HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM Dr Sarah Ramsay, Chair of the Scottish Board of the Royal College of Anaesthetists (RCoA), on behalf of the RCoA

About the RCoA

- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, the RCoA is the third largest Medical Royal College by UK membership
- The College represents 1,454 members in Scotland, including training grades, staff and associate specialty doctors and consultants
- Anaesthetists play a critical role in the care of two in three of all hospital patients and 99% of patients would recommend their hospital’s anaesthesia service to family and friends
- Sixteen per cent of all hospital consultants are anaesthetists, making anaesthesia the single largest hospital specialty in the UK.

General Comments

We welcome the opportunity to provide written views to the Committee and hope to be invited to participate in one of the stakeholder evidence sessions being held through September 2018.

Team working - In hospitals it is not individual staff groups that provide quality care, but it is well-staffed, well-functioning teams. Across the specialties of anaesthesia, intensive care and pain medicine, the membership of the RCoA work with many other health professionals to provide a safe and high-quality service. We rely on anaesthetic assistants and nurses, physician assistants (anaesthesia), recovery nurses, advanced critical care practitioners and specialist pain nurses in order to augment effective service delivery, as well as a host of other medical, nursing and allied health professionals and ancillary workers.

Cross-specialty working - The March 2016 ‘Trauma and Orthopaedics ACCESS Review: Addressing Core Capacity Everywhere in Scotland Sustainably’, demonstrated the benefits of – and we would suggest the need for - inclusive team working. For example, the report notes how full anaesthetic department input into pre-operative assessment processes has enabled an increase in the proportion of day of surgery admissions for patients having a hip or knee replacement. Between 2010 and 2015, the figure rose from 29% to 64% of patients, which reduces the burden on hospital capacity and helps patient flow associated with this relatively low risk procedure. Even greater gains are possible, with one Board having been able to admit 90% of patients on this pathway on the day of surgery.

Adequate staff resource - The last NHS Scotland Staff Survey, which reported in November 2015, found that 89% of staff were happy to go the ‘extra mile’ when required, but also found that only one-third of staff felt that there were enough staff to enable them to
do their job properly. As well as investing in training and recruiting new staff, being inventive and innovative in developing pathways of care that best utilise existing expertise is a key strategy to ensure that the objectives of this Bill can be met.

1. Do you think the Bill will achieve its policy objectives?

We are supportive of the policy objectives of the Bill and believe that the Bill can achieve these objectives where a common interpretation of the mechanisms to deliver them is in place. The Policy Memorandum that accompanies the Bill notes:

Whilst the focus of this legislation is about improving the provision of high quality care across health and care settings, it will not be prescriptive or restrictive in terms of detailing specific methodologies and practices…

Though we agree that a ‘restrictive’ approach would not be beneficial, we believe that some level of prescription might be necessary to ensure that a measure of what constitutes safe staffing can be assessed against a defined benchmark and compared nationally to help facilitate best practise. Some sort of benchmarking should also support the production of unambiguous guidance on (a) what process (or processes) must be followed if staff feel they are working in an environment where staffing levels are unsafe and (b) where the responsibilities to raise, escalate and address concerns rests.

We want to note particular support for the objective to deliver multi-disciplinary and multi-agency working across a range of professionals and staff groups with the ongoing integration of health and social care. This objective is sensibly articulated in paragraph 110 of the accompanying Policy Memorandum, regarding the future development of staffing tools that take a more multi-disciplinary / multi-agency approach, rather than (just) applying to single staff groups.

Perhaps more than any other hospital specialty, anaesthesia relies on teamwork and collaboration, a reflection of working practise that embraces shared decision-making within a multi-disciplinary team. This is true when working with surgical colleagues to perform an operation or engaging with patients and carers to agree outcomes that are important.

A major new work stream for the RCoA has been the development of the perioperative care pathway, that both relies on the multi-disciplinary / multi-agency approach noted in the Policy Memorandum, and that closely aligns with the principles outlined in the Chief Medical Officer’s *Realistic Medicine* programme. Perioperative medicine places the patient at the heart of decisions about their care, which should be of consistently high quality, avoiding unnecessary and wasteful treatments, and supported by new research and innovations.

