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. For a national board such as the State Hospital, there may be benefit in collaborating with another Board to ensure that such access is not diluted to the extent of being ineffective.

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. We envisage this being mainly through internal management and governance structures with the Board, with it being exceptional that this was escalated outwith.

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 into account, 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 detrimental to effective delivery of care.

Escalation from ward / department level has to be supportive and 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 as such does not track changes in patient acuity in real time.

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

That staffing will have an equal priority in the care sector.

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 focused yet the entire Multi Disciplinary Team impacts on the quality of care and the patient experience not nursing alone. Additionally the tools are viewed as a nursing resource. There needs to be a shift in this to promote the tools as a management resource that can be utilised by HR colleagues, finance colleagues and 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 appear to 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. This is particularly important in highly specialist areas such as The State Hospital, which does not have access to a specific tool which has been developed for use in a high secure setting. In particular, the tools need to have functionality / be on a platform which allows modelling of proposed service changes.

There are practical capacity within small National Boards to manage the “common method” of use of the 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 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 reference to the acuity and dependency of the patients. This will not be achieved through application of the “common method”.

Factors reported through use of the tools locally are important to take into account, including lack of familiarity and expertise in using tools due to infrequent use, and, as a consequence, lack of confidence in the outputs from the tools.

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.

**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.
The Bill could include reference to potential for non-traditional role development e.g. development of workers in relation to action 15 of the Mental Health strategy.

**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 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 and the 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 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, 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 training periods.