OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 2 October 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 2 October 2018

CONTENTS

HEALTH AND SPORT COMMITTEE
25th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

Miles Briggs (Lothian) (Con)
*Keith Brown (Clackmannanshire and Dunblane) (SNP)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jeane Freeman (Cabinet Secretary for Health and Sport)
Fiona McQueen (Scottish Government)
Diane Murray (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 2 October 2018

[The Convener opened the meeting at 10:01]

Health and Care (Staffing) (Scotland) Bill: Stage 1

The Convener (Lewis Macdonald): Welcome to the 25th meeting in 2018 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. Although you may use mobile devices for social media purposes, please do not record or photograph the proceedings.

Apologies have been received from Miles Briggs.

The first item on our agenda is the final evidence session on the Health and Care (Staffing) (Scotland) Bill at stage 1. I am delighted to welcome Jeane Freeman to the committee for the first time in her role as Cabinet Secretary for Health and Sport. She is accompanied by Fiona McQueen, chief nursing officer; Diane Murray, associate chief nursing officer; Louise Kay, safe staffing bill team leader; and Ailsa Garland, principal legal officer. Welcome to you all.

I invite Jeane Freeman to make an opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you very much for the opportunity to talk about the Health and Care (Staffing) (Scotland) Bill and to answer the committee's questions.

The bill's aim is to provide a statutory basis for the provision of appropriate staffing in health and social care settings. That matters because in our national health service we focus all our work on meeting the triple aim of healthcare that is safe, effective and person centred, and all the evidence tells us that the provision of high-quality care requires the right people in the right place with the right skills at the right time to ensure the best health and care outcomes for those who need our services.

Our policy intention with the bill is to enable a rigorous, evidence-based approach to decision making on staffing that is safe and effective, takes account of the health and care needs of patients and service users, assists the exercise of professional judgment and promotes a safe environment. That means that we need to understand the workload that is generated in any given setting and circumstance and therefore the skills that are required and the staff mix that will provide them.

My intention is that the bill will put in place a framework to support the systematic identification of the workload needed to improve outcomes and deliver high-quality care. I know that each and every profession contributes to the delivery of positive outcomes for service users. Therefore, I have taken the decision to apply the legislation across all staff groups delivering health and social care services. In taking that broader approach, the bill achieves legislative coherence across the health and social care landscape. That coherence is demanded by the integrated approach that we are taking to health and social care, which rests on the important recognition of value across all staff groups. Providing that assurance for staff and service users is the right thing to do.

In taking that approach across health and care services, we have the advantage of having learned from the existing workload tools and methodology that were developed for nurses and midwives. The development of the tools has been an innovative, evidence-based and, importantly, professionally led approach. That has led to their use in the Welsh legislation on safe staffing and in the development of workload tools that are used by NHS England.

Even though we are starting from that positive position, it is not my intention that the current suite of tools will remain unchanged. It is imperative that they continue to be reviewed and renewed to effectively support multidisciplinary approaches to the delivery of care. The tools are important, but they are only one part of the much broader common staffing methodology and requirements that the bill sets out.

The bill puts in place a process that should be applied consistently across health and social care. It ensures that we use an evidence base to assess the workload that staff face and move away from a reliance on subjective assessments. However, critically, that is combined with staff using their professional judgment to tailor workload assessments to reflect the dynamics of their service and to take their local context into account when deciding how to staff services to deliver high-quality services. That local context will fluctuate, and it requires a common and consistent workload and staffing methodology as well as linked training, so that staff are equipped with the skills to make those assessments. That will have a positive impact on staff, on services and, importantly, on the care that is provided.

Health boards and care service providers and their staff have the shared responsibility to openly and transparently determine how best to ensure that we continue to provide safe and effective

services. However, I would expect to see real-time adjustments made to take account of workload changes and more appropriate movement of staff to acknowledge more effectively the acuity and dependence of service users; substantive posts used, rather than bank and agency staffing; staff understanding how staffing numbers are decided; and staff knowing how to raise concerns and being confident that their concerns will be dealt with appropriately.

The bill does not explicitly define outcomes—nor should it. Our health and care standards and quality measures already define the outcomes that we want to see. In addition to those improvements, the effective application of the legislation will support the wider workforce planning process. If services can clearly identify the workload that is required to meet service users' needs, it will be easier for them to do workforce planning based on that evidence. When local workforce plans are based on better evidence, provided by the consistent application of a common methodology, we will have more robust information to inform national workforce planning and supply.

In developing the bill's provisions, we have listened carefully to those who deliver the services; we have also listened carefully to the evidence sessions that the committee has held. We will continue to engage with stakeholders and consider their views. As always, I will give full and careful consideration to all proposals to strengthen and improve the bill in the weeks ahead and to the committee's own carefully considered views.

The Convener: Thank you very much, cabinet secretary—that gives us a good opening for our discussions.

You talked about the placing in legislation of existing common staffing methods and about enabling better workforce planning methodologies to be developed. Do you regard one or other of those as the principal objective, or do you suggest that they are of equal weight?

Jeane Freeman: They are interlinked. The common methodology is critical, but so are the tools to apply that methodology in order to understand the workload and the skills mix. As I said, that is all important evidence—an evidence base—for making assessments and decisions, but the application of professional judgment is critical to that. I do not think that you can strip out any area and still get as good a result as you will get if you put them all together.

The Convener: The committee has heard the suggestion that the developments, desirable though they may be, do not require legislation. For example, the use of some of the existing tools has been mandatory for the past five years. Is there any reason why you do not simply enforce what health boards are mandated to provide, rather than introduce primary legislation?

Jeane Freeman: As you will understand from some of the information that the committee has gathered, the tools might be mandatory, but there is no consistency with regard to their application. We need to be able to ensure consistency of application, not only in health settings but in social care. Given our direction of travel in terms of the integration of health and social care and how we provide healthcare in secondary and acute settings, it is right that we apply the methodology to determine workload and, from that, work out the right staffing mix to meet that workload and demand across all those settings. The ability to do that requires a statutory underpinning that ensures consistency of approach, because there will be a consistent legislative requirement that ensures that the relevant bodies work in that way.

