HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM The Royal College of Speech & Language Therapists

Do you think the Bill will achieve its policy objectives?

The Bill aims to provide appropriate staffing levels across health and social care settings that will enable safety, quality of care and improved outcomes for patients. It aims to achieve this by delivering the right people, in the right location, at the right time.

RCSLT Scotland supports the general policy intention of the Bill and the use of evidence based tools to underpin decision making on staffing and agrees these can contribute to improved workforce planning and patient outcomes.

We are concerned however that workforce planning across the NHS has been challenging, evidenced across Scotland by recruitment and retention issues and that without improved workforce planning, particularly for Allied Health Professionals, the objectives are unlikely to be achieved.

We are specifically concerned with the proposal to create a list of approved and validated tools in primary legislation of unidisciplinary tools (applied to only one part of the health care workforce) as this is likely to be counter-productive to delivering ‘the right people’ who may or may not be nursing staff.

It is stated that the aim of the Bill is to extend tools to cover more healthcare professionals. The method of applying the ‘common staffing method’ – through a statutory list on the face of the Bill – is in our view likely to inhibit this development as it will create a starting point with a one dimensional view of patient safety. The proposal does not reflect the outcome of the consultation exercise which strongly supported the need for multi-disciplinary and multi-agency tools to be developed as a priority.

To remedy this and to create a truly ‘multidisciplinary’ approach we would call for the Bill to be amended to:

- Create a general presumption that quality and safety are best supported by a multi-disciplinary workforce (Part 1)
- A specified role for Healthcare Improvement Scotland, similar to that proposed for SCSWIS, in developing multi-disciplinary tools in health care settings (121B(3))
- Removing the list of validated tools from the common staffing method in favour of a list created using secondary legislation or guidance (121C(1))
- Guarantee that all future tools will be multi-disciplinary in nature (121F)
• Alter the references to employees covered to extend beyond those under the supervision of a registered nurse, registered midwife or medical practitioner to include other healthcare professionals (121C(2))

Amending the Bill to ensure that a multi-disciplinary approach is fundamental to workforce planning and safety will we believe secure the policy objectives.

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

RCSLT Scotland welcomes and supports the specific duty on health boards to ensure appropriate staffing. We also agree that the duty should apply to contracted services, for example GP’s, as this should support the development of community based services.

We support the use of a ‘common staffing method’. Staffing decisions must be a balance between tools, professional judgement and guidance.

Provisions for better information, accountability and training to implement the common staffing method are also supported.

We also welcome the duty on Ministers to consult on guidance including professional bodies.

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

As health care staff are often present in social care settings and patients are receiving more complex care in community based settings we support underpinning integrated health and social care services with better workforce planning.

The development and validation of tools is supported by the identification of a lead agency, in this case SCSWIS. It will be important for SCSWIS to be able to collaborate with Healthcare Improvement Scotland as tools are likely to affect health care professionals working in community settings and we support the proposal in the Bill to enable this.

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

The Bill aims to support consistency across health and social care but the mechanisms to develop staffing tools vary between parts 2 and 3. To achieve an evidence led approach we would suggest an equivalent role to that described for SCSWIS in part 3 be applied to a public body in part 2, for example Healthcare Improvement Scotland.

The creation of prescribed common staffing methods in121C puts unidisciplinary tools into primary legislation. This is detrimental to achieving a multi-disciplinary and multi-agency approach; a prescribed list of validated tools does not need to be in primary legislation and could be dealt with by secondary legislation. This would
reduce the emphasis on the particular tools in favour of the common staffing method itself and taking a wider view of patient safety.

The definitions of employees in 121C cover those providing care and acting under supervision of a registered nurse, registered midwife or medical practitioner. We are concerned that this will not cover Allied Health Professionals when it comes to developing multidisciplinary tools.

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

It should be noted that in obtaining views of service users in both parts 2 and 3 that many such people will be experiencing communication difficulties or impairment and that consulting bodies should be required to still obtain the views of people even when communication or use of verbal language is impaired. The Bill could be improved in this regard with a duty to support communication needs when carrying out consultation.

**What differences, not covered above, might the Bill make?**

We believe that there is a significant risk that multidisciplinary tools will fail to emerge. The Bill proposes putting unidisciplinary tools into primary legislation and creates the wrong context for viewing safety and quality as the responsibility of all relevant healthcare professionals.

The information provided in the financial memorandum details how tool development for the next 5 years is already planned and how it will take a minimum of 3 years to develop and validate new tools. If this is allowed to proceed it could be a decade before multidisciplinary tools are in use.

The policy notes claim that the Bill will support better workforce planning and the reduction in use of supplementary staffing (from agency and bank). This is a complex matter that presents a significant financial challenge to health boards and we are concerned that the evidence for the assertion that the Bill will contribute to reducing the use of supplementary staffing is not clear. This may have consequences for staff budgets for non-nursing roles.

Successful delivery of multidisciplinary and multi-agency care will require improvements in workforce planning and achieving the right skill mix. The ambitions of the Bill will be difficult to realise if the National Health & Social Care Workforce Plan does not deliver on its aims. We have already communicated to the Committee our concerns on the gaps that have been identified in Allied Health Profession workforce planning as part of the Allied Health Professions Federation.

If the provisions in the Bill are not amended we are concerned that we may see the development of a uniprofessional service, where safety and quality unfairly sits with nursing staff instead of being the responsibility of all those who support and care for patients.