HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM BMA SCOTLAND

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

We welcome the opportunity to respond to the Health and Sport Committee’s call for views on the Health and Care (Staffing) (Scotland) Bill. To respond to each of the points in turn.

• Do you think that the Bill will achieve its policy objectives?

Legislating for safe staffing levels in our healthcare system is an important step and demonstrates that the Scottish Government rightly takes the issue extremely seriously.

With a system that is under severe pressure and doctors and their colleagues stretched to their limits, it has never been more important to have the right mechanisms in place to ensure that staffing levels are safe.

However, it must be acknowledged that in the case of doctors, at this stage the bill is about enabling future measures that may deliver safe staffing levels, rather than practical steps that will make an immediate difference.

The bill purely sets a framework through which more effective delivery of safe staffing could potentially be achieved. For example, the section 121C: Common staffing method: types of health care, covers a range of types of healthcare, but only Emergency Care Provision extends this to doctors in any form. All the rest of the settings cover purely nurses or midwives.

As a result, the Bill does not provide any specific measures on what safe staffing levels might be for doctors, or how they may be enforced or delivered. There is an indication that a “staffing level tool” or a “professional judgement tool” to cover doctors could potentially be introduced at some point in the future, but there remains considerable uncertainty on the process for beginning the development of such tools or how they would be established and delivered.

Equally, the core aim of this bill must be to ensure safe staffing is in place, not to simply provide the framework under which that might happen. So, on that basis, there must also be an acceptance that this bill does nothing to tackle the core issues of supply of doctors, or recruitment and retention that are such a problem for NHS boards.

Simply legislating for the right numbers of staff does not mean that more doctors will start working in the system, or that vacancies and absences will be easier to cover. That is why, combined with this bill, we need more concerted and focussed action to recruit new doctors to Scotland, retain those we have and ensure that practicing medicine in Scotland is an attractive, effectively rewarded career choice.

Within the bill there is some recognition that achieving appropriate staffing levels requires a multi-disciplinary approach, rather than simply considering staffing numbers within each professional grouping in isolation.

However, while we are broadly supportive of the need for a multi-disciplinary approach, it is also important not to make any assumptions which underestimate the value of medically qualified staff, and any assumptions that a shortage of medically qualified staff can simply
be offset by the recruitment of sufficient numbers of other qualified staff (e.g. as may perhaps sometimes be assumed in GP out of hours services). There does need to be a recognition that certain tasks are best done by medically qualified staff, and in some cases, can only be done by those who are medically qualified. While this is not necessarily the focus of the bill, the BMA is not certain that it provides sufficient reassurance on this point.

Overall, this bill has the potential to introduce new, effective and appropriate systems that will mean staff feel safe and supported in delivering care in the demanding working environment that is Scotland’s NHS. However, this will be dependent on what happens following the successful approval of the bill – providing it receives the support of Parliament - for example through the associated guidance that follows.

One potential way this guidance can help embed safe staffing levels would be to ensure doctors are consulted effectively and meaningfully on staffing and associated decisions.

The bill and following guidance also has the potential to create a clear pathway for staff, including doctors, to escalate concerns over staffing until they are dealt with effectively. This should also ensure that doctors feel protected when they do raise and escalate those concerns. Building this process of escalation into the bill and subsequent guidance would be a welcome step.

In the longer term, some form of workforce planning tool, or a formalised way to define safe staffing limits for doctors could be beneficial. Such a tool would need to be carefully constructed and designed specifically and clearly for appropriate staff groups and settings, while taking into account factors such as time of day or night. With these caveats, a specific tool could deliver real benefits for the particular element of the profession it covers. The BMA is happy to work with the Government and relevant bodies, such as the royal colleges, to develop this approach further.

Indeed, our membership have indicated their support for these measures. In a recent survey of our members in Scotland, which 999 doctors participated in, respondents were specifically asked what would most improve their day-to-day working life in the immediate future (assuming that there couldn’t be significantly more doctors in the short term). Guaranteed safe levels of medical staffing was selected by 55 per cent of doctors, the second most popular option, after improved IT systems.

It is vital that this bill delivers on those requirements, which would mean it then has the potential to benefit both staff and patients.

However, as previously mentioned, workforce tools or formulas in themselves do not solve the core problem of supply of doctors, which simply must also be addressed urgently. If recruitment and retention is not adequately addressed, then there must be doubts about the policy objectives being achieved.

- **What are the key strengths/weaknesses of Part 2 of the Bill?**

This response will focus on Part 2 of the bill, given that Part 3 relates solely to social care.

In many respects, the strengths and weakness of this section reflect the overall position of the BMA on the bill, as set out above.

However, to explore some points in more detail.

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It is encouraging that part 121A now embeds in law the requirement of every Health Board and Agency to ensure safe staffing is in place. The inclusion of sufficient staff to provide ‘high quality health care’ is also an important element of this duty. Our members are clear that pressures on the system, including lack of staff, often hinder the delivery of high quality of care. Indeed, our recent survey found that nearly 9 out of 10 doctors who responded say that staffing is currently inadequate for providing quality care.