Perioperative care is not a new concept, nor is it a pitch to ‘re-invent the wheel’. Instead, it is about providing a smoother journey for patients from the moment surgery is considered through to a full recovery. Empowering patients to have greater ownership of their healthcare as a partner in making well-informed choices is central to the positive evolution of health services.
The ability of our membership to collaborate with other healthcare teams, and break down traditional ‘silos’ of patient care, has led to our close involvement with the NHS Scotland Elective Access Collaborative Programme. The RCoA has a seat on the Combined Action Group of this key project that aims to improve delivery and experience of elective care and improve waiting times performance.

**Comments on workforce, training and empowerment of staff**

**Workforce planning:**
Paragraph 6 of the Policy Memorandum that accompanies the Bill notes:

6. *The provisions in the Bill will enable further improvements in workforce planning…’*

However, we would suggest that rather than *enabling* further improvements, meeting the statutory requirements the Bill puts in place will *demand* further improvements in workforce planning and that the procedure for these improvements in not currently clear.

A July 2017 report from Audit Scotland, ‘NHS workforce planning: the clinical workforce in secondary care’, recommended that the government demonstrate how policy initiatives, such as safe staffing levels and elective centres, are expected to affect staffing requirement in NHS Boards. The same report also recommends that NHS Boards should fully cost the workforce changes needed to meet policy directives, such as safe staffing levels.

**Training and retention:**
The objectives of the Bill do not address the training needs of staff that are both influences on - and are influenced by - factors such as the placement of training grade staff and development of rotas and case lists.

The third report of the National Emergency Laparotomy Audit (NELA) highlighted that consultant anaesthetists and surgeons should direct patients requiring emergency bowel surgery and consultant presence also provides an opportunity for training junior doctors in the management of high-risk patients. The development of workforce plans must ensure the highest quality and safest standards of patient care and also enable training grade doctors to be able (and available) to learn from more experienced colleagues.

**Recruitment and retention of staff:**
Though it remains a serious issue in Scotland, indicators of poor welfare and low morale are less acute in Scotland compared to England. The College has recognised that initiatives developed in Scotland could support the development of best practise across the UK, including in the area of working patterns for doctors in training.

One of the initiatives that we would draw the Committee’s attention to is the Professional Compliance Analysis Tool (PCAT).
Developed by the Scottish Government’s Health Workforce and Strategic Change Directorate, in partnership with the RCoA Scottish Board, PCAT is currently being used to analyse and improve all anaesthetic rotas in Scotland. PCAT evaluates both the rota template and the supporting professional environment across three interdependent domains: patient safety, quality of training and health and wellbeing.

PCAT has been successfully implemented across Scotland via a number of different routes. Within respective specialties, both the RCoA\(^7\) and Royal College of Surgeons of Edinburgh\(^8\) have endorsed PCAT as a means of improving the health and wellbeing of doctors in training. A number of Health Boards including NHS Grampian, NHS Highland and NHS Ayrshire and Arran have also adopted PCAT and are delivering it through different methods including via Directors of Medical Education and through the allocation of Consultant session time to dedicated ‘Rota Champion’ roles.

**Empowering staff:**

Paragraph 7 of the Policy Memorandum accompanying the Bill states:

> 7. The provisions in the Bill will support an open and honest culture with the aim that all staff are engaged in relevant processes and informed about decisions relating to staffing requirements and feel safe to raise any concerns about staffing levels.

Paragraph 45 of the Policy Memorandum that accompanies the Bill also notes the lessons that need to be learnt from the Francis Report on care quality at Mid Staffordshire NHS Foundation Trust.\(^9\) The Francis Report shone a light on the danger of poor leadership and cost cutting at the expense of safe staffing levels, with tragic consequences for patient safety. We support the development of an environment in which individual members of staff feel empowered to raise any concerns about staffing levels. It is vital that individuals are not held accountable for the issues they identify if they result in patient harm.

