HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM ROYAL COLLEGE OF OCCUPATIONAL THERAPISTS (RCOT)

The Royal College of Occupational Therapists (RCOT) is the professional body representing occupational therapists in the UK.

There are currently 2,253.4 WTE Occupational Therapists directly employed by NHS Scotland. They form part of an Allied Health Professional (AHP) cohort of 11,653 WTE which represents 8.3% of the NHS workforce. In addition occupational therapists work in social care and the third sector. The RCOT is a member of the Allied Health Professions Federation Scotland (AHPFS) and have contributed to the AHPFS submission.

Occupational therapists working as part of multi-disciplinary teams provide a unique and specialist role in patient care. All Occupational Therapists have dual physical and mental health training.

Given that occupational therapists represent significant staffing numbers across both health and social care and have a unique skill set and work experience the RCOT offers a uniquely informed perspective to any discussion covering patient care in a range of settings and have therefore also submitted our own response. It is the College’s view that any legislation which considers safe staffing in the NHS and social care workforce must take full account of occupational therapists and all other healthcare professionals who contribute towards patient safety and high quality care.

Do you think the Bill will achieve its policy objectives?

This is unlikely without policy amendments. The guiding principles and general duties to ensure appropriate staffing are general, wide ranging and open to subjective interpretation.

However, the inclusion of overarching guiding principles for health and care staffing in Part 1 are welcome as they represent an attempt to extend the scope of the Bill beyond the 11 specialty specific tools currently in use. Unfortunately, the Financial Memorandum states there will be no increase in funding to provide for the extension of tools and methodologies to other settings and professions beyond the initial work with care homes for adults.

RCOT believe the Bill’s provisions and principles must be backed up by the required levels of financial investment.

The Bill as it stands is an improvement on the proposals previously consulted on by the Scottish Government in April 2017. RCOT welcomes that the proposed legislation now covers both health and care services. Although the general duty now
extends beyond the original groups of nurses, doctors and midwives it is noticeable and disappointing that there are no explicit references to other staffing groups including AHPs on the face of the Bill.

RCOT propose that AHPs should be explicitly mentioned on the face of the Bill in a manner which highlights the importance of AHPs and Multi Disciplinary Teams (MDTs).

RCOT supports the stated aim of the Bill to provide “a statutory basis for the provision of appropriate staffing in both health and care service settings thereby enabling safe and high quality care and improved outcomes for services users” as set out in the Policy Memorandum. RCOT agrees with the Scottish Government’s aim that “the right staff, with the right skills are in the right place at the right time based on assessment of the workload required to provide care”.

RCOT accept that the link between safe and sustainable staffing levels and the delivery of high quality care is well established. We are also aware that the NHS and care providers face significant difficulties in recruiting and retaining staff and in allowing staff time to fulfil existing CPD requirements. These issues are not addressed in the Bill and its’ accompanying documents and there is no evidence presented that the Bill will deliver positive developments in these key areas.

We also remain unclear as to how the Scottish Government intends to monitor and assess whether or not services are “safe and high-Quality’. RCOT believe the Bill would benefit from additional clarification at Part 1 Section 2 (2) as to what constitutes ‘appropriate staffing arrangements’.

RCOT welcome Part 1 Section 1 (b) which proposes that staffing decisions should be arranged in a manner which should take account of the views of staff and service users, ensure the wellbeing of staff and be open with staff and service users about decisions on staffing. We welcome the Scottish Government’s intention that staff should feel safe to raise concerns about staffing levels.

RCOT welcomes that the provisions of the Bill will be applicable in both health and care services and that the Bill does not set out prescribed minimum staffing levels in particular settings. This acknowledges the importance of local decision making and of professional judgement. There is a danger that a tool based approach might be too inflexible for some services.

The Bill also fails to give due consideration to the different regulatory requirements for staff working in health and social care. AHPs in health or social care are regulated by HCPC while care staff are regulated by the SSSC , Social care services by the Care Inspectorate and health care services by HIS.

