and midwives and other healthcare professionals. There is a risk that NHS Boards and the Scottish Government will model their workforce to meet the requirements of the workforce tools and staff covered within the Bill, rather than looking to use the existing workforce differently. Alternatively, NHS Boards could skew staffing levels towards those covered by the Bill at the expense of other areas of clinical service.

14. We highlighted our 2017 report that while professions can demonstrate that they consider the mix of skills required within their own profession, recruitment decisions do not fully consider how different groups of staff will work together. The Bill's policy memorandum states that the legislation is not intended to set out or prescribe minimum staffing levels or fixed ratios. Instead it intends to support local decision-making, flexibility and the ability to redesign and innovate across multi-disciplinary and multi-agency settings. Workforce planning arrangements with NHS Boards will need to be sufficiently sophisticated and informed by detailed guidance to balance the need to comply with NHS workforce tools and methodology at the same time as reflecting a multi-disciplinary approach.

**Training and consultation of staff will need to be transparent and consistently applied**

15. Section 12ID of the Bill states that “every Health Board and the Agency must—

(a) encourage its employees to give views on its staffing arrangements for 10 the types of health care described in section 12IC

(b) take into account and use any such views it receives to identify best practice in relation to such staffing arrangements

16. Our NHS workforce planning report noted that only 56 per cent of respondents to the 2015 staff survey felt safe to speak up and challenge the way things are done if they have concerns about quality, negligence or wrongdoing by staff. The report stated that the scale of staff concerns raised could be underestimated if those who do not feel safe to speak up do not do so. The risk to the Bill is that should staff not feel supported to give their views, these views will not be offered by employees.

17. There is a risk that the time needed to train affected staff will put additional workload pressures on staff and services. The Bill’s Financial Memorandum details the training costs of implementing the Bill. Section
12ID of the Bill states that NHS Boards must ensure that those employees affected receive adequate time to use the common staffing method, and understand the results and processes.

18. While we have not audited the adequacy of the training costs themselves, we reported in 2017 that pressure from increasing workloads was affecting staff. Only one in three medical staff members said they could meet the conflicting demands on their time, and forty per cent of nurses and midwives responding to a Royal College of Nursing (RCN) survey said that the one thing they would ask for, for the future of nursing, would be time to care. In the absence of any additional funding for staffing, there is a risk that the Bill will place additional workload pressures on the workforce, with resultant impact on services.

**It is unclear how compliance with the Bill will be reported and monitored, and how patients will challenge staffing levels**

19. Section 12IE of the Bill states that annually every Health Board and the Agency must publish, and submit to the Scottish Ministers, information setting out how it has met the duties of the Health and Care (Staffing) (Scotland) Act 2019. It is up to the NHS Board or Agency to consider how to publish this information, for example in an annual report. The Scottish Government will need to consider what level of detail of disclosure is required, and what level of consistency between NHS Boards it expects.

20. It is unclear whether any in-year reporting within NHS Boards or to Scottish Government is required, and how NHS Boards and Agents will identify any breaches of safe staffing in a timely way. Should this information be available publicly, NHS Boards may need to consider what legal redress patients seen during periods of identified unsafe staffing levels have against the NHS Board.

**It is unclear where roles and responsibilities will lie as integration of health and social care continues**

21. Section 12IF of the Bill includes the need for Scottish Government to consult with both NHS Boards and integration authorities. Section 12IC of the Bill covers types of health care based both in hospitals and in the community. As reform in the NHS continues, the roles and responsibilities between NHS Boards and integration authorities continue to change. Linked to the consideration of sanctions is a consideration of upon whom any sanction should be levied. This may be particularly the case in areas such as community nursing. The Scottish Government will need to be clear who is ultimately responsible for failure to adhere to the requirements of the Bill and who will bear any ultimate cost and responsibility for this.
Other comments on the difference that the Bill might make

The Scottish Government will need to clarify what sanctions or otherwise will be levied on NHS Boards who do not meet the requirements of the Bill

22. Given the supply and demand pressures facing the NHS workforce outlined in our 2017 report, there is a risk that any heightened level of scrutiny of safe staffing levels will identify failures to meet the requirements of the Bill. Our NHS in Scotland publications, as well as recent section 22 reports have set out the financial constraints that also exist within the sector. It is unclear what sanctions would be applied to NHS Boards or others who fail to comply with the Bill. There is a risk that addition financial constraints caused through sanctions could have an impact on the provision of services or the ability of NHS Boards to achieve financial targets. Conversely, there is a risk that the failure to apply sufficient sanctions could impact on the effectiveness of the Bill to ensure safe staffing levels.

Future workforce planning tools could lead to additional costs and fragmented working

23. The common staffing method currently covers a limited number of types of health care and employees, covered by workforce planning tools. This could be extended in future to other groups as more workforce planning tools are developed. We state in our report that responsibility for workforce planning is confused. As the number of workforce planning tools covered by the legislation increases, alongside the continued reforms in integrated authorities and regional working, the workforce planning arrangements risk becoming further fragmented. The costs as outlined in the Bill's financial memorandum appear to relate to training and other costs associated with the initial proposed workforce streams. It is unclear what additional costs and workforce pressures could accompany the extension of the Bill to further parts of the NHS workforce.