The issue in this case remains supply, as the challenge will be recruiting and retaining sufficient staff to address the problems currently caused by shortages and vacancies across the system.

In relation to part 121B, the ‘duty to follow common staffing methods’, this currently will be limited in its effects on staffing levels for doctors, as it is based heavily on staffing level and/or professional judgement tools, which do not currently exist for doctors. Indeed, the only group of doctors covered under the types of health care in table 121C are those working in emergency medicine.

Added to this, for example, the table makes no comment on the fact that adult and paediatric inpatient provision requires appropriate medical and AHP staffing levels as well as the staff groups identified. Wards do not exist to nurse patients in complete isolation from other practitioners as the current drafting potentially suggests.

Similarly, maternity provision is not exclusively about midwives as neonatal units cannot function without neonotologists. Also, maternity provision cannot be achieved without obstetricians. Midwives require support for complex births, emergencies, or those mothers who choose to have a consultant led birth. As it stands, this table, and as result, the whole scope of the act is extremely limited to a narrow number of staff groups, focussed almost entirely on nursing and midwifery.

To truly deliver safe staffing, it is not sufficient to simply include staff groups outside of nurses purely in the general principles, and the ‘common staffing method’ as defined by the bill. Long term, such good intentions and positive frameworks need backed up with practical action for groups such as doctors. This will require collaborative efforts with the profession to develop robust, well evidenced tools for the determination of safe staffing levels which can be used in the development of ministerial guidance.

However, there are some important steps set out in 121B part (c), the common staffing method, which put into a formal position the type of planning which we would expect all health boards to undertake.

In particular point (v): takes into account… “comments by its employees” indicates a very clear commitment that boards must engage with and listen to staff, including doctors. In a similar way, part (d) (iii), embeds the need to take into account appropriate clinical advice to decide what changes (if any) are needed as a result to staffing levels. Following on from that, the whole of section 121D deals again with the need to encourage staff to give views on staffing arrangements as a key part of the planning process.

These principals write into law the requirement for boards to consult with and, importantly, listen to staff and clinicians on issues to do with staffing levels. This is a crucial part of the bill and potentially a real strength.

Although this is welcome in principle, there is little detail about how this would work in practice. Input from the statutory professional advisory committees within Health Boards is often not effectively gathered or utilised and individuals may have a fear of being perceived as a “troublemaker” if concerns are raised in an individual capacity. There is likely to be a lack of confidence among staff that any concerns raised will be appropriately escalated.

\[2\] For details on the survey – see link above
There have previously been examples of alleged bullying to prevent accurate reporting of inconvenient and/or problematic facts, while those who have engaged in whistleblowing have frequently found the experience emotionally traumatic.

As a result, the principle of consulting with staff will be of little use if not backed up by substantial guidance, that puts in place the practical means through which boards must make this happen. Engaging with clinical interests will be crucial to get this right and the BMA is happy to work with the Scottish Government on this issue.

In respect of part 121E: reporting on staffing, any commitment to greater openness and scrutiny of staffing is to be welcomed. It will be important to ensure that this leads to clearly presented, accessible reports that allow both staff and the public to establish the measures boards are employing to deliver safe staffing, and the effectiveness of those steps. If, as suggested, this is published as part of an annual report, it must be well sign posted and openly and publicly considered. It is useful when data is shared in formats which allow central collation and comparison, and standardising reporting across organisations greatly increases the usefulness of reported information and allows the full power of the data collected to be brought to bear in the pursuit of solutions which serve all interests.

- Is there anything that you would change in the Bill?

There is the potential to add to the bill a clear framework under which doctors, and indeed all staff groups, can escalate staffing concerns.

This is particularly important in the context of the case of Dr Hadiza Bawa-Garba. Hospital doctors (junior and senior) need to be able to flag up inadequate staffing at the start of a shift.

A system needs to be put in place where escalation of concerns goes to a duty senior manager with authority to take steps to bring medical staffing up to a safe level, or potentially reduce/close a service on a temporary basis as appropriate and considering the potential effect on other parts of the service.

At present these are mainly ad hoc processes, which often don’t go beyond the local consultant on call and do not involve any senior manager, or someone with the ability to take the best decisions based on the whole service in a particular area such as a clinical lead/director, or the ability to provide authorisation in terms of finances, for example to authorise additional locum hours.

Equally, these short-term escalation measures could also be complemented by opportunities to escalate concerns over a more extended period, and over longer, more forward-looking timescales – for example around persistent rota gaps. There have been positive indications that the Scottish Government are inclined to pursue such a change, and the BMA is prepared to input into the proposals to ensure that any potential additions to the bill are drafted effectively.

There is also a need to consider how application of the law will be monitored, scrutinised and if appropriate, enforced. There is reference to Healthcare Improvement Scotland within the text of the common staffing method (121B – part (c) – takes into account – any assessment by HIS).