RCOT are deeply concerned at the partial manner in which the Scottish Government has developed the Bill to date. As a key professional workforce group, RCOT were not invited to take part in the Bill Reference Group. The membership of the Group
included representative of doctors, nurses, midwives and latterly social care services. (reference FOI 02828). The RCOT feels that the lack of input from AHPs to the development of the Bill over the past eight months has contributed to draft legislation which fails to fully consider and reflect the multi disciplinary complexion of modern healthcare teams.

RCOT would want to see the College and other AHP professional bodies represented on any Bill Reference Groups, or similar bodies, which might be set up in future to support and advise the Scottish Government in the drafting of legislation which directly affects our members. Such explicit engagement and representation would ensure that legislation and underpinning policy are consistent with the current operation of the integrated health and social care landscape and its development.

There are a number of points in the Bill where consultation with trades unions and professional bodies is proposed. In the interest of transparency RCOT would prefer to see the names of the relevant bodies to be consulted set out in an annex to the Bill.

What are the key strengths?

Part 2 of the Bill (Staffing in the NHS)

Key strengths are the explicit and specific duty in Part 2 Section 4 to ensure appropriate staffing levels.

Part 3 of the Bill (Staffing in Care Services)

RCOT supports the inclusion of care services in the Bill given the ongoing shift from acute to community based services and the integration of health and social care.

Key strengths are the explicit duty on care service providers to ensure appropriate staffing at Part 3 Section 6 and suggestions at 3.6 (2) of issues which should be taken into account in determining appropriate numbers.

We also welcome section 7 which requires care service providers to provide and support appropriate training for staff. A similar provision in Part 2 would be welcome.

Part 3 sets out an enhanced role for the Care Inspectorate in the development and recommendation of staffing methods. There is no corresponding role for HIS in Part 2. RCOT would ask the Committee to consider whether this approach might be appropriate.

What are the key weaknesses of;

Part 2 (Staffing in the NHS)
RCOT remains concerned that Part 2 of the Bill, puts existing common staffing tools on a statutory footing but doesn’t set early targets for the delivery of MDT tools. There is a risk that maintaining numbers of specific workforce groups may be seen as an easier, default position rather than identifying the correct workforce skill mix required for an effective, safe service. The Bill reflects current practice and continues to focus on a duty to follow a common staffing method based, at this stage, on an existing narrow range of workforce tools designed primarily for nursing and midwifery services by the Nursing and Midwifery Workload and Workforce Planning Programme. This leaves other professional groups, including AHP, unable to contribute to the full workforce picture, which would validate any data obtained.

Modern healthcare is delivered by a wide cohort of skilled professionals in a multi disciplinary team including Allied Health Professions (AHPs) who are the third largest staffing grouping in NHS Scotland. As the Bill stands it does not reflect this large and skilled workforce and developments in service delivery. One example of the changing models in health care is in NHS Grampian where a consultant occupational therapist is now providing clinical leadership on both stroke rehabilitation units as the lead for the Stroke Managed Clinical Network. Another is in NHS Ayrshire & Arran where a pilot in the Elderly Rehabilitation Ward to explore whether an AHP led pathway with an occupational therapist could reduce length of stay, improve patient function and increase patients and families in decisions about their care has led to a permanent appointment of an AHP Consultant.

The RCOT asserts that the development of effective staffing tools which reflect the workloads of AHPs will prove challenging. The current staffing level tools may be satisfactory for the measurement of staffing requirements in more task driven health and care services where the patient receives a specific procedure or input however it’s likely to prove more difficult in reflecting the staffing levels required to support non-linear health and care services such as enablement, self-management, risk assessment and harm prevention.