Of course, the important part of all of this is transparency. Colleagues around the table with more recent experience of the health sector than I have will recall the days when ward charge nurses or sisters used to call each other to swap staff around. That might or might not have worked in those circumstances, but it was hardly transparent and it did not necessarily allow a consistent assessment of workload, based on an assessment of acuity, patient need and so on.

Setting out the system in legislation means that everyone knows what is expected, how to apply the process and how to make decisions based on that process. Further, the important point for the Government is that that gives us better and more robust evidence on which to do our workforce planning.

The Convener: There is a suggestion in some of the evidence that the committee has heard that any inconsistency in the application of the tools that are already mandatory might be because the tools are of different levels of value and usefulness in the eyes of the practitioners whose job it is to evaluate and apply them. Therefore, it might be that the issue is one that perhaps might be best addressed through management. In other words, if something that is mandatory seems not to be working for various reasons, is that not a matter to resolve in discussion, in light of people's management responsibilities, rather than by putting on a statutory basis tools that are clearly not 100 per cent satisfactory in the eyes of those who apply them?

Jeane Freeman: People might argue that they did not use the tools because they were not satisfactory, but I do not have a great deal of patience with that, I have to say. That seems to be a proxy for "Cannae be bothered", and that will not do. If people have a genuine view that the tools

require improvement, there are plenty of opportunities to bring forward those propositions to me or the colleagues who are with me today. The tools are constantly reviewed and developed as we go along.

Although a requirement might be mandatory, it might not necessarily be followed because other pressures might get in the way. If we make the requirement a statutory one, everyone, including our health boards and their chairs, who are directly accountable to me, will understand that they have an obligation to ensure that that approach is taken consistently, across the board and social care providers, and also between boards. That will give all of us a much sounder basis for making decisions, based on workload, about what our workforce needs are and what the right skills mix is in any given circumstance.

The other advantage of that approach, which is a result of a particular facet of the tools, is that there is a capacity to be dynamic and to measure things in real time. As we know, circumstances around a cohort of patients or care home residents can change from one day to the next in acute hospitals and from one week to the next in social care. You need to be able to flex your resource in order to meet that workload demand.

The Convener: Would it be fair to conclude that at least part of the purpose of the bill is to enforce a mandatory approach that has not been properly applied thus far?

10:15

Jeane Freeman: It is fair to say that part of the purpose of the bill is to ensure that we have a statutory framework that is well understood and therefore consistently applied across our health and social care settings.

Brian Whittle (South Scotland) (Con): We understand that there is a lack of consistency in the application of the tools across different health boards. If we are to ensure consistency, we must also ensure that there is consistency in the dissemination and implementation of training across the boards. Rather than there being that "Cannae be bothered" attitude, it is more likely that the training is not in place to ensure that people can deliver using the tools. If we pass legislation on using the tools, what will be different about the way in which you support training and disseminate information?

Jeane Freeman: I am not sure that I completely accept your premise that, where the current mandatory approach is not applied, that is because training is not available. However, I absolutely take the point that when the bill is passed—if it is passed—there should be a requirement to ensure that it is rolled out consistently, with support and information available to staff so that they know how to use the tools and apply the methodology, and what to expect when others are doing that and placing demands on them as staff. There is also a requirement for consistency of monitoring, to ensure that the work is being done across health and social care settings.

The role of Healthcare Improvement Scotland is critical in that regard, as is the role of NHS Education for Scotland, the education body, to ensure that we have a consistent planned programme of roll-out and training and that training is continuous so that as new staff come on board we are able to meet their training needs, too. Should the bill be passed, that will be covered in the guidance on the bill and in the programme of work that is carried out by the chief nursing officer and their colleagues.

Alex Cole-Hamilton (Edinburgh Western) (LD): One of the things that the committee is concerned with is barriers to integration. I am not talking just about the metaconcept of integration as it appears in the Public Bodies (Joint Working) (Scotland) Act 2014, but about there being a streamlined, integrated health and social care service throughout our country.

One of the concerns that has been raised in several evidence sessions is who the bill does not cover. For example, the bill does not cover allied health professionals and certain aspects of social care, such as care at home. Are we risking the creation of yet more silos by not including those equally valid healthcare and social care professionals in their work settings?

Jeane Freeman: Mr Cole-Hamilton raises an important point. I am keen not only that we should break down some of the current barriers, but that we should not create additional barriers. I understand the concerns that he raises.

Fiona McQueen might have more to say about this but, when the developed tool is worked through in social care settings, it will include the skill sets that come from AHPs in many cases, so it is not entirely accurate to say that they are excluded. As one applies the assessment of workload and then considers the skillsets that are required to deliver against the detail of that workload, AHPs in particular will have a critical role to play. They are covered in that way.

The point about care at home is well made. I am not saying that, over time, the approach will never apply to that setting—in part, that is the concern underlying Mr Whittle's question and some of the other issues that have been raised in the committee. We want to take a stage and planned approach to the issue.

In the health and social care setting and in the setting of care homes—unlike in the health setting, where the bulk of care is provided by the national health service—we have a large number of independent providers, and we want to properly engage them in the development of a methodology and set of tools that are appropriate for their setting. We then want to test that to demonstrate its value to their work and provision of care. We would then look to see whether we can move on with that once people are confident in the approach and can see its value.

At this point, it is arguably a step too far to include care at home, as there are issues that need to be teased out around self-directed support and other questions that need to be properly thought through. We need to ensure that stakeholders have the opportunity to bring forward the issues that they want to raise and work with us to resolve and find solutions to those. In my opinion, that is the direction of travel, but it is too early to put that in the primary legislation. Clearly, if we and others wanted to go in that direction in due course, that would come forward as secondary legislation, and appropriately so, so that Parliament could give it the right scrutiny at that stage.

