OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 29 January 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 29 January 2019

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HEALTH AND SPORT COMMITTEE
3rd Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
*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)
Alison Johnstone (Lothian) (Green)
Monica Lennon (Central Scotland) (Lab)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 29 January 2019

[The Convener opened the meeting at 10:00]

Subordinate Legislation

Foods for Specific Groups (Medical Foods) (Miscellaneous Amendments) (Scotland) Regulations 2018 (2018/392)

The Convener (Lewis Macdonald): Good morning, and welcome to the third meeting in 2019 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are switched off or to silent mode. It is acceptable to use mobile devices for social media purposes in the room, but please do not take photographs or record proceedings.

The first item on the agenda is consideration of the Foods for Specific Groups (Medical Foods) (Miscellaneous Amendments) (Scotland) Regulations 2018 (2018/392). The instrument is subject to negative procedure. No motion to annul it has been lodged. The Delegated Powers and Law Reform Committee considered it at its meeting on 22 January and agreed to draw it to the attention of the Parliament on the general reporting ground, because the preamble to it does not follow proper drafting practice. However, that committee does not think that the inadequacies justify asking for the instrument to be redrafted.

As members have no comments to make on the instrument, does the committee agree to make no recommendation on it?

Members *indicated agreement.*

Health and Care (Staffing) (Scotland) Bill: Stage 2

10:01

The Convener: Agenda item 2 is stage 2 consideration of the Health and Care (Staffing) (Scotland) Bill.

The Cabinet Secretary for Health and Sport, Jeane Freeman, is accompanied by Diane Murray, who is associate chief nursing officer; Louise Kay, who is the bill team leader; Julie Davidson and Johanna Irvine from the Scottish Government legal directorate; and Jonathan Brown, who is a parliamentary counsel. The officials at the table will change according to which amendments are being debated. I welcome you all.

I also welcome Monica Lennon, and welcome back Alison Johnstone, who are here because they have lodged amendments to the bill. I welcome in advance of his arrival Anas Sarwar, who will join us for the same reason.

Members should have with them a copy of the bill as introduced, the marshalled list of amendments, which was published on Thursday, and the groupings of amendments, which sets out the amendments in groups in the order in which they will be debated.

It might be helpful to members and others if I briefly explain the procedure. There will be one debate on each group of amendments. I will call the member who lodged the first amendment in the group to speak to and move that amendment, and to speak to all the other amendments in the group. I will then call other members who have lodged amendments in the group. Members who have not lodged amendments in the group, but who wish to speak, should indicate that by catching my attention in the usual way. If the cabinet secretary has not already spoken to the group, I will invite her to contribute to the debate just before moving to the winding-up speech. I will conclude the debate on the group by inviting the member who moved the first amendment in the group to wind up.

Following the debate on each group, I will ask the member who moved the first amendment in the group whether he or she wishes to press it to a vote, or to seek to withdraw it. If the member wishes to press the amendment, I will put the question on it. If a member wishes to withdraw their amendment after it has been moved, that must be agreed to by the other members of the committee. If any member present objects, the committee will move to a vote on the amendment.

If a member does not want to move their amendment when it is called, they should simply

say, "Not moved." Please note that any other member present may move the amendment. If no one moves the amendment, I will immediately move on to the next amendment on the marshalled list.

Only committee members may vote on the amendments. Voting in any division is by show of hands. I remind members to indicate their intention clearly and to keep their hands in a position in which they can be seen, so that their votes will be recorded fully by members of the clerking team.

I will ask the committee to approve each section of the bill at the appropriate point.

We will make whatever progress we can make today and seek to get through as much of stage 2 as we can by 12 o'clock.

Section 1—Guiding principles for health and care staffing

The Convener: Amendment 81, in the name of Monica Lennon, is grouped with amendments 82, 1, 83, 2, 8 to 12 and 14.

Monica Lennon (Central Scotland) (Lab): Amendments 81 to 83 would ensure that the definition of the purpose of staffing includes a reference that it should achieve the best possible outcomes for patients. Together, the three amendments would ensure that individuals, whether they are national health service patients or people using social care services, would be placed at the heart of what the bill is trying to achieve.

I am sure that we all agree that staff are the backbone of the NHS, but they are not there to deliver a service for the sake of it; they are there to look after and care for patients and users of its services. That is also reflected in amendment 1, which is in Alex Cole-Hamilton's name. The health and social care sector operates with that mindset, and the policy memorandum for the bill states that the bill's aim is to be an enabler of

"high quality care and improved outcomes for service users."

However, if that is the intention, it should be explicit in the bill, especially as the rest of the duties in the bill are to be interpreted and implemented through the lens of the guiding principles. Otherwise, the bill runs the risk of becoming process driven and setting a new tick-box exercise, which no one at the table wants.

Amendment 8, which is in the name of the cabinet secretary, will add "improving ... outcomes" to the list of considerations that are to be factored in when arranging health and social care staffing. However, section 1 is caveated as being required only

"in so far as consistent with the main purpose".

Ensuring the best outcomes for patients and people who require social care should not be caveated, because it is the reason why we have health and care services and staff in the first place.

I move amendment 81.

Alex Cole-Hamilton (Edinburgh Western) (LD): Amendments 1 and 2, which are in my name, should not be controversial. Monica Lennon has alluded to the reasoning behind them, which is to recognise that person-centred planning is absolutely key throughout our health and care services. The bill does not necessarily reflect that in its language. Amendments 1 and 2 seek to extend the reach of that to recognise that the approach has to be about the

"health, wellbeing and safety of service users"

as much as it is about staff.

The one amendment in the group that I have a problem with is amendment 9, which is in the name of the cabinet secretary, because I believe that it would dilute the intention of the bill by changing it from being about having the right staff in the right place at the right time to being about

"making the best use of the available"

staff and resources. We need to throw our caps over the wall on the issue and to be a bit stronger in our intention.

