HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM NHS WESTERN ISLES

Do you think the Bill will achieve its policy objectives?

Yes, in part.

Nursing staff already have a professional accountability to the Nursing and Midwifery Council (NMC) to raise and escalate concerns about patient safety or the level of care people are receiving but the Bill if passed will put the use of the workforce tools and the acknowledgement that the results need to be acted upon onto a legislative footing.

The concern that most Boards and management teams will have is the capacity and the ability to be able to run the tools frequently and effectively and then to be able to respond not only to the outputs from the tools being run but from a day to day perspective. Care, demands are dynamic, and sometimes unpredictable, can any tool be real time in response to need changing hour by hour.

The recruitment to Project Advisor posts is welcomed but it is essential that the Board Nurse Directors have access to this resource rather than creating a central team.

When developing guidance to support the Bill there will need to be clear information for Boards on how compliance will be monitored / measured. The escalation process will also be very important. We are supportive that there needs to be such a process but it will be important that this is contextualised and measured in terms of what the criteria are for escalation and what that response is.

In the absence of an appropriate tool to provide reliable baseline data it is difficult to see how a credible consensus on staffing numbers could be derived, so including specialities where this is the case in the legislation will not provide any greater protection than already exists. Similarly the existing Staffing Tools are inappropriate for use within small Hospitals. The low staffing numbers involved and the variation in configuration of the nursing areas provides challenges for the application of the standardised Staffing Tools, even when using a “small Hospital” model.

The Bill anticipates no increase in costs. There are potential costs if Health Boards are required to use agency to cover vacant posts or other staffing requirements, particularly at very short notice.
**What are the key strengths of Part 2 of the Bill?:**

It clearly articulates responsibilities and expectations of health boards / agencies and creates a “common method” across Scotland.

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

The ability to look at the roles that others e.g. Allied Healthcare Professional's and skill mix play in ensuring safe and effective patient care, although the tools do not currently take other roles (except the Emergency Department tool) into account therefore it will be difficult to be consistent in the approach taken across Scotland in the extent of the contribution attributed to other roles. This will hopefully be considered in terms of future iterations of workforce tools for other professional groups.

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 to meet the needs of patient acuity or individual requirements.

The professional advisory role of the senior nurse / Nurse Director is recognised in the “common method”; however this needs to be made clearer, especially in relation to organisations accountability in the application of the legislation. The Executive Nurse Director should be the identified lead role for the provision of clinical advice to the process.

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 of the “common method”. This may however lead to conflict between the professional view and the operational requirements / Board priorities / available funding. It will therefore be important that ‘others’ such as service managers and senior operational 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 this is a well designed local arrangement in place as escalation through national scrutiny bodies on a day to day basis would potentially be unrealistic, detrimental to effective delivery of care, and introduces an external stakeholder into the management of risk and accountability.

Escalation from ward / department level has to be supportive and organisations need to have the capacity in place to take remedial measures operationally in a timely, realistic and pragmatic way. The assurance / escalation from senior nurses / Nurse Directors may be more appropriately managed through governance groups with the remit to challenge on behalf of the Board, e.g. Board sub committees before escalation to the Healthcare Improvement Scotland or Scottish Government.
The legislation 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. It must be noted that the extant professional judgement tool does not operate on a day by day basis and does not track changes in patient acuity in real time. Organisations react and respond in real time to changes in patient need.

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

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

That tools will be developed to support the care sector in setting realistic staffing levels.

**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 delivery and quality of care and the patient experience not nursing / midwifery alone. Additionally the tools are viewed as a nursing and midwifery resource, there needs to be a shift in this to promote the tools as a management resource that can be utilised by service managers in relation to service redesign. The Bill, whilst making provision for both health and social care staffing and proposing tools specifically be developed for social care services, does not make provision for staff working across organisational boundaries where both groups of staff work in one multidisciplinary integrated team.

The Bill relies on the extant NMWWP tools which require to be refreshed and subject to a cycle of review on an ongoing basis. In particular the tools need to have functionality / be on a platform which allows modelling of proposed service changes. The Bill lacks clarity around how areas where tools are not yet available e.g. Community Mental health Teams or Community Midwifery/ Home birth services will be able to demonstrate compliance with the legislation.