Alex Cole-Hamilton: I have a question about a slightly different issue. The rooting of the tools in statute will ensure their uniform application across the health service and social care, as you described. To my mind, a tool is something that we decide is best practice and then expect those at the front line to deploy. However, we know from the committee's other inquiries that, actually, best practice sometimes germinates from the grass roots up. For example, wards find better ways of doing things and adapt to the particular situations that they face. How responsive will the toolkit be to grass-roots initiatives when people say, "We can do this better," so that we can then apply that across the board and do it better?

Jeane Freeman: If you do not mind, I will pass at least part of your question to the chief nursing officer and the associate CNO, who have a greater understanding than I do of the origins and development of the core tools for nursing. However, I point out that although the tools are important, they are not all that the bill is about. The common staffing methodology is a critical element, of which the tools are part. I ask Ms McQueen to respond on the capacity and flexibility for the tools to be developed and new ideas to come forward.

Fiona McQueen (Scottish Government): We have heard a lot of talk from staff about whether the tools are helpful, and some of that perhaps involves a lack of understanding. It is also about lack of transparency—people do the work and then think that they will get more or different staff, but it does not happen. The transparency that will come through the bill will help with that.

I absolutely expect there to be a professional-judgment element. The grass-roots staff know best how to deliver most effectively, and professional judgment should support that. If someone consistently says, "I'm not going to say that; I'm going to say this", that would, through time, be built into the tool. In acute medicine at the moment, in a medical ward the tool is just a nursing tool. The grass-roots element is about also involving the occupational therapist, the speech and language therapist and the physiotherapist, because they are fundamental to the quality of care, to outcomes and to safety. It is about on-going openness and transparency, professional judgment and moving forward so that we do not say that something that we developed 18 years ago will continue for the next 18 years. It is about moving forward and having constant review.

Jeane Freeman: I can give an example of that. Yesterday, I was fortunate enough to be in Aberdeen to open the first of our major trauma centres. One of the distinctive features of the work of the Scottish trauma network is recognition of the importance of bringing in occupational therapy, physiotherapy and psychological therapy early in the rehabilitation of people who have suffered major trauma. The Aberdeen trauma centre has built into its model new posts that will provide that, and new posts that will provide co-ordination and casework-management functions in circumstances of high acuity that involve trauma.

My intuition is that what the centre has done makes sense and is certainly built on professional judgment, but a common methodology does not lie underneath what it has done. We will have four such centres. I hope that learning from Aberdeen will be picked up and used in the three other centres, but there is not a common basis on which they must do the work. Views might differ in other centres, and people might decide that a different approach is needed.

With our approach, we have a much more solid basis for deciding that there is evidence for doing something rather than just thinking, intuitively, that it is the right thing to do. Where there is commonality of service—major trauma, in this instance—we expect a range of skills to be delivered by different groups of professionals in order to meet particular patient needs.

Emma Harper (South Scotland) (SNP): I suggest that the whole bill process will allow for the development of multidisciplinary and patient-pathway centred tools. As you described, when a trauma centre opens in one place, its evidence can inform the other centres. In that way, we can take an evidence-based approach to the whole system so that the tools can be developed and

delivered in a way that works for the care sector as well as the acute sector. That is important. Can you confirm that the bill process allows for development of an evidence base that can work across the whole health and social care sector?

Jeane Freeman: That is absolutely right. It is important that the approach will also contribute to increased robustness in workforce planning at local level. If local plans are more robust and evidence based, we will be able to collate more robust evidence-based data at national level to help us to work on national workforce planning with increasing acuity.

Emma Harper: At the moment, there are no tools for work in care homes or care in the community. I assume that we will be informed by the evidence from the nursing and acute care tools, and that care homes will not be left behind.

Jeane Freeman: I will pass over to Diane Murray to give some of the detail.

The important thing about care homes is the work that we asked the Care Inspectorate to do to enable discussion with key stakeholders on development of the tools, so that they are appropriate for care homes. There will not be a rigid lift; the nursing tools that work in a health setting will not necessarily be applied to a care home. As we develop the tools, we will take into account the different circumstances in care home settings.

Diane Murray (Scottish Government): That is absolutely right. We want to learn from the approach that we use to develop tools, but we do not want simply to import what we have done for nursing and midwifery to an acute adult setting, for example. Tools are developed with the people who know how to develop them and know what the workload and patient pathways are like. The developers use a reference group and look at particular models of care in a specific area.

As we heard earlier, the care in a care home should be about everything in the patient's life and, most important, about making sure that they are as healthy and as well as they can be and that they are enabled. That is quite different. That is part of the evidence that we would be looking at.

10:30

We would also look at care homes that deliver successful models of care in order that we understand what is in those models. We would look at research into best provision of care and best outcomes for people, and look for where the best practice sits.

As we work up a tool, we will look at acuity and dependency, which are quite different in care homes: it is not acuity in terms of the sick patient, but acuity in terms of how we support a person to stay as well and as healthy as possible.

As people move through the process and gather the evidence, they work out what the workload looks like and what skills, knowledge and expertise are needed around a person to make care as successful as possible. That could mean nursing care, AHPs, inreach from a district nursing team or an advanced nurse practitioner. Most important is that the tool will be developed for the service by the service and with the service.

The Care Inspectorate will have a lead role, but it will work with key partners including the Scottish Social Services Council and the Convention of Scottish Local Authorities. We know that the SSSC has a huge database of information on the workforce and on training, education and skills in the sector, so the work will be based very much within the sector. We might find that the key skill that we need in a care home is occupational therapy, but it would be for that sector to decide that for itself, with support from the methodology that we know works.

The Convener: The cabinet secretary has talked about some of the dynamic day-to-day staffing challenges that are faced on wards. The bill is clearly designed to assist with establishment workforce planning, if you like, at local level. Will it do anything for the dynamic decisions that need to be made every day?

