HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM NHS BORDERS

Do you think that the Bill will achieve its policy objectives?

Yes, but with some qualifications.

We welcome the fact that the Bill, if passed, would put the use of the workforce tools onto a legislative footing together with a requirement for the results to be acted upon. Our concern is with our ability to be able to run the tools frequently and effectively enough and with our capacity to respond to the outputs from a day to day perspective.

Achievement of policy objectives will be reliant on ensuring that the correct support is put in place locally to work with additional resource available within the national team to prepare for and implement requirements. The commitment to roll out workload tools in all of the Nursing & Midwifery areas, and in future across wider multi-disciplinary teams is significant and will require dedicated resource to co-ordinate.

The ability to use results from the tools to inform decisions on funded establishments is potentially very valuable as is the scope for ensuring consistency of approach across health boards when reviewing workload/workforce. There is a potential risk of it being too prescriptive unless we are clear that we are staffing wards “like for like” around the country.

The escalation process will be very important. We are supportive of such a process but it will have to be contextualised and measured in terms of what the criteria are for escalation and what that response is.

What are the key strengths of Part 2 of the Bill?

It clearly articulates responsibilities and expectations of health boards and agencies and creates a common process across Scotland.

There is a great opportunity for staff to be more widely engaged in reviewing safe staffing levels.

That there is a focus around patient safety and the need to ensure that we have taken the appropriate steps to ensure that the right level of staffing/skill mix is in place.

The professional advisory role of the senior nurse / Nurse Director is recognised in the common process. We believe this should be made clearer, especially in relation to organisation’s accountability for application of the legislation.

Nurse staffing budgets will be based on professionally agreed, risk assessed, prioritised processes taking account of the tools and the other factors in the triangulation “common process”. This may however lead to conflict between the professional view and operational requirements, Board priorities and available funding. Boards will therefore require to have management systems to ensure that service managers, senior operational managers, finance managers and directors are also familiar with the tools and the process.
Escalation is a good thing and it will be important to ensure that there is a well designed local arrangement in place as escalation through national scrutiny bodies on a day to day basis would potentially be detrimental.

Escalation from ward / department level has to be supportive and have the capacity to put in place remedial measures operationally in a timely, realistic and pragmatic way. Escalation from and to senior nurses / Nurse Directors may be more appropriately managed through scrutiny bodies with the remit to challenge the Board.

The Bill recognises that there is a requirement to review workload and available nursing and midwifery staffing resources daily at a ward / team level and to review the safety, quality and risk management at a hospital or community level. The policy memorandum refers to this as professional judgement. Some Health Boards, including NHS Borders do not currently have a professional judgement tool that operates on a day by day basis and tracks changes in patient acuity in real time so these would have to be acquired.

A key strength of the bill is that it does not impose minimum staffing levels and recognises that local context is a significant aspect to consider when reviewing results of the workload tools. The workload tools are based on an average ward within a particular specialty therefore local context and professional judgment are significant elements, particularly in district general hospitals where it’s not unusual for wards to have patients from a variety of specialties/multiple conditions.

The duty placed on Health Boards to ensure appropriate staffing, with appropriate levels of training, development and experience will support them to have flexibility to consider new roles, e.g. Band 4 Advanced Nurse Practitioners when rolling out workload tools.

The frequencies at which tools are expected to be used and reported on under the Bill will be helpful if they are reasonable and achievable, e.g. once or twice per year with flexibility to use the tools more locally if a service is going through service redesign to build trend data etc.

We welcome the encouragement to employees to give views on staffing arrangements, using the common staffing method. The Bill therefore recognises the importance of training and consultation with staff.

**What are the key strengths of Part 3 of the Bill?**

Staffing considerations will have an equal priority in the care sector, where in some instances there are currently financial priorities which can adversely impact on staffing.

Tools will be developed to support the care sector in setting realistic staffing levels to care for the patients and clients.

It is encouraging to see that the experience of developing Nursing and Midwifery tools and workforce planning methodologies will be built on with development of specific tools for the care sector, and that should bring a level of consistency in how establishments are developed across Health and Social Care.
What are the key weaknesses of Part 2 of the Bill?

The tools are almost exclusively nursing and midwifery focused (with the exception of the emergency care tool) yet the entire Multi Disciplinary Team impacts on the quality of care and the patient experience not nursing / midwifery alone.

The Bill relies on the extant NMWWP tools which could benefit from a refresh both in relation to the technical platform upon which they sit and the sensitivity to patient acuity (e.g. IV drugs and their incumbent work load) as opposed to patient dependency which the current adult in patient tool uses.

There is a lack of capacity within Boards to manage the common method for using the tools across their full range, to analyse the outputs and align them with the workforce and financial planning cycles. The capacity is also linked to the frequency with which tools will be used.

The Bill aims to achieve two different things using one set of tools. The common method describes a distinct process which uses the extant tools to do the finance and workforce planning for establishment setting on an annual basis. The day to day review of staffing requires a different approach to provide an assessment of the right number of nursing staff with the right knowledge, skills and experience, in the right place at the right time in real time. For this, an appropriate tool will be required to provide a twice (or three times) daily census of patient acuity to the available staffing determine the extent to which patient needs can be met and allow senior decision makers to deploy the resources to the optimum.

Tools which are used annually are not familiar to staff and may not deliver outputs at a time that is useful to the planning or financial cycle. Currently the Workforce and Finance planning cycles are not aligned therefore to achieve full benefit, it's important that the workforce plan is aligned to the financial planning cycle.

What are the key weaknesses of Part 3 of the Bill

The fact that the Bill has two parts to reflect the two different regulatory bodies means that it does not capitalise on integration between health and social care. There is an opportunity to look at staff education and training and an opportunity to enable skill mix and cross cover at times when staffing levels may be reduced in one area.

The current complete absence of tools for social care and the proposal to develop only one tool over the next 5 years will continue to give a silo type approach to staffing across health and social care. It would have been useful to see some encouragement to develop workload methodologies and tools that could be used across Health and Social Care to support the integration agenda.

Is there anything that you would change in the Bill?

Recognition of the importance of linking Health and Social Care Workload Tools, Methodologies and Reporting.

Recognition of the need to synchronise planning cycles.
What differences, not covered above, might the Bill make? (for example: will the Bill have any unintended consequences, will it ensure that staffing levels are safe, does the Bill take account of health and social care integration, how are 'safe and high-quality services' assured/guaranteed by the Bill?)

Non nursing staff groups might feel that their contribution is not appropriately recognised, for example AHPs. The potential for resources to be diverted to nursing and midwifery to meet the mandatory requirement could be to the detriment of other professionals' contribution to the care of patients.

The arrangements for scrutiny and sanction are not clear in the Bill. The scrutiny of application should be independent to the bodies charged with developing the tools (HIS and the Care Inspectorate). It is important that the sanction is proportionate, applied only where there is persistent, prolonged failure to act by a Board. The scrutiny and sanction arrangements should provide a first level opportunity for organisations to flag with the Scottish Government wider issues, such as supply or financial resources to engage the required level of staffing. This may be best reviewed by Audit Scotland.

There is a lot of work going on in Scotland to develop new roles, to encourage modern apprenticeships and other access to employment. The tools do not currently lend themselves to embracing these roles which do not make a full contribution during training periods. This may be an issue that could be picked up in the guidance.

The bill should lead to improved Nursing and Midwifery projections which would hopefully translate to improved predicted training numbers for universities and help address future recruitment issues.