HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM IRENE BARKBY EXECUTIVE DIRECTOR OF NURSING FOR NHS LANARKSHIRE

Do you think the Bill will achieve its policy objectives?

Yes, in part.

The Bill if passed result in the workforce tools and the outputs from running the tools being acted upon, onto a firm legislative footing. However there will be a clear need for funding to support the establishment of an appropriate infrastructure to support implementation of the policy as without it the level of rigour with which the findings will be applied and the priority given to staffing levels will be impacted significantly on by pressures in other parts of the health system.

The concern that most Health Boards and management teams will have is the capacity and to be able to run the tools annually and respond not only to the outputs from the tools but more importantly ensure on a day to day perspective staffing is adequate for peaks in activity and short notice absence.

The escalation process will therefore be very important. There will need to be a clear process which is appropriate for the environment of care and specifies what the criteria are for escalation and what response is expected. The Executive Director of Nursing is accountable for and has the ultimate sign off in relation to nurse and midwifery staffing levels. Escalation will be tiered within the various levels of management within the Board. Escalation beyond the Board should only occur when there is evidence that there has been a failure to address shortages over a predetermined period and where there may be staff and patient safety concerns that remain unresolved.

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

It clarifies responsibilities and expectations of Health Boards / and other bodies and defines what is the “common method” of workload and workforce planning for nurses and midwives across Scotland.

There will be an increased level of transparency on the rationale for determining staffing and actions to mitigate risks and more importantly for staff they will be more widely engaged in reviewing and understanding the safe staffing establishments.

Currently the tools do not take account of others roles with the exception of the Emergency Department which includes Medical staffing requirements. The ability to look at the role others play will be crucial going forward. A methodology for doing so should be considered for development in the future.
This will provide an enhanced level of focus on 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/client group.

The professional advisory role of the Nurse Director/Senior Nurse 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 role for the provision of clinical advice. They may delegate this function to an appropriate deputy or chief nurse but the final accountability should continue to rest with the Executive Nurse Director for all nursing and midwifery staffing across the Board area. They should also provide professional advice to independent contractors (e.g. GPs) recruiting nursing staff as an when required.

Nurse staffing budgets will be based on professionally agreed, risk assessed, prioritised processes taking account of the tools and the other factors as detailed in the refreshed triangulation process. It will be important for other managers such as service managers and senior operational managers and hospital directors to be familiar with the tools and process. However, there will undoubtedly be occasions where risk assessment and prioritisation will require to determine Board priorities based on available funding.

The need for an agreed escalation process is welcomed and it will be important to ensure that this is tiered and designed in such a way as to align with a range of care environments. Escalation through any national scrutiny body on a day to day basis would potentially be extremely disruptive and detrimental to the dynamic process of day to day management and deployment of staff. Escalation where there are pressures that are beyond a Boards area of control and where external support would add value would however be acceptable and in fact welcomed.

Escalation from ward / department level has to be supportive and have the capacity to put in place remedial measures operationally in a timely, realistic and pragmatic way. The assurance / escalation from senior nurses / Nurse Directors should be managed through Board governance groups with the remit to challenge on behalf of the Board, before any escalation to Healthcare Improvement Scotland or the Scottish Government.

The policy memorandum refers to professional judgement as the requirement to review 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 current professional judgement tool does not operate on a day by day basis at present and does allow patient acuity to be recorded real time. There are tools available that have the functionality however this is not widely used and there would be costs associated with its implementation on a national level.

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

Tools will be developed and/or adapted to support the care sector in setting realistic staffing levels.
What are the key weaknesses of Part 2 of the Bill?:

The tools are seen as being a nursing and midwifery resource, there needs to be buy in and ownership from other managers in relation to their understanding and use with regards to resource allocation and service redesign. Currently the tools are almost exclusively nursing and midwifery focused with the exception of the emergency care tool, yet the entire Multi Disciplinary Team impacts on the quality of care and the patient experience not nursing / midwifery alone.

The current NMWWP tools require refreshed and maintenance to remain fit for purpose both in relation to the IT platform upon which they sit and to ensure they remain sensitive changes in patterns of care and the intensity and dependency of the care required by a patient.

There is currently a capacity issue within Boards to manage use of the full range of tools each year and align the outputs with the workforce and financial planning. The capacity is linked to the frequency with which tools are used. The current resource in NHS Lanarkshire could not facilitate any more frequent use than the annual rolling programme that is currently in place. If an annual cycle requires to be established for running all tools this will required additional resources at Board level.

Once establishments are set and staff a recruited and deployed, the day to day review of staffing requires a very different approach to that laid out in the Bill. It requires that there is an assessment of whether the number of nursing staff with the right knowledge, skills and experience, have been deployed and are available in the right place. On site senior nursing staff currently operated a daily dynamic process based on activity and patient acuity to deploy and/or redeploy the available resource to meet the needs of patients.

Other factors to bear in mind:

- Those tools which are used annually are not familiar to staff
- Those tools used annually require to be scheduled to run at a point in time which allows alignment with the planning cycle this would require appropriate resourcing
- Currently some tools are complex and time consuming making staff less willing to participate for no apparent gain

There will be times when what the tools say is adequate/safe may be perceived to be inadequate/not safe due to rapidly changing circumstances in the clinical environment. No tool can predict this and therefore we need to ensure that patients, the public and staff understand the limits of the Bill and the outputs for use of workforce and workload planning tools.

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 fails to recognise staff are already working in integrated Health and Social Care teams in almost all Boards and therefore the opportunity could have been
taken to look at adaptability of existing tools and methodologies to fit with the evolving care delivery teams, staff education and training and facilitate/enable skill mixing and cross cover. The fundamental elements of almost all of the tools are that they are based on observational studies of tasks undertaken on patients/clients.

The current absence of nationally validated tools for social care environments 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 and fails to recognise that care delivered to a patient/client in a nursing/care home does not vary that much from care delivered to a patient in a hospital ward in terms of the ability to determine the level of support and care needed albeit that the level of nursing interventions observed may be much less.

What differences not covered above might the Bill make?

Other staff groups might feel that their contribution is not appropriately recognised

The demand and thus the supply of staff across health and social care

The ability to benchmark staffing levels across Scotland

Opportunity to develop workforce planning capacity and skills in the nursing profession

Enhance level of engagement with staff and patients / families and carers around staffing levels

The scrutiny and sanction is not clear in the Bill. The scrutiny and sanction arrangements should provide an opportunity for organisations to flag with the Scottish Government wider issues, like supply or financial resources to engage the required level of staffing.

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, prolonged failure to act by a Board.

The tools currently do not lend themselves to measuring workload of specialist/advance roles (new or evolving) therefore as well as modernising and making more dynamic the current tools consideration needs to be given to developing tools for the outstanding areas such as treatment rooms/outpatients/Specialist/Advance/Consultant Nurse and Midwives going forward.