Jeane Freeman: Yes. A consistent methodology, of which the tools are part, and ensuring through training, information and development that the methodology is widely understood and transparent, will allow what my colleagues described to me earlier, which is that across our healthcare and hospital settings, every day there will be what is generally called—it has different names—a huddle. That huddle could be at ward level, specialism level and so on. In the old days, it was about transfer reports from the night shift to the day shift and it was about the patients—how many there were and what was happening with each of them. The huddle is a version of that process, but it is also where people might raise the fact that they are short of a qualified nurse or a specialism. That shortage might well be acknowledged, but people are asked just to accommodate it.

What we would have happen in such circumstances is that people would bring evidence about why they need particular skills—acuity levels in their ward might have changed and the situation is different, so they need someone else, for example. That will allow proper deployment of staff between two situations in real time, and it will allow it to happen in a more transparent way because everyone will be working from the same starting point.

The approach in the bill is more transparent and allows for better decision making because it is evidence-based, with application of professional judgment. It also allows senior staff who are clinically led to flex their resources to meet changing circumstances every day. As we know, that happens a lot, particularly in the acute setting.

The Convener: The evidence that we have heard suggests that the tools are helpful in determining things from year to year, but not day to day. I am interested in how the bill will change provision in a way that makes a difference.

Fiona McQueen: The convener is absolutely right about the annual basis. As we know, workload has peaks and troughs, so as part of our ongoing work we will look at our approach. Whether we call it escalation or dynamic risk assessment, we will build in quick and easy, but open and transparent ways of ensuring that when staff are concerned that care cannot be delivered on that day-to-day basis, what is needed can be accommodated or moved.

However, we would also expect professional judgment to be applied. That will all be reviewed in a systematic way but we would, depending on the situation, expect judgments to be taken sometimes hour by hour and certainly shift by shift or section by section of the day, so that we can ensure a comprehensive approach across our services every day, rather than once a year.

David Stewart (Highlands and Islands) (Lab): Thank you for coming along today, cabinet secretary. I also welcome your officials.

As other members have, I have sat through all the evidence sessions and read all the consultation reports. I think that everyone agrees that we want to see improvement in quality and in staffing, but what I struggle with—I am very happy to listen to your views, cabinet secretary—is how the bill will make a substantial difference, and be a real jump from what we have now to the brave new world of the future. Could you outline what the differences will be in quality of care and adequacy of staffing once the bill is passed?

Jeane Freeman: Thank you for that. I should start by saying that I am not promising a brave new world. Even if I were, the bill alone would not deliver it. The bill will be an important part of increasing our confidence that quality of care based on sound evidence is consistent across our health service. Our health service is, primarily, delivered by people; in those circumstances, as we all know, there will always be occasions when things are not perfect or do not work quite as planned. No legislation that I could introduce could guarantee that that would never happen.

With those clear commonsense caveats, I think that the bill provides two things. It provides for an approach that has been proved to work effectively to be consistently applied across our health service, and one that can be translated into and modified appropriately for our social care setting. That is the right thing to do, because we are moving strongly in the direction of health and social care integration. That consistency of application and, more importantly, the evidence that it produces will allow decision making to be more clearly scrutinised, not only at local level in a ward or care home, but at board level or even nationally. When board X says that it needs a certain number of nurses or AHPs, or that it wants to realign its skills mix in a particular area, it will have an evidence base that is consistent with board Y's evidence base for a different set of propositions. It will mean that there is a process that we can better understand and that is more transparent, having appropriately involved all the staff who should be involved, rather than there simply being management decisions.

The whole approach is led by an increased understanding of the workload that is produced as a consequence of patient or service-user need. That workload tells us what staffing mix we ought to have. It is a transparent and open approach, therefore it can be challenged. Decisions that I might make, or that a charge nurse on a ward or a care home manager might make, will be open to challenge and scrutiny and will be evidence-based. That will allow us to set out our workforce needs, not only now, but for the years ahead.

That information will be produced directly from an understanding of what service user and patient needs require by way of workload. What the bill provides will make a substantial difference and significant grounding for work that we need to do nationally and locally.

David Stewart: You mentioned transparency, and I want to raise a further point about transparency and the empowerment of staff and patients.

I will give you a practical example. I know New Craigs psychiatric hospital in Inverness fairly well. I know some staff who work there and, in my previous life, I did my mental health officer training in the old New Craigs, so I have experience of that organisation. I know from the personal experience of staff who work there that there is an absolutely chronic staffing problem, which I have raised with the health board. I have visited key managers to discuss it.

If the staff wish to complain about the issue, we have the current procedures. What would they be able to do in relation to contacting HIS? I asked some of the key staff who were at last week's evidence session about what the new regime would look like. What would the mechanisms be

for staff and for patients if they were unhappy about inadequate staffing in that establishment?

Fiona McQueen: We would want to work with stakeholders to determine how we could do that most effectively, because staff will tell us that they are not quite sure what to do, or else they put something into the incident reporting system and either nothing happens or something happens three months later. It is something that we would work on with stakeholders, the colleges, HIS and staff.

For patients and service users, we would want to work with people to get something that is meaningful and practical and makes a difference.

David Stewart: Okay. I have a final question—

Jeane Freeman: Before you ask it, can I add to that? One of the things that the RCN said about the legislation is that it welcomes the provisions on escalation. The RCN obviously has a view about further strengthening of that and what that might look like. We are certainly open to further discussion with the RCN about situations such as the one that you have described and how staff can escalate their concerns about staffing levels that are needed to meet a workload demand when they believe that those concerns are not being properly listened to.

It is an important point—as is the earlier point about how we extend training and information and ensure that what is in the bill is implemented consistently—that we will give some further thought to.

David Stewart: I am sure that the cabinet secretary has a busy schedule, but I would certainly like to invite her to visit New Craigs, along with Fiona McQueen and her colleagues.

My final question is to do with looking at what we currently have and what we will have in the future. What recourse, other than the board's own complaints procedures, could an individual pursue if there was a failure in service?

The cabinet secretary will be aware of the view of the Royal College of Physicians of Edinburgh. It does not feel that there is full transparency about what would happen if boards do not fulfil their duties under the bill. What does the bill provide that is new in relation to transparency?