The lack of capacity within Boards to manage the “common method” of use of the tools across the full range of tools and to align the outputs with the workforce and financial planning cycles with the current resources available to do the analysis required in this work. The capacity is also linked to the frequency with which tools are used. The common method and the current tools do not lend themselves to frequent review, the aspiration of an annual rolling process in each area should be the entry level, any more frequently will create a hefty workforce planning and analysis ask that is not currently resourced in Boards.
The Bill is trying to do two different things using one set of tools. The “common method” describes a distinct process which uses the extant tools to do the finance / workforce planning for the 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 and in response to the acuity of the patients.

Reliant on extant tools

- Those used annually are not familiar to staff
- Those used annually are not recognised as delivering outputs useful to the planning cycle (as may not be used / reported on at a time that feeds the planning or financial cycles)
- Some tools (Community, perioperative, ED) are extremely time consuming and staff are unwilling to participate

The perception of what is safe and what has been agreed may differ and we need to ensure that this doesn’t in turn become an area of tension between staff and managers. Whilst there are many operational policies the Bill could be clearer around organisational systems anticipated to support nurses to escalate concerns, i.e. clinical opinion as part of triangulation and professional judgement.

Bill as it stands does not offer the Executive Nurse Director as having the ultimate sign off for the nursing and midwifery staffing levels, this should be integral to the Bills provision.

The Bill does not place any duties for ministers to consider the supply and funding of the overall workforce. The Bill conflates two issues proposing that the legislation will address the shortfall in students becoming registered nurses and will reduce need for supplementary staffing. The legislation will not address the vacancy / sickness rates without significant investment in substantive staffing. The local context needs to be as flexible as possible. Health Boards with an older workforce may require to adjust the establishment calculations to take account of the actual contribution some staff make to the workload.

The Bill might increase the challenges for staffing between the NHS and the Care Home sector. With the impending pay awards for NHS Staff there may be an additional pressure brought to bear in relation to Care Homes being able to compete with the health service in terms of their ability to recruit staff and in turn provide safe and effective staffing levels. There is therefore a clear need for both health and social care colleagues to work together to look at options in relation to sustaining Care Home provision.
What are the key weaknesses of Part 3 of the Bill?:

Whilst it is recognised that the Bill is set out in two parts to reflect the two different regulatory bodies the Bill is not capitalising on integration between health and social care in blurring the staffing that may be deployed across the partnerships. By this we mean the opportunity to look at staff education and training and the opportunity for enabling 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 five years will continue to give a siloed approach to staffing across health and social care.

Important to be explicit how this will apply to private/third sector partners that provide health and social care.

Concern re expectations in relation to training staff for private/third sector, is the expectation to release staff practical/achievable?

Need to include potential for non traditional role development e.g. development of workers in relation to action 15 of Mental Health strategy. The roles are not 'professional' but will work across contexts e.g. primary care/prisoner healthcare.

What differences not covered above might the Bill make?

Other staff groups might feel that their contribution is not appropriately recognised.

The potential for resources to be diverted to nursing and midwifery to meet the mandatory requirement could be to the detriment of other professional’s contribution to the care of patients.

Increased competition for the available workforce across health and social care.

Consistent approach and ability to benchmark staffing levels across Scotland.

Opportunity to develop workforce planning capacity and skills in the nursing profession.

Engagement with staff and patients / families and carers around staffing levels.

The consequences on workforce requirements and the need for the Scottish Government to make provision to train more nurses and midwives.

The scrutiny and sanction is not clear in the Bill. The scrutiny of application must 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, prolonger 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, like 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 apprenticeship and other access to employment. The tools do not lend themselves to embracing these roles which do not make a full contribution during traini

The influence the Bill will place on Higher Education Institutes and Further Education Institutes, both in relation to the recruitment of students and to reduce the attrition rate, and the requirement to include workforce planning and an understanding of the safe staffing principles, legislation in pre registration curriculum is not insignificant.

The requirement to review / revise the predicted absence allowance and the consequential cost of implementing any increase.