It is interesting to note that in June 2015, NICE was asked to suspend it’s research on safe staffing levels as the work would be taken forward by the newly formed NHS improvement, in conjunction with NHS England. These challenges are notable in terms of community healthcare and rehabilitation but there are also difficulties in fitting occupational therapy into existing tools in acute services as well. Occupational therapists often cover several wards and much of their workload is not patient facing as it involves linking with other agencies, for example, to ensure arrangements are in place to allow successful patient discharge. There is a danger that the complexity which arises in occupational therapy due to context and tailoring services to a high degree of individualisation and adaptation on an ongoing basis may not be captured easily by existing tools and may, as a result, lead to the incorrect skills and staff mix being assigned to situations where therapists are required in greater numbers.
The Bill’s provisions do not support the ongoing development of the MDT. In Part 2 (section 4(2)) with reference to the common staffing method table the staff mentioned explicitly are (a) registered nurse, (b) registered midwives and (c) medical practitioners and “includes other persons providing care for patients and acting under the supervision of, or discharging duties delegated to the person by registered nurses, registered midwives, of medical practitioner (as the case may be)”. AHPs work in all of the 11 types of healthcare listed. This drafting does not reflect the reality of multi-disciplinary working and decision making in modern healthcare teams. AHPs are autonomous professionals who do not act under the supervision or delegation of duties by other healthcare professionals. In modern health care AHPS are often leaders making a huge contribution to patient care and being innovative in modernising healthcare. RCOT wish to see that reality reflected in the Bill.

It will take a minimum of 5 years to develop robust, reliable Multi-disciplinary tools. There is a risk that the legislation’s incremental approach might also limit aspiration and modern service development given the length of time required to develop new workforce tools, the level of funding made available to do so and the continued focus on nursing, midwifery and medical staff rather than the multi disciplinary nature of modern health and social care. This might mean that it is more difficult to implement transformational change in health and social care and that this basis of workforce planning constrains rather than supports service redesign. It is also important to consider the valuable contribution to the workforce of non-professional staff – occupational therapist work with support workers to great effect with appropriate delegation to build the workforce and improve service delivery. The Bill will not achieve the policy objective of a multi disciplinary team approach without much more explicit direction on the face of the Bill and a much accelerated timetable for the development, delivery and deployment of MDT tools.

RCOT also note the Part 2 Section 4 (2) 121D section outlining Training and consultation of staff. While we welcome the training and consultation of staff we are disappointed that this would only apply to the types of health care covered at 12IC i.e areas where workplace planning tools are already in place. It’s essential that other types of health care and the views of the wider MDT are listened to.

RCOT would wish to see

the inclusion of a guiding principle at 1 (1) (b) of the Bill which recognises the multi-disciplinary nature of service delivery and the principle of integration of health and social care services

amendments to Part 2 to reflect modern MDT working in health services

amendments to Part 2 to expand the types of health care beyond those covered with existing workforce tools

support for staff training similar to Section 7 in Part 3
As it stands the Bill says little about reporting or accountability. Part 2 Section 4 12IE proposes Health Boards and Common Services Agency should report to Scottish Ministers through their annual report. These provisions only cover the existing types of health care covered by the existing staffing workforce tools and don’t say anything about how Boards might assess and monitor their staffing performance. The Bill doesn’t contain any provisions for sanction.

RCOT would wish to see the inclusion of sections covering scrutiny and accountability as well as sanctions when required.

Part 3 of the Bill

Key weaknesses are that workforce planning tools will take several years to develop. It will take a minimum of 5 years to develop staffing methods for care home services for adults and potentially, other care services.

What differences might the Bill make?

It’s unclear how ‘safe and high-quality services’ are guaranteed by the Bill without further work on care assurance and while there are provisions on reporting there’s no details about any sanctions.

RCOT remains concerned that Part 2 of the Bill, puts existing common staffing tools on a statutory footing but doesn’t set early targets for the delivery of MDT tools. The Bill reflects current practice and continues to focus on a duty to follow a common staffing method based, at this stage, on an existing narrow range of workforce tools designed primarily for nursing and midwifery services by the Nursing and Midwifery Workload and Workforce Planning Programme. This leaves other professional groups, including AHPs, at a disadvantage. As a result, the Bill may be counter productive in moves to support and enhance MDT e.g GPs Contract if it fails to develop workforce tools capable of recognising and representing MDT.

RCOT are concerned that no increase in funding has been set out in the Financial Memorandum to provide for the extension of tools and methodologies to other settings and professions beyond the initial work with care homes for adults. Section 8 of the Financial memorandum states that “a focus has been given on how the Bill can be used to maximise the effectiveness of the resources that are currently available”. However Section 20 says the consequential impact of the legislation on staff numbers won’t be covered in detail as this would be dependent on Health Boards.