Jeane Freeman: Could you just explain that a little bit more? Are you talking about what a patient might do or about what a staff member might do?

David Stewart: I am talking about both—I was lumping both together. It is important that we empower both staff and patients, because clearly, if there is a failure in the quality of service or a failure in staffing, that will impact on staff and on the quality of the experience that the patient gets.

10:45

Jeane Freeman: This bill contains amendments to the National Health Service (Scotland) Act 1978, so it is linked to that act. The 1978 act gives a number of powers to ministers that we can exercise, which include the power of direction if we believe that a board is failing to adequately meet its statutory responsibilities.

That is at the upper end of the scale, if you like. In getting to that end, there are a number of steps. Patients, of course, have the opportunity to make complaints, and if a person thinks that a health board has not fully addressed their complaint, there is the Scottish Public Services Ombudsman. The stories on the Care Opinion website are important—although there are no direct sanctions in that regard, they are widely read and used by our boards, and I review the site regularly to see what people are saying about the care that they have received.

For staff, there is of course the formal grievance procedure. In addition, I am more than happy to consider anything that comes forward from the Royal College of Nursing and others about the escalation process. We also have the regular reviews that go on between my officials and boards. That includes the work of the Scottish partnership forum and the Scottish workforce and staff governance committee, as well as clinical reviews and the annual review of board performance that I and my fellow ministers conduct.

David Stewart: If there is a postcode lottery such as has been described to us in other contexts, whereby there is provision for treatment in one board area and not in another, will you have more central control to ensure that a board does what is laid down in legislation?

Jeane Freeman: I currently pick up on and pursue situations that are raised with me—as they often are by you or one of your colleagues—in which an individual is not receiving a treatment for reasons that I do not understand. Of course, no politician should start guddling around in clinical decisions—Lord help us, if we ever do so. However, there are circumstances in which what I expect boards to do is not necessarily being done consistently, either within a board area or between board areas. We pursue matters in those individual circumstances.

The Convener: On the same topic, if a provider in social care is unable to comply with the new statutory requirements, what will the consequences be?

Jeane Freeman: The Care Inspectorate has a number of powers that it can and does exercise to secure improvement, from putting in place an improvement notice right through to seeking a

court-approved sanction to close a care home, if it thinks that the residents are at risk. We know that it exercises those powers. The Care Inspectorate will inspect on the basis of what is in legislation, should the Parliament agree to the bill.

Sandra White (Glasgow Kelvin) (SNP): My question probably takes us back to David Stewart's initial question. I hope that you will forgive me, cabinet secretary; I have listened to all the evidence and it is becoming clearer to me what is happening with not just the tools but how the approach to staffing will drift down into the care sector—that is the issue that people have raised with me, to put it in a nutshell.

You talked about secondary legislation and translating and modifying approaches for the care sector. Is there a timescale for getting tools in place? There are tools in place for nursing in the hospital setting; when will the approach filter down to social care? Last week, the committee heard from AHPs, Unison and the Care Inspectorate that they are working together and looking forward to the tools being available, but no one knows whether there is a timescale for the approach filtering down to grass-roots level. I am interested in that and in how integration and what health boards do affect people in care homes. Can you give us a timescale, cabinet secretary?

Jeane Freeman: Fiona McQueen or Diane Murray might want to add to what I am about to say. The fact that bodies are working together as you described and looking forward to the bill becoming law gives us a significant indicator of how quickly we should be able to manage this. We are taking the proven, evidence-based methodology that is used in nursing and midwifery and, with those people's direct involvement and the involvement of the Care Inspectorate, we are enabling those tools to be taken and modified for the care home setting, in a way that involves the organisations that are active in the care home setting.

As soon as that is achieved, the tools will be applied. In one sense, those organisations are the masters of that timescale, and will have been directly involved in developing and designing the tools. However, they are starting with a methodology and set of tools that have already been proved to work in a particular setting; they will then look at how to apply them in the care home setting.

That is the care home setting; that is not care at home. As I explained to Mr Cole-Hamilton, that is the direction that we would look to take for care at home, but the bill does not cover that—rightly so, because we are not yet ready to move there. Should we get to that point, it would be appropriate for that to come back as secondary legislation so that Parliament can give it due scrutiny.

Diane Murray: We have increased the infrastructure around this as part of the development of the bill. We have a process for the review and maintenance of the current tools and for taking forward evidence on where we feel that the development of new tools needs to go next. A national group is working on where we should go next and will come forward with proposals, based on its intelligence of the sectors that it is working with.

Fiona McQueen: For care homes, the timescale is right away; in other cases, it is with due regard to providers' need and so on.

Jeane Freeman: If I can add further information in response not only to Ms White's question but to Mr Whittle's, the financial memorandum sets out the costs, which cover the development of the tool, including staff training and support for boards and others. We are planning all of that into what we have before us.

Sandra White: I raised the issue about the financial memorandum previously, and I am pleased to see that that information is there. I assume that this is a moving feast, and that there will be checks and balances as it moves along, so that things are transparent. The trade unions raised the issue of the variation between local authorities. As you have said, the bill does not include care at home, which you will be looking at in the future.

Can I put something into the mix, or maybe take something out of the mix? Obviously, Brexit is coming up and, as was mentioned in evidence, we have an ageing workforce. That is particularly the case in care homes, which can have more multifaceted nursing provision. How will that affect the bill? For all the tools, have you taken into consideration Brexit and the effect on care homes if the number of staff coming here is affected?

Jeane Freeman: I dearly wish that you could have taken that out of the mix—it would have been a significant help to all of us—but unfortunately you cannot and neither can I. Equally, putting it into the mix is a bit difficult too, because we do not know the circumstances that we will be in.

There is no doubt that if fewer European Union nationals are working in Scotland's health or care settings or, even worse, if those who are currently here no longer want to remain, and return to their home countries, there will be significant difficulties in workforce numbers. That will be exposed in part by the application of a methodology and tools that provide evidence on workload demand. After that evidence is provided, professional judgment will be used, which will tell us what kind of skills mix

we should have and where we should be getting it from.