My amendment 11 is really important in terms of the debate that we heard throughout stage 1 about extending the reach of the bill to allied health professionals. The amendment recognises that the toolkit and the tools that it contains have an application that goes far beyond primary care clinicians. We heard strong testimony from a range of allied health professionals about their desire to be included in the bill, to work towards best practice, and to work together with primary care colleagues. The Royal College of Nursing Scotland had some anxiety about use of the word "together", but is happy with amendment 11 as long as its intention is that a collaborative approach be taken, rather than people just working side by side or cheek by jowl. I confirm that that is the case.

The Cabinet Secretary for Health and Sport (Jeane Freeman): In its stage 1 report, the committee asked the Scottish Government to place in the bill an additional guiding principle linking the outcome focus to the health and care standard and quality measures. Amendments 8 and 12 are intended to do just that. They will insert a new general principle of

"improving standards and outcomes for service users",

alongside a definition that provides that by

"standards and outcomes for service users",

we mean the health and social care standards.

Amendment 9 will remove the phrase

"allocating staff efficiently and effectively"

from the list of guiding principles in section 1(1)(b) and replace it with

"making the best use of the available individuals, facilities and resources".

That wording, which was used in the Public Bodies (Joint Working) (Scotland) Act 2014 integration planning principles, makes it clear that we do not wish health boards and care services to address each and every risk simply by bringing in agency staff. We wish to see them managing their services and staff "efficiently and effectively", and to see them considering whole-service redesign where appropriate, in order to ensure that they are providing the best possible service to their patients and service users.

I heard the concern from some staff groups that the bill is not specific enough about their inclusion, and that it does not recognise the importance of multidisciplinary working. Amendment 10 will make it clear in the guiding principles that multidisciplinary approaches to staffing should be considered where appropriate. I confirm that the Government is happy to support amendment 11, which is in the name of Alex Cole-Hamilton, which will place a definition of "multi-disciplinary services" in section 1.

Related amendment 14 will provide further clarification in the general duty in proposed new section 12IA of the National Health Service (Scotland) Act 1978 in order to ensure appropriate staffing and that the contribution of all professional disciplines to delivery of high-quality care must be considered.

Although I am supportive of the aims of amendments 1 and 2, which are in the name of Alex Cole-Hamilton, I say with respect that they are entirely unnecessary, and seem to have stemmed from a slight misunderstanding of the bill as drafted. The duty in proposed new section 12IA of the 1978 act to "ensure ... appropriate" staffing already sets out that, for the national health service,

"It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals are working in such numbers as are appropriate for ... the health, wellbeing and safety of patients, and ... the provision of high-quality health care."

Part 3 of the bill contains an equivalent duty for

"Any person who provides a care service".

Sections 2 and 3 of the bill set out that "every Health Board", in complying with proposed new section 12IA of the 1978 act, and

"any person who provides a care service",

in complying with section 6 of the bill,

"must have regard to ... the guiding principles".

Therefore, the principles and the general duty are intrinsically linked. Those who must follow the general duty must also

"have regard to the guiding principles"

in doing so.

Amendments 1 and 2 are therefore not necessary, because they would add nothing new to the bill but would, instead, duplicate—indeed, through amendment 2 they would, arguably, triplicate—something that is already clearly set out in the bill. Taken literally, they would mean that a health board would be legally required to provide appropriate numbers of staff for

"the health, wellbeing and safety of"

patients, and, in doing so, would have to arrange staffing for the health, wellbeing and safety of patients, and—in so far as is consistent for that purpose—arrange staffing for the health, wellbeing and safety of patients. I am sure that the committee gets my point. I say to Alex Cole-Hamilton that we do not need to replicate statutory duties in order for them to have legal force. On that basis, I ask the committee not to support amendments 1 and 2.

On amendments 81, 82 and 83, which are in the name of Monica Lennon, the guiding principles in section 1 apply across health and social care and must recognise that the positive outcomes that service users wish to see are not just clinical or medical in nature. Amendment 83 would state that the purpose of staffing for health and care services is

"to ensure the best health care outcomes",

but neglects to mention the wider health and care outcomes, which are set out in the health and social care standards. For that reason, I ask the committee to reject amendments 81 to 83.

The Convener: As no other member wishes to speak, I ask Monica Lennon to wind up.

Monica Lennon: The cabinet secretary has made some valid and interesting points. However, I am sure that members have put a lot of work into their amendments, and there might be some points that we disagree on. I do not have much to add. I know that I do not have a vote in the committee, but I support the amendments. I had concerns about amendment 9, because I know that the RCN has expressed concerns about it. However, I know that the cabinet secretary has expressed a different view.

10:15

The Convener: The question is, that amendment 81 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 81 agreed to.

Amendment 82 moved—[Monica Lennon].

The Convener: The question is, that amendment 82 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 82 agreed to.

Amendment 1 moved—[Alex Cole-Hamilton].

The Convener: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 1 agreed to.

Amendment 83 moved—[Monica Lennon].

The Convener: The question is, that amendment 83 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 83 agreed to.

Amendment 2 moved—[Alex Cole-Hamilton].

The Convener: The question is, that amendment 2 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 2 agreed to.

Amendment 8 moved—[Jeane Freeman]—and agreed to.

Amendment 9 moved—[Jeane Freeman].

The Convener: The question is, that amendment 9 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

Against

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 9 disagreed to.

Amendment 10 moved—[Jeane Freeman]—and agreed to.

Amendment 11 moved—[Alex Cole-Hamilton]—and agreed to.

Amendment 12 moved—[Jeane Freeman]—and agreed to.

Section 1, as amended, agreed to.

Section 2—Guiding principles in health care staffing and planning

The Convener: Amendment 84, in the name of Miles Briggs, is grouped with amendments 85 to 89 and 110.

Miles Briggs (Lothian) (Con): The purpose of amendment 84 is to place a duty on commissioners to be satisfied that, in contracting or agreeing services, they have taken

"all reasonable steps to ensure that"

providers are able to deliver health services that have

"appropriate staffing arrangements".

