SUBMITTING EVIDENCE TO A SCOTTISH PARLIAMENT COMMITTEE

DATA PROTECTION FORM

HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM Society of Personnel and Development Scotland (SPDS)

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

The Bill appears to have a fair possibility of reinforcing existing requirements to achieve appropriate staffing levels in NHS contexts given there are already well established tools in place. It is less clear that it will achieve its objectives in the Care setting and our position remains that further legislation is unnecessary, given there is already a statutory requirement on IJBS to Workforce Plan, therefore why is additional legislation required.

The legislation assumes that the use of agency staff and other expensive staffing options is caused by failures in workforce planning and that better workforce planning will automatically address this. This does not take account of the wider demographic, societal, service delivery, and individual reasons that drive these forms of people resource provision. One example of this is where large amounts of short term cover are required to ensure continuity of care provision across a range of separate providers in a geographical area. Individuals will be motivated to make themselves available for work through employment agencies as this means they will be offered work more often across all providers in the area using the agency for interim staffing. If on the other hand, the individuals were directly employed by specific care providers they would find the work offered was insufficient to meet their employment needs and the employer would incur employment costs for an individual required to provide minimal hours. So imposing a statutory duty to undertake workforce planning will not address the issues that cause small employers to have to use agency staff and motivate qualified workers only to make themselves available for work through agencies.

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

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

The duty to ensure appropriate numbers of suitably qualified staff to deliver care appears to be positive. If such staffing levels are in place is likely, if all other requirements are in place, to contribute to a service which appropriate for the health wellbeing and safety of service users and is of high quality. It may also result in staffing levels that contribute to staff health and well-being.
3. What are the key weaknesses of: Part 2 of the Bill?

There is an imbalance between comprehensive list of formal tools prescribed for use in health settings and the lack of such tools in the care settings. This raises that an IJB will be motivated to channel resources in a multifunctional setting to those staff groups where levels are staffing-levels are set by a tool. Conversely an IJB might be motivated to move patients/service-users from a health setting to a care setting where the latter was not subject to the application of statutorily required staffing levels.
What are the key weaknesses of: Part 3 of the Bill?

Use of any structured workforce planning tool is not a no-cost activity. At the very least there will be opportunity costs in management and administrative resources being diverted to collect data, enter it into a tool and apply the outcomes. (either option redirecting resource which could be better used on direct care provision) in some cases an organisation might decide that they had to employee additional administrative staff to undertake the work. There will be costs associated with creating the tool and also staff training in relation to using the tool. There is also the potential for the tool to determine a greater staffing resource is required which will result in more significant additional costs. There is a danger organisations focus on data collection and do not spend time on improvement / OD activities which would bring about transformational change required to meet demands

The Scottish Government analysis published with the Bill states that there are 2,644 employers. While the time to undertake workforce planning might be small annually, perhaps equating to only a couple of weeks work for one or two people per organisation, cumulatively this may represent a significant piece of activity for the sector. Also deficit in skill set and resources locally to deliver on this.

The Scottish Government analysis states that 80% employers have under 50 staff. The benefits of a formalised workforce planning process are much less for small employers than for larger employers. While a large employer will benefit from planning for large scale demographic or training needs changes in their workforce a small employer will generally be aware of individual employee intentions, skills and training needs, and put in place appropriate steps to ensure continuity of care where a retirement or other predictable staffing event is on the horizon. To really see benefits would need infrastructure to support this on regional basis which would be required to resource to really see aspirations achieved. There is danger activity which should be spent on improving services is directed towards measurement and performance.

Given the geographic size of large organisations like a local authority, the low level of wages offered to care workers, and that individual care homes tend to be small and geographically dispersed units (at least by comparison with the typical NHS hospital) the benefits of organisation wide workforce planning will be difficult to realise. As noted previously an individual unit manager will be more likely to make staff planning decisions based on their personal knowledge of readily predictable changes in their (comparatively) small staffing group and on the basis of knowledge of local labour market.

As the Care Inspectorate is being tasked with deployment it is reasonable to assume that they will give a negative audit and threaten to close a service if the tool is not used, even in situations where in all other respects a service was being delivered appropriately. This would place costs on other local service providers having to provide emergency services for displaced service users and costs associated with redundancy and unemployment benefits for staff affected by the closure. This represents a risk and how providers are supported will be key to success given they will not have skill set to deliver on this.
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?)

There appears to be a fundamental dichotomy between the commitments stated paragraphs 11 and 12 of the Policy Memorandum (that the Bill is not intended to prescribe minimum staffing levels, stifle flexibility, integration and innovation) and the requirement to use specified tools in the Bill itself. Once an activity, such as the use of a planning tool, becomes a statutory requirement it would become organisationally very difficult to ignore the outcomes of the tool even in a situation where it was abundantly obvious those outcomes were not appropriate to the services being delivered or the service users in receipt of them. How will it be possible to have both a statutory planning framework imposed by the Care Inspectorate and “flexibility and the ability to redesign and innovate across multi-disciplinary and multi-agency setting”? Also how could auditors (i.e. the Care Inspectorate) measure this?

Workforce planning and the duty to ensure statutory staffing levels and methods of service delivery without a commitment to provide appropriate funding also introduce risks. In services delivered by Local Authorities unfunded additional staffing commitments potentially introduced by the Bill raise the risk that other essential services delivered will have to be cut back and could destabilise services if this is not properly resourced.