If workplaces are struggling because some of the individuals who provided capacity in the past are no longer here, the difficulty is self-evident.

I firmly believe that no responsible Government would ever say that it is possible to mitigate all those risks completely, but part of what we are doing involves looking at how we grow our own, as it is described. For example, last week I visited Wishaw general hospital, which has developed its own theatre academy—as the Golden Jubilee national hospital has—in order to upskill its nursing staff. As the newly qualified trainees—we have seen a significant increase in student trainee numbers for six years in a row—come out ready for work, existing staff can be upskilled to take on additional roles. As part of the "grow our own" approach, there is on-going work with our further and higher education sector on articulation from college-based courses to higher education, and with young people before they leave school to ensure that they have done some foundation-level work in health and social care. That is all about increasing the number of individuals who look to health and social care as an opportunity.

Last night, as it happens, I was at the Prince's Trust awards. The get into healthcare programme produced a couple of award winners, and we were able to talk about the new partnership with the Prince's Trust that will give an additional 400 young people opportunities in health and social care. Through a range of actions, not only within my portfolio but across other Government portfolios, we are seeking to increase the opportunities for, and the throughput of, young people and others, including women returners, in health and social care. That is the right thing to do. Will it mitigate the difficulties that Brexit—whatever form it takes—will give us? No, it will not mitigate those difficulties completely, and there will be difficult decisions to make and issues to resolve once we know what we are dealing with.

The Convener: For the avoidance of doubt, can you confirm that there is nothing in the bill or in the financial memorandum that in any way helps employers who are faced with severe staff shortages in health or in care?

Fiona McQueen: Can I say something?

Jeane Freeman: Yes, absolutely—you can do so in a minute. The financial memorandum talks about the costs of implementing the bill, but—appropriately—it does not talk about the cost of employing staff. There is nothing in the bill in that context. I will bring in Fiona McQueen.

Fiona McQueen: I will leave Brexit to one side and come back to the point about older workers that Sandra White rightly raised. When we listen to staff, they talk about workload being difficult. We know that there is a real evidence base that shows that meaningful and fulfilling work is good for one's health. Putting aside differences about the pension age, the reality is that meaningful work is good for people's health. The bill will enable an appropriate assessment of workload so that, no matter what age someone is, they should be able to come in and do their job, and be fulfilled by and take pleasure in it rather than being exhausted. We will also be able to look at how we support the older worker to continue to work.

The cabinet secretary has spoken eloquently about the work that we are doing to widen access and to bring other people in. That will help, and I would expect it to make a difference to our older workforce, as we will able to keep them in employment because we will absolutely have in place safe and appropriate staffing that is commensurate with the workload that people are facing.

Sandra White: I was going to apply for a job, but you are fine—thank you very much. [*Laughter*.]

Brian Whittle: It is probably appropriate that I refer members to my entry in the register of members' interests. I am still a director of a company that is developing a communication and collaboration platform and tools, including for the healthcare profession.

The Scottish standard time system piggybacks on the payroll platform. That is not unusual, but it means that we are basically bolting software tools on to a platform that was not initially designed for that purpose. The suitability of that platform has been questioned in the evidence that we have heard.

11:00

What sequence of events led the Government to legislate for using tools that are—as we have heard—becoming outdated on a potentially unsuitable platform before we have a new bespoke platform and then reviewing and developing robust, workable tools for that specific platform?

Jeane Freeman: I will let Ms Murray take you through some of the detail on that. As Mr Whittle knows, one of the key pieces of advice that Audit Scotland always gives in relation to information technology and IT platforms is not to build something brand new, if at all possible. It advises us to consider what we have that works and see how it can be adapted or examine what proven, workable platforms there are on the shelf and see whether those can be adapted to meet our needs. Only if none of that works or if there is a gap should we build from new.

That is the approach that the Government takes. It is the approach that I took in my social security brief and that I will take in health.

I will ask Ms Murray to deal with the specific details of that.

Diane Murray: Mr Whittle will be aware that the SSTS—Scottish standard time system—platform is the NHS Scotland payment platform. The tools were put on to that platform because it was the most appropriate place for them at the time. When people know how to use the IT and how to put the information into SSTS, it is all fairly simple. I hope that the team was able to show members that earlier this morning.

As the committee is aware, we are going to procure an e-rostering system and that process will be completed by the end of 2018. When that system is in place, it will give us real-time information about our rosters, which will fit into the approach. We will then take a view on where the best place is to situate the tools, whether that continues to be on the SSTS platform, a new payroll system or a new platform that links with our electronic rostering. We need to understand the capabilities of each before we move towards making such a change.

The tools are capable of being revised and renewed as we go along. The tools can take into consideration the context of the service in which they are provided. The platform that they are on is a repository of that information and produces reports for us. When we better understand how that works as we go along, we will know the best place to situate the tools.

There has to be a link between the electronic rostering system and the tools platform. We will be absolutely clear about that in the procurement exercise to ensure that the systems can talk to and feed into each other. That work has not yet concluded. That is probably as much as I can say on that.

The first premise is to understand and be sure about what we need from any IT system and the next step is procurement.

Brian Whittle: Cabinet secretary, you are right to say that we should not build from scratch if we can avoid it and, in the health sector, there will be a platform that can be taken off the shelf and adapted, at the very least. However, when developing tools that will sit on the current platform, would not the best process be first to understand the platform on which they sit? Without question, you would develop a different tool for a different platform.

Diane Murray: We will have to do both. The tools that sit on that platform do so as we intended. However, if we develop something different that might sit within an integration joint board setting, we would have to consider the platform. That consideration is an important part of the process.

Brian Whittle: So you are in a procurement loop in which you are looking at the platform on which the new tools will sit.