As the bill is drafted, commissioners must only

"have regard to—

(a) the guiding principles ... , and

(b) the need ... to have appropriate staffing arrangements in place."

Commissioners should be clear about their part in ensuring staffing for safe and effective care. As commissioners, NHS boards and integration authorities should therefore be under a clear duty to commission services in a way that allows health service providers to arrange staffing for safe, high-quality care. If services are not commissioned with sufficient funding to ensure that there are appropriate numbers of staff, or staff with appropriate expertise, it is the provider and not the commissioner who will be held accountable. Ultimately, it is patients who may experience poor-quality care as a result.

Amendment 86 is similar and replicates amendment 84 for care services.

I move amendment 84.

Monica Lennon: Amendments 85, 87 and 89 are aimed at improving the ease with which there can be scrutiny of staffing levels and the implementation of the duties in the bill. For health services, amendment 85 does that by, first, improving the information that is made available about decisions concerning staffing levels in health services; secondly, ensuring that decisions about staffing levels are linked to improving outcomes for service users, rather than being made for financial or practical reasons; thirdly, requiring the Scottish ministers to make the information public by reporting to Parliament; and, finally, requiring the Scottish ministers to respond to decisions that have been taken by health service providers about staffing, setting out what action they intend to take in relation to staffing in the health service. The intention of that final obligation on the Scottish ministers is to connect the bill, which is process driven and focused on on-the-ground workload planning, to national-level workforce planning. Decisions that are made at national Government level have an impact on the ability of health and care providers to provide staff for services, whether because of the budget choices that are made, the number of training places that are made available, or the registration and recruitment process that is required.

I note that amendment 90, in the name of Alison Johnstone, although not in this group, is complementary, as it places a duty on ministers to ensure an adequate supply of healthcare staff.

Amendment 85 is intended to provide full scrutiny of the decisions that have been made up the chain of accountability. Amendment 87 is a small amendment that ensures that commissioners must consider all the obligations on providers, as opposed to only those that are listed later in the bill. Amendment 89 gives the same obligations of reporting to commissioners of care as amendment 85 does to healthcare providers. Similarly to amendment 85, it is aimed at improving scrutiny of the implementation of the bill and the staffing levels in the social care sector.

Should amendments 86 and 88, in the names of Miles Briggs and David Stewart, be agreed to, amendment 89 will also require commissioners to report when financial decisions have been made about staffing levels and available resources for staffing in the commissioning of care services. As with amendment 85, amendment 89 provides for scrutiny of the decisions made by ministers and requires them to respond to the situations that are faced by the sector.

A slight difference between amendment 85 and amendment 89 is that amendment 89 requires reporting on the risk that is faced by commissioners of care in complying with the duty. It is important that that is included, so that the context in which decisions are taken is made clear. That would apply, for example, to the financial context as many social care budgets are squeezed, or to a lack of available staff.

Although a reference to risk is not included in amendment 85, it has not been totally left out. Instead, it has been added to an amendment in a different group, which is about the content of health board reports to Scottish ministers on staffing and seemed a more appropriate place.

David Stewart (Highlands and Islands) (Lab): Amendments 88 and 110, in my name, seek to ensure that commissioners of care services bear a similar responsibility and duty with regard to the staffing of care services as are given to care providers.

In the evidence sessions during stage 1, the committee heard from groups in the social care sector that were concerned that the bill placed all the focus on care providers and did not adequately recognise the impact that commission decisions about funding and resources have on staffing levels. I recognise that amendment 86, in the name of Miles Briggs, seeks to ensure that sufficient funding is given to providers in order to provide adequate staffing arrangements. I believe that amendment 110 complements that aim. The reference to "resources" would include funding but, by mirroring the wording of section 6, amendment 110 would require commissioners to specifically consider the same factors that service providers are required to consider when determining the appropriate staffing levels. Locating the provision relating to the commissioners' new duty before the existing duty that is contained in section 6 indicates the shared responsibility of commissioners and providers to provide adequate staffing and the reliance by the latter on the former for their ability to comply with that duty.

I acknowledge the note from Scottish Care that was given to the committee yesterday, which references amendment 110, and the concern that it would limit the ability of providers to embrace new technologies. However, I respectfully suggest that the additional considerations that are set out in subsection (2) of the section that amendment 110 would introduce, specifically paragraph (e), which refers to

"the needs of service users",

provide flexibility in how the required number of staff is assessed. Similar wording is used in section 4 with regard to healthcare services. I am aware that the social care sector differs from the health sector, but new technologies have adapted how services in the healthcare system are provided, and subsequently the staff and professions that are needed to provide such services. There is no reason in principle why a similar situation should not apply in social care.

Amendment 88 is consequential to amendment 110 and requires commissioners to consider the additional duty. If it is passed, amendment 89, in the name of Monica Lennon, would close the feedback loop and ensure that reports to the Scottish ministers would include a reference to the additional duty that would be placed on commissioners.

Jeane Freeman: Amendments 84 and 86, in the name of Mr Miles Briggs, are parallel provisions that apply respectively to healthcare planning and care service planning. I therefore intend to speak to both amendments before addressing the rest of the amendments in the group.

In truth, I am not clear what would be achieved by amendment 84 and what its aim is. It would require health boards to "take all reasonable steps" to provide sufficient funds to persons from whom they have contracted a service or with whom they have entered into an arrangement under the National Health Service (Scotland) Act 1978. Amendment 84 amends section 2, but section 2 does not apply to the commissioning of services by the integration authority: it applies to the contracting of services from a private health care provider or agency staff. Agreement on the payment that is required for the provision of a service is an integral part of the contracting process. More importantly, in contracting a service by virtue of the 1978 act, a health board retains accountability for the services that are provided under that contract and must ensure that they are delivered in an appropriate way. Put simply, a service provider would not agree to the contract if the amount that was set out in it was insufficient, and a board would not agree to a contract if it had not satisfied itself that the provider would deliver the required quality of care and level of staffing.