The RCoA’s data\(^10\) show that 30% of anaesthetic departments in Scotland reported a gap in the consultant rota approximately once a week (this compares with 26% in England). Against this backdrop we would caution that individuals, hospital management, Boards and Integration Authorities guard against any ‘casualisation’ of rota gaps and a lack of appropriately trained staff, by ensuring that current levels of staffing are not considered the norm, or a benchmark for future designation of a ‘safe’ level of provision.

**Comments on integration of services and development of Integration Authorities**

The College is supportive of the government’s twin approach of ‘investment and reform’, and the principle of integrated health and care services that form the bedrock of this.

Paragraph 77 of the accompanying Policy Memorandum notes:

> 77. The Integration and Planning Principles in the Public Bodies (Joint Working) (Scotland) Act 2014 are the lens through which all integration activity should be focused to achieve the national health and wellbeing outcomes
However, the preceding paragraph (76) notes that ‘Integration Joint Boards (IJBS) are not currently employers themselves’ meaning that, in effect, the main vehicle through which the Act is currently – and will continue to be delivered – is distinct to its mandate. With particular reference to specialty staffing decisions, paragraph 114 of the Policy Memorandum notes:

114. To ensure that staff understand the staffing decisions made, Health Boards and, as appropriate, Integration Authorities will have to take account of staff views in relation to staffing and provide staff with information about the use of the methodology and staffing decisions reached [emphasis own]

There appears to be a gap between the responsibility of Integration Authorities ‘to take account of staff views in relation to staffing and provide staff with information…’ and the accountability of Integration Authorities who are not employers. By not being designated as the employer, the Integration Authority may be limited in its control over staffing decisions and, as an extension, may not be able to influence or implement decisions informed by staff views.

This is key, as one of main intentions of the Bill is to imbue professional judgement into decision-making. Any disconnect between the responsibility to take account of staff views and provide staff with relevant information and, on the other side, the limited control of staffing, appears to ask Integration Authorities to perform a role that they do not have full powers to undertake. How, in turn, this is compatible with the Integration planning principles in section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014 may warrant further scrutiny from the Committee.

2. What are the key strengths of:
   a. Part 2 of the Bill?
   b. Part 3 of the Bill?

3. What are the key weaknesses of:
   a. Part 2 of the Bill?
   b. Part 3 of the Bill?

Points in relation to Part 2 of the Bill are made above and it is for the Committee, with its scrutiny function and due diligence, to make a judgement as to whether these constitute strengths or weaknesses.

Regarding Part 3 of the Bill, our membership are chiefly secondary care professionals working in the hospital setting. However, the impact of under resourced social care services are felt by hospitals where delayed transfers of care (DToCs) place avoidable strain on hospital services and staff that may undermine optimal patient outcomes. A DToC

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* After the (Public Bodies (Joint Working) (Scotland) Act 2014) came into effect in April 2016, Audit Scotland noted that the governance arrangements for integration authorities can be complex and in several NHS board areas there are different reporting regimes in place.
describes a situation where a medically fit patient is unable to be discharged from hospital and can be particularly harmful to some of the most vulnerable groups of patients.

To ensure that patients are able to prepare for their operation and, subsequently, achieve optimal wellness during recovery and outcomes at discharge, available social care provision is vital. Proper provision of social care services is key to avoiding DToCs.

A joint-survey of 500 anaesthetic doctors, undertaken by the RCoA and the Alzheimer’s Society that reported in December 2017, explored the issue of DToCs experienced by vulnerable patients. Results from the survey found that more than nine out of 10 (96%) of anaesthetists and intensivists believed that a patient with dementia who remains in hospital due to a DToC would experience a worsening of their condition.

Often patients who access critical care services can also have significant social issues, either pre-existing or relating to the aftermath of their severe illness and require adequate care resources to help with their physical, mental and social recovery after discharge.