Diane Murray: We are looking at the e-rostering platform, after which we will take a decision about whether to stay on the present site or to transfer over to that. As part of the procurement exercise, we will be asking about the ability of the platform to feed into our workload tools platform.

Brian Whittle: The financial memorandum refers to the work of the nursing and midwifery workload and workforce planning programme in developing the new tools. Will the programme include work on tools for other NHS staff groups and settings, as the financial memorandum indicates?

Diane Murray: As we said in relation to the care home setting, we will use the learning from that, but the work cannot take place in isolation from the staff who know how to undertake that work. If we were thinking about developing a multiprofession tool, we would bring together a clinical reference group that includes all the people who would use that tool. It would have to involve more than just nursing input.

The important part is the learning that takes place. Such learning is being taken forward in the Nurse Staffing Levels (Wales) Act 2016, in the tools that have been developed in some of the English settings and in some of the multiprofession tools. We know that that learning is robust, but we need to bring the evidence from the other services and the other professions into that process. Rather than throwing the baby out with the bath water, we need to be able to change and adapt, according to the requirements that we find.

Brian Whittle: In the context of multidisciplinary teams and multidisciplinary tools, we have had evidence from allied health professionals, who feel that there is a danger that a two-tier system might be created and that they might be left behind. When do you envisage bringing them into the development of the tools?

Jeane Freeman: As I said earlier, when the tools that have been developed are applied in the care setting or even the hospital setting, it might be the case that, as consideration is given to what the right skills mix is for the workload, allied health professionals will turn out to be the very people who have the skills that are required to meet that need. As we have described, the Care Inspectorate will enable work to be done to review the current tools and to look at how they need to

be modified and applied to a care home setting. We expect a degree of AHPs' expertise to be involved in that work to develop the tools that would be appropriate for a care home setting.

Keith Brown (Clackmannanshire and Dunblane) (SNP): As a new member of the committee, from listening to the evidence sessions, the idea that I have in my mind is that what is proposed is a bit like intelligence-led policing, which the cabinet secretary will be familiar with from one of her previous roles. It is an evidence-based approach, but one that involves professional judgment.

In its evidence, Unison was concerned about staffing, as you would expect. I made the point that I would have thought that the bill would help, because if we continue to apply the tools and the common methodology, that will show where there is a requirement for increased staffing. I do not think that that is how Unison saw the bill, but that is how I see it.

Ms McQueen said that it had sometimes been the case that when existing tools were applied, that had led to an expectation that there would be increased staffing, only for people to be disappointed. Are you confident that that was because the evidence showed that additional staffing was not required? Do you think that the bill provides a tool that will help providers and commissioners of health and care services to recognise when there is a need for increased staffing?

Jeane Freeman: The short answer to that is yes. There are a couple of reasons for that. First, I mention in passing the point that I made earlier about escalation and how that works. Secondly, when we have a consistent methodology that produces evidence on the workload, to which professional judgment is applied, and that process takes place on a statutory basis, with Healthcare Improvement Scotland and the Care Inspectorate being required to look at whether that has been applied properly and acted on, we diminish the opportunities for people to be disappointed because they believe that they produced evidence that a set of skills was needed and it did not happen.

We also increase the likelihood that those who made the decision not to respond positively to the evidence have that decision very clearly scrutinised as to why they did not do that when the evidence was there and the professional judgment was applied. If people know that that is the basis on which they will be inspected and on which improvement notices will be put on their service, that will help them to understand the importance of not only consistently applying the methodology and the tools but acting on the results of that. I expect the situation to be significantly improved from the current one.

That does not mean that the passing of the legislation will guarantee that staff will not be disappointed. They may be disappointed, because they may nonetheless feel that the solution that is provided to them is not the one that they wanted. As long as that solution can be defended, in terms of the proper use of the evidence and clinical judgment in the circumstances and the local context, as I described earlier, that decision is fair. The most important thing is that the decision is clearly set out and understood.

That is my point about transparency. If I cast my mind back quite a long time, I can recall that part of the disappointment is feeling that decisions were made and nobody ever really explained why they were made. You did not know why ward A got the extra pair of hands and your ward did not. Was it just because the manager did not like you or liked someone else more? All sorts of possibilities run through your mind when you do not know transparently and clearly the basis on which a decision has been made. Of course, one of the things that the bill does is to address that.

David Torrance (Kirkcaldy) (SNP): The cabinet secretary has touched on flexibility. Does the bill allow sufficient flexibility for changes in working practices and technology? How quickly will we be able to react and implement changes?

Jeane Freeman: In what sense?

David Torrance: I am talking about changes to working processes and technology, which have an effect on staff levels.

Fiona McQueen: There is absolutely flexibility in relation to changing working practices. Over the past 10 years or so, the changes in healthcare delivery have been dramatic and remarkable. There is no point in saying that we will just continue with the staffing that we needed 10 years ago. Developments in technology sometimes mean that more complex care can be carried out for people who are more ill or frail, for which we need more staff. Sometimes, technology means that no staff are needed because there is a technological solution. With the consistent, routine and regular application of the tools, with the use of professional judgment and by involving service users, patients and staff in moving forward, we will absolutely be able to embrace change. We know that the future will be different, so we would expect to see that change.

David Torrance: What mechanisms are in place to share good working practices across the NHS? Sometimes, management is slow to adapt or take change on board.

Jeane Freeman: That is a fair point. One important thing about the bill is that, because we are putting the approach on a statutory footing, it will become part of the work that Healthcare Improvement Scotland and the Care Inspectorate do in conducting inspections. They will rely less on the spread of good practice, because there will be a statutory requirement. I am not suggesting that we have statutory requirements in every area where we might want to spread good practice, but it takes us away from relying on the spreading of good practice. That is not to suggest that people do not want to pick up good practice, but other priorities get in the way, such as the work that they do day to day and statutory duties. Having a legislative framework will give what needs to happen greater robustness and force.

11:15

The Convener: I seek clarity on some points. Is it still the intention that boards will be required to report on whether the tools have been properly applied rather than on the outcomes of the common staffing method for future staffing numbers?

