HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM NHS GREATER GLASGOW AND CLYDE

The NHS Greater Glasgow & Clyde (NHSGGC) response to the Health and Sport Committee of the Scottish Parliament who are gathering the views of those who are involved with local workforce planning to the Scottish Government’s Health and Care (Staffing) (Scotland) Bill, is as follows:

PART 1 - GUIDING PRINCIPLES FOR STAFFING

Through extensive consultation and discussion within NHSGGC and others, the overall view was that:

- In principle having a coherent legislative framework across Health and Care (H&C) to underpin workforce planning and appropriate staffing will ensure that all services are provided with opportunities to have governance in place to ensure that staff are well supported, trained and skilled to be able to carry out their role and care delivery safely and effectively in a professional manner.

- There is a failure to mention any apportion of appropriate funding applied to the legislation policy which threatens to either influence the precision with which the findings will be applied or affect investment into other priorities with potential detriment in other parts of the healthcare system. It states that there is unlikely to be any additional cost arising due to safe staffing and workload tools already being in place. Whilst this is not unreasonable, it has not been fully tested, and will be significantly dependent on the determinations from any new tools which are developed from the Bill’s implementation.

- It is also important that the H&C workforce are fully supported throughout this process with robust induction and support to be able to deliver the quality strategy objectives whilst ensuring the workforce can deliver that care in a flexible and person centered manner, which includes a clear focus on service user and patient feedback.

- Positive outcomes for people and staff must be at the heart of decision making and the need for professional judgement, quality metrics and consideration of local context will be essential to ensuring safe and effective staffing.

- The principles need to consider environmental and other factors during development, so that all the objectives are fit for purpose, and that safe and appropriate staffing should be consistent across all H&C environments. Nonetheless, this should take into account demographic differences, local market place etc; and there should be further consultation to ensure that observational work which may influence tool development takes account of settings in both urban and rural areas as needs may be different thus influencing service delivery.

- Guiding principles should allow more flexibility while ensuring that there is governance around the structures and processes already in place. These should be monitored by use of the assurance systems in which the workforce tools is essentially a starting point although there needs further development on complexity.

- While the Bill is not exclusive to Nursing and Midwifery (N&M) staff groups and it is likely that application and spread of additional tools for other health and care providers will be developed, it is important to ensure the principles of the Bill incorporates an NMAHP and much wider approach and should also take into account the requirements’ of the Active
Monitoring should be based on existing assurance measures in place through governance structures, which would include monitoring and escalation. Current inspection processes include assessment of staffing levels. Employers/operational managers/professional leaders are well placed to provide managerial and professional judgement on safe and effective staffing and quality metrics two essential elements of the triangulation of data currently gathered within the nursing and midwifery community. Hence, any proposed monitoring should be based on existing internal scrutiny, audit and performance programmes as part of self-evaluation through existing governance structures and via existing external inspection processes and service improvement plans.

Also, careful consideration needs to be given to the monitoring framework to ensure that it does not focus specifically on quantitative data which does not provide the full picture. Lengthy, complex and cumbersome reporting systems would be unhelpful - the focus must be on ensuring monitoring processes are streamlined as much as possible.

As a professional, registered body we would expect them to be monitored and governed as other services. This would also help when teams are integrated that they all of equal value.

Collaboratively work with service providers and commissioners from the appropriate parts of the health and care sector to develop and validate workforce planning tools and methodologies to demonstrate that they are practicable and beneficial for specific settings. Therefore, consult with the sector before a requirement to use validated workforce planning tools and methodologies is confirmed in regulations.

Consideration need to be given to registered H&SC staff to ensure they are equipped to revalidate with their professional body to ensure safe and effective staffing/working practices.

There is a need to work with employers/service providers and commissioners from the sector to identify and agree specified settings where there is a need for the development of workforce planning tools and methodologies.

Historically, existing tools are predominantly applied to a uni-disciplinary group of staff (with the exception of the ED/EM tool) which is contrary to the way multi-disciplinary integrated services are configured. An unintended consequence may be to inhibit to plan workforces effectively. Other staff groups might feel that their contribution is not appropriately recognised resulting in 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.

Therefore all areas require a workload planning tool of some description and there should be assurance that the methodologies used are accurate and evidence based. For example, validated workforce planning tools exist for nursing and midwifery services although not for all services. There are no tools available for mental health, learning disability, addiction community nursing staff groups or for prison and police custody services.

Workload assessment tools developed within nursing and maternity services required engagement from a wide range of key stakeholders with front line clinicians playing a pivotal role in their development, testing and evaluation and ongoing refinement.

We would concur with Social Work Scotland’s response to this consultation who believe that, “the development of workforce planning methodologies is important in the area of
Social Work delivered by local authorities as defined by schedule 13 of the Public Services Reform (Scotland) Act 2010."

PART 2 - STAFFING IN THE NHS

- Part 2 clearly articulates key roles and responsibilities including the expectations of Health Boards and other bodies to create a "common staffing method" across Scotland giving an opportunity for staff to be more widely engaged in reviewing safe staffing levels.
- This opens up the opportunity to address the appropriate skill mix in ensuring safe and effective patient care would be of benefit, although the current specialty tools do not currently take this into account. This will hopefully be considered in terms of future versions of the workload tools.
- The challenge will be developing tools and methodologies which capture the complexities of the work undertaken within a diverse range of settings and delivered in highly complex landscapes within a multiagency/ multidisciplinary/ multi-professional/ interagency/ inter-professional context.
- The N&M community have been working with the workload assessment tools for some time and important learning has taken place. It is imperative that this learning is shared and that ongoing challenges in relation to the application and interpretation of the data and current limitations of the tools in the context of capturing the complexity of patient/client care shape further refinement of existing and development of new tools.
- There is a need for investment in and regular review of existing tools to ensure they are fit for purpose.
- All underlying principles should be a commitment to quality improvement and be informed by best practice – evidence base and focus on achieving positive outcomes for people using services.
- There needs to be consideration around environmental and other factors during development, so that tools are fit for purpose.
- The requisite data and analytical support needs to be available to support consistency, transparency of methods, communication, and reporting.
- Involve the workforce and other stakeholders in workforce planning process.
- In delivering our aspirations for the diverse range of services within the H&C and against a backdrop of significant transformational change the exclusion of social work from the scope of the legislation would not resonate with our integrated organisational and working arrangements and arguably could create unnecessary tensions within the system. For example, as health are already mandated to use workload tools this has the potential to create an imbalance in the context of budget setting and allocation of integrated resources.
- An unintended consequence could be a real distraction of focus into the administrative function as opposed to the significant transformation agenda which requires energy and focus at all levels within the organisation. Energy within system needs to focus on service re design and quality person centred provision. Whilst the potential output from the development of validated tools has real potential benefit they will take time to develop and embed.
- There would be a significant administrative and cost burden. Preparation, application interpretation and analysis of the tool outcomes is time and labour intensive. Concern that this will take staff away from their respective duties specifically those delivering front line health and social care.
• Focus may be on scrutiny of the use of a tool rather than the implementation (focus on process and not outcome)
• Data publicly misrepresented
• Inaccurate reporting and or interpretation of the workload tools would potentially impact on future SG funding for specific care groups/services.
• Within the tools do not consider staff skill mix and as such an unintended consequence could be an increase in unregistered staff and consequent reduction in registrant/professional cover in order to “make up the numbers” despite current evidence which supports an increase in registered nurses in relation to the current community nursing workforce tools.
• Inaccurate reporting and or interpretation of the workload tools would potentially impact on future SG funding for specific care groups/services.
• Insufficient resources to provide staffing resource to the required safe and effective levels.
• Training and Development - Learning and development plan would require to be in place - resource pressure
• Ensure effective consultation and engagement with key stakeholders and ensure that subsequent testing, particularly for social care, is undertaken in both urban and rural settings. Important lessons learned from nursing community.
• Financial framework in place to support project plan to develop, test, implement, evaluate (upgrade/ refine as appropriate) workload tools with sufficient resource made available for the training of the use of tools and an evaluation of their effectiveness coupled with requisite support for all elements of the plan (includes appropriate investment into workforce planners and IT)
• Monitoring and scrutiny is outcome focussed.
• Clear, concise and consistent communication in relation to safe staff messaging for staff and public – this is critical – Realistic expectations of the potential value add given the complexity of the environment, the diverse range of staff with differing philosophical and theoretical backgrounds, qualified and non-qualified staff and need for a flexible and dynamic workforce (including third sector) to deliver health and care to our population.

PART 3 - STAFFING IN CARE SERVICES

• From a social work / social care perspective engagement with the following key stakeholders should include:
  o Chief Social Work Officers
  o The Chief Officers of Integrated Authorities
  o Social Work Scotland
  o SOLACE
  o COSLA
  o Scottish Care
  o CCPS
• In relation to the Care Inspectorate, we would concur with the view of Social Work Scotland i.e. that the professional should lead on collaboration with employers and regulators. This was the approach adopted by nursing and midwifery colleagues.
• There are concerns that increased competition for the available workforce across health and social care.
What differences not covered above might the Bill make?

The Bill doesn’t make reference to the role of the Senior Charge Nurse/Midwife (SCN/M) in relation to the supervisory / non case load holding role as part of their job description. For the success of safe staffing legislation that it would be beneficial and supportive to ensure this continuity of the role of the SCN/M is considered. This would incur costs but the benefits of this would significantly enhance the implementation of the legislation at a local level and provide the right professional and managerial support for safe staffing.

In addition there needs to be cognisance of cost implications of training other staff groups such as finance managers, HR managers and other senior service / operational managers should be considered as an additional cost to NHS Boards as a result of the Bill.

The professional advisory role of the NHS Board’s Executive Nurse Director (END) is documented in the “common method”; this further clear clarification, in particular to organisational accountability in the application of the legislation. The END should be the identified responsible position for the provision of professional and clinical advice to the process. In reality, to establish this function in practice the END may choose to delegate to an appropriate deputy. Nonetheless, final accountability will lie with the END for all NMAHP staffing across the Board. Ideally this should extend to the provision of professional advice to independent contractors (e.g. GPs) recruiting nursing staff.

There needs to be cognisance of nurse staffing budgets based on professionally agreed, risk assessed, prioritised processes. This should take into account the tools and the other factors in the triangulation of the “common process”. This may result in the potential for conflict between the professional view; operational requirements; Board priorities and available funding. It will therefore be important that other managers such as service managers and senior operational managers and hospital directors are also familiar with the workload tools and the associated process.

Although, Scottish Government are putting in place short term commitments to support NHS Boards in applying, analysing and implementing the outputs from the workload tools, which is welcome, nonetheless there may be additional unseen costs that we may arise through the process as the Bill is finalised and the fuller implications understood.

NHSGGC applies the national process, with an annual schedule of the application/analysis of the outcomes of the workload tools. However, staffing levels will need to be adjusted to accommodate the impact of service changes linking to the national strategic drivers such as the 2020 vision and other the regional programmes may indicate that the acuity of patients in some areas will continually change and that more patients will be cared for in their own home e.g. end of life care. Therefore the costs may not be directly attributable to the safe staffing legislation but to other drivers with alternate funding streams.

One area of concern is the predicted absence allowance (PAA) currently nationally guided at 22.5% for all areas delivering a 24/7 service. As the balance of care shifts we need to consider how to fund community services with a predicted absence allowance to maintain consistent safe levels of staffing. We have to consider that these tools are not only for inpatient areas. There is also the consideration that with the introduction of other family friendly initiatives that the 22.5% PAA is reviewed to reflect current demands on staffing levels.
The Bill does not pick up on other contextual challenges such as shift patterns and the impact of periods of workload and service delivery.

Overall, 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. This may be an issue we could pick up in the guidance?

One unknown concern is the potential impact on NHS Boards that may ‘fail’ to meet safe staffing levels and the escalation process. The latter will be important to understand both in terms of what actions, and indeed sanctions may be placed on Boards and the financial consequences of this which in essence could further impact service delivery.