Similarly, for many patients with chronic pain issues, learning to live with their pain becomes an important coping strategy and adequate care resources are needed to allow the individual to maintain their contribution to society and, as much as possible, their quality of life.

4. **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’ assured/guaranteed by the Bill?)

A safe staffing level is not a numerical test and the welfare, morale and overall wellbeing of staff is a significant metric in adjudging in the threshold of properly staffed services.

A 2017 survey undertaken by the RCoA and the Association of Anaesthetists of Great Britain and Ireland (AAGBI), published in the journal *Anaesthesia*, demonstrates the impact that fatigue is having on anaesthetists in training in the UK.

Key findings from all 2,170 UK respondents (of which around 11% were based in Scotland) showed that:

- 75% of trainees drive to work and 84% of those have felt too tired to drive home after a night-shift
- More than half of respondents (57%) have had an accident or a near miss during their commute
- Less than two-thirds of respondents (64%) have access to rest facilities and 74% of respondents reported that fatigue has adversely affected their physical health.

A separate RCoA survey of 2,300 anaesthetists in training, exploring issues related to welfare and morale, found that 85% of anaesthetists in training across the UK were at risk of burn out (as measured on the Oldenburg Burnout Inventory).
Promoting staff welfare and resilience, and appropriate provision to accommodate the needs of those wishing to work less than full time and/or flexibly, are also core components of any planning which aims to ensure safe staffing levels. Workforce planning strategies must facilitate an appropriate number and mix of highly skilled staff, to sustain an NHS that is supportive and offers fulfilling employment.

The conclusions of Audit Scotland’s report ‘NHS in Scotland 2017’\textsuperscript{14} noted that:

\textit{Comprehensive workforce planning across all staffing groups is essential if the appropriate numbers of skilled staff are to be in the right place at the right time as services are provided in new ways. It has become significantly more complex to plan the health workforce due to the integration of health and social care, and regional and national planning arrangements. Integration authorities are now responsible for identifying their local workforce needs in primary and social care and working with NHS boards and local authorities to ensure this links to their respective workforce plans.}

Lastly, the impact of an ageing consultant population must be considered in any long-term workforce planning, to ensure safe staffing remains a sustainable objective.\textsuperscript{15} The common methodology to validate workforce planning should include a forecast of the impact of demographic change within an area’s workforce.

\textsuperscript{1} NHS Scotland (in association with the British Orthopaedic Association and Getting It Right First Time). \textit{Trauma and Orthopaedics ACCESS Review: Addressing Core Capacity Everywhere in Scotland Sustainably}. March 2016
\textsuperscript{5} Audit Scotland. \textit{NHS workforce planning: The clinical workforce in secondary care}. July 2017
\textsuperscript{6} National Emergency Laparotomy Audit. \textit{October 2017}. Accessed at \url{https://www.nela.org.uk/reports}
\textsuperscript{7} RCoA. \textit{A report on the welfare, morale and experiences of anaesthetists in training: the need to listen}. December 2017.
\textsuperscript{8} The Royal College of Surgeons of Edinburgh (RCS(Ed)). \textit{Improving the working environment for safe surgical care. A discussion paper from RCS(Ed)}. 2017.
\textsuperscript{10} Royal College of Anaesthetists. Medical workforce census 2015. Available at \url{https://www.rcoa.ac.uk/census2015}
\textsuperscript{11} Royal College of Anaesthetists. \textit{RCoA survey shows resources needed for vulnerable patients}. December 2017
\textsuperscript{12} McClelland, L et al. \textit{A national survey of the effects of fatigue on trainees in anaesthesia in the UK}. First published 5 Jul 2017
\textsuperscript{13} Campbell, D. \textit{Two-thirds of young hospital doctors under serious stress, survey reveals}. The Observer. 11 Feb 2017
\textsuperscript{14} Audit Scotland. \textit{NHS in Scotland 2017}. October 2017
\textsuperscript{15} Audit Scotland. \textit{NHS workforce planning: The clinical workforce in secondary care}. July 2017