HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM Glasgow City Health and Social Care Partnership

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

For both Health and Social Care Services we strive to ensure that there are effective staffing levels and that there are the required minimum staffing levels on our directly provided services i.e. inpatient services and residential services. Agencies require to have the flexibility to deploy staff where there is the greatest need and to develop a workforce that is flexible in relation to skill and grade.

- Objectives can be met if there is an increase in training of required clinical and social care professionals to reflect this policy context. There are also other wider workforce challenges ahead for both the NHS and social care as we deal with an ageing workforce, an increased demand on a range of specialist roles and the emerging impact of other policy initiatives, such as the GMS (General Medical Services) and new GP contracts. All of these pressures combined are placing significant demand on an already stretched clinical and social care workforce.

- Careful consideration would also have to be given to overall training arrangements for qualified nursing and social care staff to ensure adequate numbers are available to meet demand, whilst also implementing new roles and exploring other opportunities for recruitment and retention of staff.

- We have concerns in relation to the cost implications of this Bill. Our concerns around financial resourcing are highlighted in a separate submission to the Finance and Constitution Committee in respect of the Financial Memorandum of the current Bill.

2. What are the key strengths of:

Part 2 of the Bill? (STAFFING IN THE NHS)

- It is helpful that there does not seem to be an intention for a prescribed number of health staff to be identified.

- Consistency of approach across all clinical areas, confirmation of appropriate training, the application of quality measures alongside staffing numbers, recognition of short term pressures when service change is underway.

Part 3 of the Bill? (STAFFING IN CARE SERVICES)

- It is helpful that there does not seem to be an intention for a prescribed number of social care staff to be identified.
• We note that there is no plan to implement the social care workforce tool at the same time as the health tool. This hopefully will afford the opportunity to refine the methodology between its implementation in health settings and possible subsequent implementation in social care settings.

3. What are the key weaknesses of:

Part 2 of the Bill? (STAFFING IN THE NHS)

We have several issues, questions and concerns in relation to Part 2 (NHS) of the Bill. These are given in brief below:

• The use of workload tools as part of the process is noted, but we have limited knowledge of the current tools in place. The use of a ‘professional judgement’ measure is of concern as this has caused some inconsistency in the past in terms of individual responses to clinical workload issues – i.e. different individuals respond to and record issues differently, although we appreciate that the triangulation process attempts to take this into account.

• The Bill does not take cognisance of the significant overlap of governance responsibilities between Health Boards, Integration Joint Boards and Local Authorities so would require to be accompanied by clear guidance.

• The Bill gives a significant amount of detail about existing arrangements/applications of the workload tools in health but it doesn’t tell us a lot about how these will be used in relation to identifying consistent safe staffing numbers. It also refers to ‘taking staff’s views into account’ – we need more detail on what this will mean in reality. It is possible that staff could refuse to work in certain circumstances?

Part 3 of the Bill? (STAFFING IN CARE SERVICES)

We have several issues, questions and concerns in relation to Part 3 (Social Care) of the Bill. These are given in brief below:

• A workforce “toolkit” would need to be developed for social care. It’s unclear how the model would work in the absence of it.

• Integration requires a commonality of approach in terms of workforce tools. How will this legislation complement/support integrated or new ways of working? How does it fit with integrated workforce planning? It’s not clear from this Bill.

• There is no description in the Bill of a timeline around the development of a workload tool for social care services.

• As already stated under Q1 of this consultation, several of the principles in the act will put significant pressure on agencies to recruit and retain staff. There needs to be a national strategy in relation to the education and development of some key
professional posts. It is unclear how the national workforce tools would be used and applied across different professional groups.

- We considered that the existing legislative framework in respect of social care services is satisfactory and does not require to be replaced.

- In relation to the proposal for the Care Inspectorate to lead the development of a tool for the care sector; we suggest that a national working group should lead this. The involvement of the Care Inspectorate in any such development could lead to a conflict of interest should they then carry out future inspections which are, in part, about the application of tools it has itself developed.

- If the social care workforce is within the scope of this Bill we would respectfully request that the legislation becomes an enabler to safe staffing provision within care establishments rather than a potentially prescriptive inhibitor.

Please note – the following points detail weaknesses and issues common to both Health and Social Care within Part 2 and Part 3 of the Bill. To avoid duplication we have presented these together.

- The legislation may impede or stifle innovation in the area of service redesign and transformation which are at the heart of health and social care integration. Additional legislation requiring the use of specific tools set at a national level runs the risk of removing the scope for plans to be tailored locally.

- There must be acknowledgement that there is already a statutory requirement, articulated in Integration Schemes, that Integration Joint Boards should produce a workforce plan which is developed in line with local needs and local requirements.

- An overly prescriptive approach could have a negative impact on the flexibility Partnerships require in order to meet the needs of the communities they serve.

- There is a risk that a focus on the use of specific tools would result in a ‘tick box’ culture focused on processes rather than patient/service user outcomes.

- The cost burden of new legislation given that mechanisms are already in place to ensure safe staffing levels in our health and social care services.

- There is significant risk that this legislation will add an additional layer of administration and bureaucracy to existing systems.

- There is also a real risk that Partnerships will be unable to deliver on any new legislative requirements should they not be fully funded. Alternatively, resources may have to be diverted from other frontline services in order to deliver on these requirements.

- This Bill may add additional significant demand on the already stretched health and social care workforces.
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?)

We would like to highlight the significant challenges already experienced by both health and social care workforces in terms of recruitment and workforce maintenance.

- We are concerned that the legislation will add another process and pressure on the system which is not time or cost effective and lacks robust evidence that it would have a positive impact on outcomes for patients and service users.

- Currently the NHS and social care providers need to recruit to a wide range of roles from a limited number of trained/qualified staff. This legislation potentially could further exacerbate this issue given supply issues already manifesting across the workforce.

- The development of tools considering one professional group (or a limited number of groups) in isolation may be detrimental to the development of integrated services across health and social care.

- Whoever is tasked with leading the development of a staffing method for social care must take into account the diversity of the workforce and the range and scale of providers. A 'one size fits all' approach to workforce planning simply will not work.

- The guiding principles which are being developed should be aligned with what is already in place including the new Health and Social Care Standards and the National Workforce Plan, otherwise these additional principles will add confusion to what is already a complicated landscape.

- Similarly, regarding the initial focus on a staffing tool for the adult care home sector; there is work ongoing in relation to the National Care Home Contract to develop a dependency tool (focused on measuring the individual’s level of need) which will assist in the delivery of high quality, person centred care. A staffing tool being developed in conjunction with this could be overly complex.

- There is a concern that tools are not sufficiently dynamic to meet changing demands in the integrated health and social care landscape, nor sophisticated enough to respond to the significant diversity across Partnerships in terms of geography, scale, needs and demand.