However, this remains to some degree unclear. Improved openness and reporting, as also set out in the bill, can help promote scrutiny, but only if effective and consistent measures are in place to make that happen. For example, it would be useful to clarify whether the

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3 For more information on the case see: https://www.bma.org.uk/collective-voice/influence/key-negotiations/training-and-workforce/the-case-of-dr-bawa-garba
provisions of the bill would be taken into account as part of the regular assessment of NHS services that HIS undertakes. Or will there be separate mechanisms to deliver such monitoring and enforcement? And if boards are not found to be complying with the bill, or effectively utilising the common staffing method, there are no clear steps or actions set out as to how this would be potentially addressed, or remedied. Clarity on how monitoring of compliance with this legislation will work is required from the outset and must strike a balance that ensures it is effective while avoiding becoming a burden for hard pressed clinical staff.

Although the bill clearly and rightly exists primarily to create a corporate responsibility to address staffing issues, there must be appropriate disciplinary procedures for staff who wilfully fail to comply with its aims, especially where, for example, concerns about staffing which have been appropriately escalated are ignored at a managerial level.

As we have made clear about the bill throughout this response, however, it is also vital that there is flexibility to move away from a ‘one size fits all’ approach and ensure that the approach to safe staffing is sufficiently nuanced to take into account a whole range of staff groups. All of these groups will have different ways of working, very different requirements for the job and where the term safe staffing will inevitably mean different things.

This may be particularly true for doctors as, once they are fully trained, doctors generally don’t have the flexibility of other staff groups. For example, a consultant dermatologist can’t realistically be asked to cover a surgical clinic, however an outpatient nurse could safely and appropriately cover both. The capacity to deliver medical care needs to be adequate to meet the peaks of demand as additional capacity cannot be parachuted in. Staffing therefore needs to be capable of delivering more than the average workload and in this doctors may be different from other staff groups who can generally deal with a wider range of issues.

Developing specific tools for specific sections of staff based on the evidence and the setting they are working in could help address this – but this will be a significant undertaking requiring close engagement with all elements of the medical profession.

In this respect it is helpful that the bill avoids simply specifying minimum numbers of staff and recognises that the process will be more complex. It is also helpful to recognise that there is no “perfect tool” for determining appropriate staffing levels, and to recognise that there will be multiple factors causing day to day variation in workload, which will require to be taken into account when determining staffing levels.

The lack of nuance in respect of time of day provision is concerning - minimum safe levels of staffing generally do not need to be equal throughout the whole 24-hour period, 7 days a week. There is often variable clinical activity in a given area throughout the course of the day, so safety may dictate additional staff for at least some part of the day/week. For example, it might be safe to have one FY1 covering a given ward at night (with appropriate senior support) but not during the day when there are admissions and discharges in addition to ad hoc and emergency tasks. Staffing need could also change at times of high demand and a high number of patients, such as in winter or when there is a local event causing a rise in attendances. There are particular problems when patients are boarded into multiple wards across a hospital, and a single team of doctors is responsible for their care. Any staffing solution must of course include sufficient numbers that education, leave, continued professional development, and other non-clinical work can be delivered without disruption to the service. Unfortunately, it is very common in our stretched health service for some or all of these to fall by the wayside, with negative consequences for staff training and wellbeing.

On this basis, it is a strength of the bill that it allows for an element of professional judgement in determining appropriate staffing levels. However there also needs to be significant caution about how professional judgement is applied, or potentially misapplied. It is all too easy to envisage a situation occurring when professional judgement is applied in a
manner which conveniently concludes that the required level of staffing happens to be a level that the organisation is able to achieve, and hence avoid reaching a less convenient (but perhaps more honest) conclusion when the organisation is unable to attain an appropriate standard.

- **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 services’ assured/guaranteed by the Bill?)**

As set out above, the bill in itself will not ensure that staffing levels are safe. It will, for the areas it covers or comes to cover, aim to put in place a robust system of planning, checking and reporting on staffing levels and, with amendments as suggested above, demand a robust system in which concerns can be escalated and must be acted upon. It is essential that data generated from this process is used to guide staffing policy in Scotland and that attempts are made to recruit, retain, and train professionals to fill the gaps we are sure will be revealed.

It is also extremely important that full consideration is given to how the bill may interact with the new GP contract⁴. For example, section 3, part (2), which relates to any person providing a care service, or securing the provision of care from another person under contract’ may have direct relevance for GPs. As boards have no scope to alter the GP contract, any attempt, under this provision to assess or alter a GP practice’s staffing would be both be potentially extremely difficult and also potentially undesirable. While GPs will always have in mind the requirements of delivering a safe service, it is hard to see how this requirement will be in any way overseen or have regard to the GP contract itself.

Finally given the reliance, and central focus of the bill on the use of staffing tools it is vital that boards do not simply feel they have delivered safe staffing by complying with the limited tools currently in place. This would tell far from the full story and ignore large and crucial parts of the whole workforce. Equally, diverting resources simply to meet the requirements as set out by the tools and as a result the requirements of the law would be potentially damaging. There must be whole system planning, which takes into account the whole staffing requirement, and not simply the staff groups covered by the planning tools in this bill, if safe staffing is truly to be delivered.

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⁴ More information on the contract available here: https://www.bma.org.uk/collective-voice-committees/general-practitioners-committee/gpc-scotland/gp-contract-agreement-scotland