Jeane Freeman: No. We will expect boards to report not only on the application of the tools but on the outcomes, and Healthcare Improvement Scotland will look at that in its inspections.

The Convener: Will Healthcare Improvement Scotland have the powers and the ultimate sanctions in parallel that we have heard are available to the Care Inspectorate, which can take significant measures when commitments are not fulfilled?

Jeane Freeman: In its inspection role, Healthcare Improvement Scotland has a number of powers, which it will continue to have. It also has an important improvement function so, when standards are not being met and duties are not being complied with, it has a responsibility to offer support to allow people to improve and meet standards or fulfil duties. If improvement does not happen, other steps can be taken.

The Convener: What would you expect a health board to do if it undertook the statutory obligations that are being created in the bill and could not meet all the requirements that were put on it as a consequence?

Jeane Freeman: If a board used the tools and applied professional judgment but could not fill the roles—I think that you are asking about that—I would expect it to speedily inform the Government of the situation, to discuss alternative solutions with us and to work with us to resolve the situation in the medium to longer term. I would also expect the Government's health directorates to note the situation for workforce planning purposes and to take a view on whether it involved local circumstances or whether it was evidence of a trend for particular skills or a particular expertise.

Emma Harper: I have a couple of questions about care homes and the Care Inspectorate. Paragraphs 84 to 90 of the policy memorandum talk about the Care Inspectorate. Paragraph 84 says:

"the Bill sets out a mechanism to develop tools and a methodology for care homes for adults, in the first instance. The legislation does not seek to prescribe an approach to workload or workforce planning on the face of the Bill in care service settings, but rather to enable the development of suitable approaches for different settings".

Concerns have been raised about the difficulty of recruiting staff for care homes. The comment has been made that

"we are already at the bottom line in terms of resource for providing the service."—[*Official Report*, *Health and Sport Committee*, 18 September 2018; c 7.]

I am interested to know what efforts are under way to address the care sector's concerns and the risks of consequences because of the recruitment challenges.

Jeane Freeman: I understand the care sector's concerns, although it would be inaccurate to say that such concerns are evidence based across our entire country. In some parts, care homes are successfully recruiting at a significant level to meet their needs.

A number of initiatives are under way to ensure that staff are available for care homes. Some care homes work in clusters; for example, if they need allied health professionals, such as occupational or physical therapists, they can share that staff resource. At least one local authority has reorganised its services and, under its policy of no compulsory redundancies, has offered retraining opportunities for staff whom it still employs and who want to take up opportunities in care homes and childcare.

I spoke about initiatives with regard to the articulation between school, college and higher education. That work is focused on young people and adult returners. In local settings, there are often opportunities for women to return to work in a care home setting. Our application of the living wage to care home workers is an important element of making care home work attractive to people.

Would Fiona McQueen or Diane Murray like to add to that?

Fiona McQueen: My team leads on work with Government colleagues, Scottish Care, the Royal College of Nursing and other stakeholders to enhance—almost to define—the nursing contribution to care homes. We recognise that the

area can be a challenge. There are some practical issues, for example around support for care workers in care homes to do nurse training, which has been done in the NHS for some time. There is also wider work to look at general support for care home staffing.

The Convener: I know that work is going ahead jointly with COSLA under part 2 of the national workforce plan. My final question to the cabinet secretary is simply whether she is satisfied that there is no contradiction between the requirements in the bill and the work that is already under way, and that there will be no disruption to that joint working?

Jeane Freeman: I am satisfied that there will be no disruption to that joint work, which is really important. Should the bill be passed, I am confident that it will contribute significantly to robust workforce planning across health and social care.

The Convener: I thank the cabinet secretary for attending with her officials. I suspend the meeting for two minutes to allow the panel to leave.

11:22

Meeting suspended.

11:26

On resuming—

European Union (Withdrawal) Act 2018

Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations

Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations

Blood Safety and Quality (Amendment) (EU Exit) Regulations

The Convener: We will now consider European Union (Withdrawal) Act 2018 measures. We have a further proposal from the Scottish Government to consent to the UK Government legislating, using the powers under the 2018 act, in relation to three statutory instruments.

Members will have seen the paper from the clerks, which notes that each set of regulations is identified by the Scottish Government as falling under category B. Most of the content is technical and minor, but involves matters about which we may wish to take evidence relating to the notification from the Scottish Government and, potentially, external stakeholders. Colleagues will recognise that the regulations relate to matters that we will consider in great detail after the October recess, so there is relevance there.

Joe FitzPatrick states in his letter that he requires a reply within 28 days—the 14 days of the recess are not included, so we have until 10 November. Although the Scottish Government's paper reached members only on Friday, I suggested that we include it on today's agenda to enable us to decide whether we want to obtain evidence before approving the proposal or otherwise.

Sandra White: I have looked at the suggestions about writing to people or bringing them in to answer questions. I am quite concerned about the contents of the regulations, which relate to human tissue, blood and transplants. I will not go into the whole thing, as that is for questioning, but it is imperative that we have an evidence session. We are considering things that have far-reaching consequences.

The Convener: Those points are certainly relevant, but we do not have to make that judgment today. All we need to decide today is whether we agree to write to the parties with the most interest in the regulations. At our first meeting after the October recess, when we will

have their replies, we can decide whether that information is enough or whether we want to take further evidence.

Alex Cole-Hamilton: What flex does our work plan have, should we decide to take such evidence?

The Convener: There is a little. After the October recess, we will run into the Human Tissue (Authorisation) (Scotland) Bill, which is pertinent in the sense that the regulations clearly relate to it. Given that convergence, a half-hour session is possible, if we feel that that is needed on the basis of the evidence. I suspect that we should obtain written evidence before coming to a view on that. Do members agree to issue correspondence to the organisations that are mentioned in the clerks' paper, and to return to the matter to consider the responses at our meeting immediately after the October recess?

Members *indicated agreement.*

The Convener: Thank you very much.

11:30

Meeting continued in private until 12:03.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba