HEALTH AND SPORT COMMITTEE
HEALTH AND CARE (STAFFING) (SCOTLAND) BILL
SUBMISSION FROM NHS EDUCATION FOR SCOTLAND

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

Yes, in part

This is an important contributing area of work to support high quality health and care services and patient and staff safety. Provides summary of key duties, responsibilities and reporting, and builds on previous work on use of mandated tools for nursing and midwifery workforce. Offers a broader perspective of service staffing, taking into account well-being and experience.

Important consideration for accurate staffing levels is core mandatory training for part-time staff, i.e. midwifery services. Practice is evolving with changing service models, differing roles, functions and evidence informed practices. One example is work ongoing within mental health on changes to observation practices. These dynamic contexts may not lend them themselves to annual reporting.

Whilst a common method is supported to reduce variation, there is a need to ensure consistency of tool usage across organisations.

There is no overt guiding principle for the provision of education and training of staff to ensure patient safety by the provision of appropriately trained staff in 1. (b) (vi) and this would strengthen the achievement of a policy of improving care quality and patient safety.

Any tool used should have due regard for the number and needs of training posts, for example in an emergency department there should be appropriate supervision at a senior level for doctors in training. There should also be recognition of their requirement to both train and provide service and that this may mean their capacity may be less than a trained doctor.

In 121F the consultation does not overtly reference consulting statutory regulators. The tools used should also have regard to the requirements of the regulator as appropriate. Boards may have to be very clear where the failure to meet the duty and appropriate measures taken to resolve that, conflict with regulatory advice e.g. from the GMC https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/raising-and-acting-on-concerns in terms of managing individual patient safety especially where a duty can be met for one staff group covered by the legislation but not for another which is not.

2. What are the key strengths of:
   o Part 2 of the Bill?
Recognising, and addressing an issue of concern for patient care, and the provisions (of 121F) that there is full consultation on the proposed tool and that guidance will be sought from the professions concerned.

This Bill connects NHS Board responsibility and accountability of nursing and midwifery staff to their Professional (NMC) Code, for example in areas of dignity and rights of service users, patient safety and professional judgement. We also welcome the emphasis in 121D on ensuring that any person who provides care services must have appropriate education and training, and provisions in 121D for consultation with employees in implementing the prescribed tool.

The Bill puts health, safety and well-being of patient at the centre and promotes quality improvement approaches with a clear understanding of duty and expected use of mandated tool for specific staff groups (121B/C)

There is a strong message on ensuring feedback loop for organisations, staff and patients, with Board responsibility for national reporting on conduct of duties and sharing though annual reports (121E).

Within the common method the professional voice is central, and the Director of Nursing should be clearly articulated as the clinical lead.

- **Part 3 of the Bill?**
  - Provision of a requirement for a staffing tool for care services

**3. What are the key weaknesses of:**

- **Part 2 of the Bill?**

  121D and 121E and F refer to employees. There is a risk that lead employer arrangements may mean some staff are not entitled to be consulted, although good practice would suggest that they would. 121G does still refer to an individual in paid employment by a Health Board – can this cover lead employer arrangements if the lead employer is also a Health Board? Part 3 section 9 in contrast has a looser definition.

It would be a sensible addition to have clarity that in Part 2 121A ‘suitably qualified and competent’ staff includes the requirement for the provision of staff trained and currently updated in processes and procedures relevant to the area and patients. Also propose inclusion in Part 2 121A of ‘c) the health and safety of staff’. Wellbeing of staff and engagement with workforce may have positive effects on productivity.

Concern over fitness for purpose of some tools and specifically gaps of staffing groups such as Community Mental Health and Community Learning Disability (121B/121C). Further clarity on longer term plans for inclusion of other nursing/health professions would be helpful to reflect multi-agency nature of care as articulated in health and social care workforce plans. Tools will require to be continually reviewed to ensure they remain fit for purpose and responsive to dynamic and changing contexts.

How practicably do Boards/Agencies demonstrate 121D in so far as it is a duty and therefore reportable, and if due regard to the views of staff derogates from the staffing levels demonstrated by the tool as set out in 121B?
Whilst recognising differences across health care, having 2 distinct parts within the Bill does not facilitate a unified approach. Recruitment and retention of workforce are key factors in safe staffing, with variation in vacancy rates across health, care and geographical settings. Although this Bill is focussed on registered staff, health care support workers are core to health teams and the delivery of service. The wider workforce requires knowledge of this work and an understanding of processes and outcomes.

- **Part 3 of the Bill?**
  - Staff in Care Services - No further comment

**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?)

Policy intention is not to set out minimum staffing requirements and further consideration required on implications of/ response to reporting of understaffing. The Bill is silent on what the action of the Board is if the duty cannot be met. What is the expectation for organisations to continue to provide service in that event? Will an unintended consequence be increased closure to admissions in some units? Will the approach be sanctions or is it more about improvement?

In the longer term the Bill/Act will support the policy objectives but at present limiting the duty to nursing staff and emergency department medical practitioners will not, as it does not take into account the multidisciplinary integrated health and care nature of provision, nor does it address the potential disadvantage to staff groups not covered in terms of prioritisation of resources. It may be an unintended consequence that staffing in for example AHPs is reduced if resource is focused on meeting the duty in one staff group where a tool determines the level.

The aims of the Bill are clear and desirable in terms of supporting provision of high quality health care. It does not provide any guidance in delivering this aim by addressing the supply of health care professionals to support the required staffing levels.

There is no parallel duty on educational establishments to have due regard to the impact of this duty, and to consult with Health Boards where students are trained, on the impact of this on capacity for service and patient care.

There is a risk in using one lever (staffing numbers) to address a multifactorial challenge that pressure can then result in other areas.

Recognition of context in which this is being introduced and any unintended consequences which could exacerbate pressures on a health or care service/facility. There may be enough staff in the system, but there may areas that remain understaffed or have challenges recruiting.

In looking at safe staffing, the focus should also be on longer term requirements.