Amendment 86 would amend section 3 to place a similar duty on local authorities and integration authorities to provide sufficient funds to those from whom they contract a care service. Section 3 applies to the contracting of a service by a local authority or the integration authority from a care service provider. It may be the case that Miles Briggs has lodged amendments 84 and 86 due to a concern that local authorities are contracting services from care service providers, as planned by the integration authority, in cases in which the amount paid does not allow a care service provider to have appropriate staff in place. As is

the case with the contracting of services in health, when a care service provider tenders for a contract with a local authority, both must agree that the amount that is paid for the service allows them to comply with their respective duties before agreeing to the contract. Section 3 requires local authorities and integration authorities to have regard to the duties that are placed on care service providers. As drafted, the amendments do not work, because it is not the responsibility of the health board or local authority to provide funds; rather they pay for a service and are accountable for ensuring that the service meets the legislative requirements. If Mr Briggs has any remaining concerns, I suggest that we work together to fully understand them and seek to draft an amendment at stage 3.

I ask Mr Briggs not to press amendment 84 and not to move amendment 86, on the understanding that I will work with him to address his concerns and bring forward an amendment at stage 3, if he so wishes.

10:30

Amendment 85 would require health boards to report on how they have complied with the duties that are placed on them under section 2. That is something that could be included in the reporting duty that is set out in proposed new section 12IE of the 1978 act and I would be happy to make that more explicit for stage 3. I ask the committee to reject amendment 85 on the basis that I will amend section 12IE at stage 3.

Amendment 87 would create a circular reference. Section 3(1) imposes a duty to have regard to the guiding principles when carrying out the section 6 duty. Section 3(2) is about the planning aspect and when arrangements are being secured to get the care service delivered operationally by another person. The guiding principles already apply under section 3(2)(a). Given that commissioners already have to have regard to them under that provision, to create a duty to have regard to the duty to have regard to them is clearly circular. On that basis I ask the committee to reject amendment 87.

Amendment 89 would require local authorities and integration authorities to report on their compliance with section 3(2) and any risks that may affect their ability to comply. There are already statutory requirements on integration authorities to plan for the use of their resources in the context of their available budgets, publish those service and financial plans annually, and report on them annually. Amendment 89 therefore duplicates existing statutory duties, and for that reason I ask the committee to reject it.

I have serious concerns about the impact that amendments 88 and 110 would have on the success of integration. Integration authorities are already under a statutory obligation to deliver best value in terms of the quality of care that they commission within the resources that are available to them. By bringing together expertise in health and social care services, integration authorities are developing innovative approaches to care that focus on prevention, support and independence for people with multiple complex needs, for whom community-based support can often provide a better outcome at lower cost than would be found in a hospital or care home. By focusing on an obligation to provide a defined amount of money for a defined service for a particular period of time, amendment 110 risks inhibiting local partners' capacity for innovation within their total available resources.

I point out that amendment 110 focuses only on social care and does not apply to health. I assume that amendment 110 has been lodged due to the same concerns about adequate funding for care service providers. Therefore, I extend the same offer to David Stewart as I do to Miles Briggs, which is to work together on drafting something that will work for stage 3. For that reason, I ask David Stewart not to move amendments 88 and 110.

The Convener: I ask Miles Briggs to wind up and to press or withdraw amendment 84.

Miles Briggs: Amendments 84 and 86 are intended to place a duty on commissioners to be satisfied that, in contracting or delivering services, they have taken "all reasonable steps" to ensure that providers are able to deliver health services with appropriate staffing arrangements. Given the constructive aspect of what the cabinet secretary has said, which I welcome—and if David Stewart agrees—I am happy not to press amendment 84 and not to move amendment 86.

Amendment 84, by agreement, withdrawn.

The Convener: Amendment 85 has already been debated with amendment 84.

Monica Lennon: I did not quite catch everything that the cabinet secretary said, but I think that there was a welcome commitment to amending proposed new section 12IE of the 1978 act. I am not sure whether that captures everything that I was looking to do; I am happy to discuss the matter with her, but I will move the amendment today as a safeguard.

Amendment 85 moved—[Monica Lennon].

The Convener: The question is, that amendment 85 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 85 agreed to.

Section 2, as amended, agreed to.

Section 3—Guiding principles in care service staffing and planning

Amendment 86 not moved.

Amendment 87 moved—[Monica Lennon].

The Convener: The question is, that amendment 87 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 87 agreed to.

Amendment 88 not moved.

The Convener: The next group is on ministerial guidance on staffing by care services. Amendment 13, in the name of the cabinet secretary, is grouped with amendments 68 to 71.

Jeane Freeman: Amendments 13 and 68 to 71 relate to the guidance on staffing by care services that ministers can produce under the bill.

Amendment 13 would allow ministers to issue guidance on the duty on commissioners of care services under section 3(2) to have regard, when commissioning services, to the guiding principles for care staffing and to certain statutory duties on care service providers in relation to staffing. As with the other guidance powers in the bill, that would be subject to consultation and would have to be published.

Section 8(1) already sets out that guidance can cover the duties placed on care service providers under sections 6 and 7 on ensuring appropriate staffing and adequate training of staff, respectively. Amendment 68 clarifies that that guidance can cover the guiding principles, too.

Section 8(2) lists those whom ministers must consult before issuing the guidance, and amendment 69 will add the Scottish Social Services Council to that list. In evidence to the committee, the SSSC highlighted its omission from the list, and I agree that it is essential that its view as the regulator for the social service workforce in Scotland is sought. As it had always been my intention to consult with SSSC through section 8(2)(d), which allows ministers to consult with

"such other persons as they consider appropriate",

I was therefore happy to lodge the amendment to assure the SSSC that it will be consulted.

Amendment 70 will add those who commission services to the list of those whom ministers must consult before issuing the guidance. That will include integration authorities, whose addition was suggested in some of the written evidence to the committee.

I have listened to the views that have been expressed to the committee by third sector bodies that wanted the bill to contain a stronger commitment to seeking the views of service users, their carers and the third sector organisations that represent them. Section 8(2)(b) already requires ministers to consult representatives of service users, but amendment 71 will add representatives of carers to the list of those whom ministers must consult before issuing guidance under section 8 to care service providers.

I move amendment 13.

Sandra White (Glasgow Kelvin) (SNP): I want to mention one issue again. The bill is inclusive, in terms of nursing and social care, and amendment 13 goes some way to putting across that it is about not just acute and primary care but social care, too. I welcome this addition from the cabinet secretary.

Jeane Freeman: I welcome what Ms White has said. It is important to be reminded of that issue at this stage in our deliberations. The bill is intended to cover both health and social care. Therefore, we need to be careful neither to overmedicalise nor to ignore social care and the views of those operating and delivering in that service area. Amendment 13 is entirely compliant with overall cross-party support for integration of health and social care, so I am grateful to Ms White for

making that point. Other than that, I have nothing to say.

The Convener: The question is, that amendment 13 be agreed to. Are we agreed?

Amendment 13 agreed to.

Amendment 89 moved—[Monica Lennon].

The Convener: The question is, that amendment 89 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 89 agreed to.

Section 3, as amended, agreed to.

Section 4—NHS duties in relation to staffing

Amendment 14 moved—[Jeane Freeman]—and agreed to.

The Convener: The next group of amendments relates to the duty to ensure appropriate staffing and the purposes of staffing. Amendment 3, in the name of Alex Cole-Hamilton, is grouped with amendments 4, 5, 15 and 16.

Alex Cole-Hamilton: I hope that this group of amendments will not prove to be controversial. They are about extending the reach of the bill and recognising that although the safety of patients has to be paramount, so must that of staff. At stage 1, I gave an example that I had heard from a stakeholder about a psychiatric unit where professionals were asked by their union whether they had a safe staffing complement that night. They said, "We have a safe staffing complement for the patients, but because we work on an attack-response basis, if something happens, we can't guarantee that we have enough staff to keep our staff safe." My amendment recognises that sometimes we put clinicians, nurses and front-line professionals in harm's way in our health and social care settings, and that their safety should be as paramount as patient safety.

The meaning and intent of my amendments 4 and 5 extend that point and recognise that the bill reaches further than just hospital and service settings.

I also want to say a word about the cabinet secretary's amendment 15. Our interpretation—I hope that she will clarify the matter in her remarks—is that, according to amendment 15, the focus on staff wellbeing relates only to whether patient care could be compromised. Our staff's wellbeing and safety should be a concern at all times, not just when patient care is unsatisfactory. As I have said, staff operate in a fluid and dynamic environment and although everything may seem fine, well staffed and safe, that might change in a heartbeat. On that basis, I will oppose amendment 15.

I move amendment 3.

10:45

Jeane Freeman: I appreciate amendment 3's valid aim to ensure that staff wellbeing is considered when ensuring adequate numbers of staff. With the bill, we seek to ensure safe and high-quality services. Success will create a virtuous circle of better outcomes for patients, together with improved wellbeing for staff. Evidence demonstrates that one affects the other.

An almost identical provision to amendment 3 in relation to staff already exists in health and safety legislation and we want to avoid replicating any duty that already exists in primary legislation. We must also be mindful that employment and health and safety law are reserved matters into which we should not stray.

I support the aims of amendment 3 and we already have a guiding principle that ensures the wellbeing of staff. However, given my concerns about the specific wording and the risk that it poses in terms of reserved legislation, I propose the replacement amendment 15, which answers the request of the Royal College of Nursing to include staff wellbeing in the duty on care service providers to ensure appropriate staffing, while aligning with the rest of the bill and, most important, keeping the primary focus of the legislation on the welfare of service users. I agree that staff wellbeing is crucial, but we should be looking at how it impacts on the service while maintaining our responsibilities in relation to reserved health and safety legislation.

I have no concerns about amendment 4, given the clear aims of the bill to secure safe and high-quality healthcare.

Amendment 5 is unnecessary because the term "health care" is already defined in proposed new section 12IG of the 1978 act as meaning

"a service for or in connection with the prevention, diagnosis or treatment of illness."

Amendment 5 would duplicate that definition, so I ask the committee not to support it.

Amendment 16 lists factors that health boards should consider when fulfilling the general duty to ensure appropriate staffing. It responds to stage 1 written evidence from the RCN and the Royal College of Physicians of Edinburgh. It follows a similar format to the list for care services in section 6, and it requires factors such as local context and the needs of patients to be considered.

I point out that the reference in proposed new section 12IA(2)(e) of the 1978 act to having regard to "appropriate clinical advice" was suggested for inclusion by Alex Cole-Hamilton during the stage 1 debate. The Scottish Government's position is that amendment 16, in conjunction with further references throughout the bill to the seeking of appropriate clinical advice, as defined in proposed new section 12IG of the 1978 act, is the appropriate way of ensuring that all staffing decisions are informed by clinical advice.

I therefore ask the committee to support the amendments in my name and not to support amendments 3 and 5.

George Adam (Paisley) (SNP): I have listened to what the cabinet secretary and Alex Cole-Hamilton have said. If I am getting this right, I am concerned that amendment 3 could mean we are stepping into reserved health and safety legislation. If that is the case, is there not a way that we could work on the issue during the coming weeks to get it right?

I will back amendment 4, because it gets the balance right. It might be the case that we can have some kind of workaround or compromise for amendment 3. When we start moving into legislation that is not defined by the Scottish Parliament, we are getting ourselves into muddy waters and I want to make sure that we are in a safe place.

Emma Harper (South Scotland) (SNP): I share George Adam's concerns about encroaching on reserved legislation. Questions about health and safety, which is a reserved matter, versus what we can do in our devolved Parliament have come up in a lot of my constituency work. I am interested in making sure that we are clear that we do not encroach on reserved laws when we pursue our legislation.

The Convener: As no other members wish to speak, I call Alex Cole-Hamilton to wind up and to press or seek to withdraw amendment 3.

Alex Cole-Hamilton: I am not persuaded that amendment 3 would fail a competence test in respect of the Scottish Parliament or Scottish Government. The first letter in SHANARRI—the safe, healthy, achieving, nurtured, active, respected, responsible and included indicators—which we apply to getting it right for every child, stands for "safe". It is not a reserved concept. Yes, health and safety legislation is reserved, but working in a policy context to make our staff safe should not be seen as outwith the purview of the Scottish Parliament. To that end, I press amendment 3.

The Convener: The question is, that amendment 3 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 3 agreed to.

Amendment 4 moved—[Alex Cole-Hamilton]—and agreed to.

Amendment 5 moved—[Alex Cole-Hamilton].

The Convener: The question is, that amendment 5 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 5 agreed to.

Amendment 15 moved—[Jeane Freeman].

The Convener: The question is, that amendment 15 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

Against

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 15 disagreed to.

Amendment 16 moved—[Jeane Freeman]—and agreed to.

The Convener: We move to the next group, which is on real-time staffing assessment and the risk escalation process. Amendment 17, which is in the name of the cabinet secretary, is grouped with amendments 17A to 17I, 107, 123, 39, 41 and 48 to 65.

Jeane Freeman: During the stage 1 debate, I undertook to lodge an amendment to place a more explicit duty on health boards, relevant special health boards and the agency to ensure that there are clear mechanisms for day-to-day assessment of staff needs, and clear routes for the professional voice to be heard in those assessments. I believe that amendment 17 and the other Government amendments in the group would achieve those aims.

Healthcare settings are dynamic working environments in which situations can change swiftly. The bill already places a duty on health boards, special health boards

"and the Agency to ensure that at all times suitably qualified and competent individuals are working in such numbers as are appropriate for"

ensuring

"the health, wellbeing and safety of patients, and ... the provision of high-quality health care."

Amendment 17, which would insert new sections into the 1978 act, takes that a step further by placing a duty on those bodies to have

"in place arrangements for the real-time assessment of"

staffing requirements and

"for the identification ... of ... risks caused by staffing ... to the health, wellbeing and safety of patients ... the provision of high-quality healthcare, or ... in so far as it affects either of those matters, the wellbeing of staff."

As is only logical, those criteria for compliance would mirror the criteria in the general staffing duty on boards in proposed new section 12IA of the 1978 act, which would have been amended by amendment 15, which we have already debated. Those criteria set out that a procedure must be in place that allows any member of staff to identify and report such a risk. A procedure must also be in place that allows the mitigation of such risks by the person with the lead clinical professional responsibility in that area.

Where it has not been possible to mitigate a risk at local level, amendment 17's proposed new section 12IAB of the 1978 act would place a duty on health boards, relevant special health boards and the agency to have in place procedures

"for the escalation of ... Risk"

to the appropriate decision maker within the organisation, who would have to seek appropriate clinical advice, as necessary, in reaching any decision. That is in recognition of the importance of the professional voice in the decision-making process.

Amendment 17 was developed in collaboration with stakeholders from professional and trade union bodies, and with nursing and medical directors. During discussions about what the proposed amendment should seek to achieve, the feedback was that it should not only put in place a new process for real-time staffing assessment and escalation of risks but ensure that, where staff have highlighted a risk, they should receive feedback on any decisions that are made as a result.

With that in mind, amendment 17 sets out that decisions must be relayed to all those involved in identifying, attempting to mitigate or reporting the risk and to those who have given clinical advice. Any of those individuals may record disagreement with the decision that is reached.

That also applies at the level of the board. If, having offered their clinical advice to the board, a nurse director or medical director were to feel that they disagreed with the decision that was subsequently reached, they would have the ability to record that. Of course, any nurse or doctor would also act in accordance with their professional code, which would require them to note their disagreement. Amendment 17 would require boards to have in place a procedure to allow nurse directors, medical directors or any member of staff to record their disagreement.

Regard should be had to professional clinical advice at all levels of the organisation, and clear processes should be in place for transparency of decision making in the light of such advice. That is why I have ensured that the need for clinical advice is woven through every provision in the bill; it should not be a stand-alone provision and should not refer to just one person or a small number of people. The health board would also be required to raise awareness of the procedures among staff.

Amendment 39 would place a duty on the health board to include in its annual report details of how it had carried out its duties in relation to the new real-time staffing assessment and risk escalation provisions, thereby providing transparency and accountability for their delivery.

Amendment 41 clarifies that the guidance to which every health board and the agency must have regard may, in particular, include provision about

"procedures for the identification, mitigation and escalation of risks caused by staffing levels in arrangements put in place"

under proposed new sections 12IAA and 12IAB of the 1978 act. During discussions on the proposed amendment, the majority of stakeholders were keen to point out that they already have in place processes for staffing assessment and escalation of risks. They did not want to reinvent the wheel, and their preference was that the amendment should not be overly prescriptive in setting out the processes and procedures that must be followed. Furthermore, the bill needs to work across a variety of settings and to take account of the changing landscape brought about by integration. I am therefore keen to avoid placing too much administrative detail in primary legislation, as that would risk its being too inflexible. Such detail is better set out in guidance that can be amended over time should changing needs require it.

Amendments 48, 49, 50, 52, 53, 54, 55, 56, 58, 59, 60, 62, 63 and 64 would insert references to proposed new sections 12IAA and 12IAB of the 1978 act into section 5. In doing so, they would apply the provisions that are set out in those proposed new sections to the special health boards that provide clinical health care—the State Hospitals Board for Scotland, NHS 24, the National Waiting Times Centre board and the Scottish Ambulance Service board—by amending their governing secondary legislation.

Amendments 51, 57, 61 and 65 are technical amendments. Section 2 of the bill places three duties on health boards and the agency: one to

"have regard to the guiding principles"

and two on health boards when commissioning health services from other providers. References in the bill to section 2 refer to the duties to capture all three. The amendments would therefore change the references in section 5(3)(b), section 5(6)(b), section 5(9)(b) and section 5(12)(b) respectively from "Duty" to "Duties", to clarify that all three duties apply to the special health boards that are covered by section 5.

11:00

I turn to amendments 17A to 17I, which have been lodged by Mr Stewart. I am happy to accept the majority of the amendments. However, amendments 17D and 17I are unnecessary.

Scottish Government amendment 39 will, as I have just described, add the duty to have in place a real-time staffing assessment and a risk escalation process to the list of duties that health boards and the agency must report on under proposed new section 12IE of the 1978 act.

Amendment 39, coupled with amendments 37 and 38, which are to be debated under group 14, sets out that health boards and the agency will, within one month of the end of the financial year, each have to

"publish, and submit to Scottish Ministers"

a report

"setting out how during that financial year it has carried out its duties under"

the new sections on risk assessment and escalation. I therefore ask Mr Stewart not to move amendments 17D and 17I.

Amendment 107, which was also lodged by Mr Stewart, sets out that:

"Every Health Board and the Agency must establish a risk management protocol ... to—

(a) identify,

(b) monitor, and

(c) assess,

risk associated with complying with the"

general duty. In essence, much of what is suggested in amendment 107 is already covered in proposed new section 12IAA of the 1978 act, "Duty to have real-time staffing assessment in place", and proposed new section 12IAB, "Duty to have risk escalation process in place", which I mentioned when speaking to amendment 17.

My intention is to set out in guidance, rather than in primary legislation, the steps to be taken by a health board or the agency to mitigate any risk associated with complying with the general duty in proposed new section 12IA of the 1978 act. That would allow greater flexibility, particularly as we move towards multidisciplinary and multi-agency working, which might open up new avenues for dealing with some of our current staffing issues.

With that in mind, I ask Mr Stewart not to move amendment 107. However, I would be happy to meet him to discuss whether proposed new sections 12IAA and 12IAB of the 1978 act could be amended in a way that might satisfy his wish to see health boards put in place some kind of risk management protocol setting out the actions that

individuals with the lead clinical professional responsibility may take to mitigate risks locally.

I am afraid that I cannot support amendment 123, which was lodged by Miles Briggs. Although I understand and agree with the intent of the amendment, it raises a number of concerns. First and foremost, much of what the amendment seeks to achieve can already be achieved through Scottish Government amendment 17. Through the proposed new sections on real-time staffing assessment and risk escalation, any member of staff will be able to report if they feel that the health board is not complying with the general duty, and action will then have to be taken to mitigate that or reasons will have to be provided for not doing so. If it is not possible to mitigate a risk locally, it will have to be escalated up through the organisation, with those making decisions having to take appropriate clinical advice before doing so. All those involved in identifying, reporting, escalating or providing clinical advice on a risk must be informed of any decision that is made as a result, and there will have to be a procedure in place that allows them to record their disagreement with the decision if they wish to do so.

It seems to me that amendment 123 is, in essence, about ensuring that the professional voice is heard. I am very much in agreement with that aim, and proposed new section 12IB of the 1978 act, "Duty to follow common staffing method", already includes a duty to have regard to "appropriate clinical advice". If amendment 17—alongside amendment 16, which we have already debated—is accepted, the general duty for health and the duty to have in place a risk escalation process include duties to have regard to appropriate clinical advice.

A further concern relates to how amendment 123 attempts to delegate operational responsibility without also delegating legal accountability. Who would be held accountable if something went wrong when the health board had carried out all the procedures and had followed the advice of the relevant designated person to the letter? The amendment would create basic legal uncertainty on that vital point. We would also need to be clear about how the provision sat alongside existing professional duties.

I see merit in ensuring that there is clarity about who can offer clinical advice when a decision is escalated all the way to the board and in ensuring that the board must seek that advice, have regard to it and clearly identify how it has informed the final decision. However, it is important that it is clear that final accountability must sit with the board, because no decision can be taken in isolation.

Were we to agree to amendment 123, we would risk the role of the health board being compromised in that a designated person would be responsible for carrying out the functions that will, in fact, be given to the health board through the bill. The amendment would further undermine the bill by allowing that designated person to sub-delegate their functions to someone who, in their opinion, was suitably qualified and competent. In the 1978 act, the board is a legal entity. To have a single board member named in the bill would create confusion in relation to any future instance when it was believed that the legislation was not being implemented and a court decision was sought. The nurse director has a responsibility to provide clinical and professional advice, as does the medical director, and guidance and directions from ministers are used to set out how a board complies with its legal duties through those individuals.

I have said that I understand and support the intention behind amendment 123, but it is crucial that we get right the detail of any amendment that addresses such a fundamental point. For all the reasons that I have discussed, I am not comfortable that amendment 123 is right. For that reason, I invite Mr Briggs to work with me in advance of stage 3 to develop an amendment that we are both content with and that meets what, I believe, is our shared aim of strengthening the professional voice in decision making.

Subsection (1)(d) of amendment 123 sets out that

"Every Health Board and the Agency must ... make arrangements for the purpose of informing patients and staff of staffing levels."

I am keen to hear how that might work in practice. Staff numbers alone are not an indicator of the quality of the service; other factors, such as the skills mix of staff, also need to be considered. As I have said, health settings are dynamic environments and, as such, staff might move from one ward to another to deal with changes in demand throughout the day. I therefore find it difficult to see how staff and patients are to be kept up to date with staff numbers in that dynamic situation.

That said, I have lodged a number of amendments that aim to strengthen the reporting mechanisms in the bill. If, as I presume, Mr Briggs's aim is to provide patients and staff with an indication of how well services are running, I would be happy to discuss strengthening the section even further by including a duty to publish the details of how health boards and—where appropriate—wards perform against outcome measures.

I therefore ask Mr Briggs not to move amendment 123. If he does, I invite the committee

not to support it on the understanding that I wish to work with him in advance of stage 3.

I move amendment 17.

David Stewart: Amendment 107, which is in my name, seeks to achieve a similar aim to that of amendment 17, which has been lodged by the cabinet secretary. It is crucial that health boards and healthcare providers have in place processes and measures to assess and mitigate the possible risks to their duty to supply appropriate staffing. Such risks could be short term—for example, members of staff being unable to work because of illness—or there could be longer-term challenges, including difficulties in recruiting and lack of available staff to fill vacancies nationwide. Amendment 107 could allow for more flexibility in local arrangements: it explicitly references the ability for staff to seek "local resolution" of a possible risk.

It is also important that any risk management or escalation process be appropriate and accessible for staff. It is crucial that staff feel that the process works for them, that their concerns are noted, escalated and dealt with, and that individual staff members are not placed in circumstances in which they need to operate in unsafe environments, or held responsible for adverse incidents that are caused, ultimately, by managerial or financial decisions that have been taken at a higher level. That said, if the Government is prepared to accept my small amendments to amendment 17, I will be satisfied and will not move amendment 107.

Amendment 17A would close a small gap in the process that is set out in the Government's amendment 17, in that any process must set out how individual staff members and employees can notify the relevant person of the risk in the first instance. Just stating identification does not explicitly include that step.

Amendments 17B and 17E would change the reference from

"the individual with lead clinical responsibility"

to "an individual", in order to ensure that the definition is flexible enough.

Amendments 17F and 17G would ensure that decision makers must not only seek but take into account clinical advice, so that decisions are not justified purely based on finance.

Amendments 17I and 17D seek to establish a feedback loop in order to ensure that any nationwide risk can be recognised.

Amendments 17C and 17H would require health boards to go further than merely raising awareness of risk management processes, and to ensure that employees know how to use them and feel equipped to do so.

Miles Briggs: Amendment 123 would place a duty on each NHS board to

"designate a person ... to carry out functions"

on its behalf in relation to the staff groups that are mentioned in it. It is right that NHS boards be made organisationally accountable for duties under the bill. Decisions on staffing are affected by many factors, including patient demand, workforce capacity and capability, finance and the NHS estate. Executive orders will cover responsibility for those matters, but the entire NHS board will remain accountable. As the cabinet secretary has outlined, the 1978 act already places on NHS boards specific duties on quality, workforce planning and health improvements.

I believe that nursing leaders have the particular skills, knowledge and experience that are needed to exercise sound professional judgment in setting nursing staff levels, managing nursing-related risks to the duty, ensuring appropriate staffing, and escalating significant concerns within the NHS board. For that reason, each board should appoint a designated person in nursing and midwifery to carry out functions on its behalf.

The professional judgment, advice and actions of nursing leaders must be placed on a statutory footing in order to guarantee that NHS boards can make informed clinical decisions in relation to their duties under the bill. The Health and Sport Committee's report looked for an "accountable person" to ensure that the accountabilities in this area remain firmly at corporate board level, which is important.

In the light of what the cabinet secretary has said, I am happy to work with her on an amendment to which we might all agree.

Emma Harper: I would like to make a small contribution on amendment 17, with regard to the proposals around a real-time staffing assessment and risk-escalation process.

As a former operating room and trauma nurse, I know that things can change swiftly and that it is important to be able to have all hands on deck. Therefore, I welcome the proposal to add a real-time staffing assessment and risk-escalation process, because I understand that people need to be able to make split-second decisions if they are to provide safe and high-quality care.

I also welcome the cabinet secretary's comments regarding the wider health and social care approaches, because the bill is not concerned only with acute care; it concerns care across the whole of health and social care. I support the idea of being flexible rather than being too prescriptive in the primary legislation, so that guidance for allied health professionals across

health and social care, in primary as well as acute care, can be developed later.

Sandra White: I have concerns about amendment 123 in the name of Miles Briggs, but I note that the cabinet secretary and Miles Briggs have agreed to work together on another amendment. My concerns relate to the possibility that the confidence of boards will be knocked slightly by the proposal in the amendment relating to a designated nursing or midwifery person. I assume that Miles Briggs will not move the amendment, so I look forward to seeing what he and the cabinet secretary come back with.

The Convener: I invite the cabinet secretary to wind up.

Jeane Freeman: I have nothing more to say, other than to thank Miles Briggs and David Stewart for their willingness to work with me before stage 3.

The Convener: I invite David Stewart to say whether he wishes to press amendment 17A.

David Stewart: In the light of the cabinet secretary's comments, and because I know that she is, in part, accepting my proposals, I am happy not to press amendment 17A.

11:15

Amendments 17A to 17I not moved.

Amendment 17 agreed to.

The Convener: The next group of amendments is on the duty to ensure appropriate staffing in respect of agency workers. Amendment 80, in the name of Anas Sarwar, is the only amendment in the group.

David Stewart: Unfortunately, my colleague Anas Sarwar has not been able to make it to the meeting. With the committee's agreement, I will speak briefly to amendment 80, in his stead.

Amendment 80 is designed as a probing amendment and, therefore, is to spark debate, which I think has been welcomed by the cabinet secretary. Although the amendment is supported in principle by stakeholders, I understand and share the concerns that have been expressed about a number of unanswered questions.

The fact is that we have to find an acceptable way of moving forward on the matter. Audit Scotland has shown that agency nurses are being paid three times what NHS nurses are paid, and it has been reported that in the health board in my area—NHS Highland—some locum consultants are earning the phenomenal sum of £400,000 a year. Amendment 80 therefore seeks to cap what an agency can charge, not what a health board can spend in total. I recognise the important role that agencies play, given the workforce crisis that we face, but Anas Sarwar's clear point is that private companies should not be exploiting the NHS and the public purse.

The 150 per cent figure that is set out in amendment 80 comes from a directive to boards in England and Wales. Obviously, responsibility for health is fully devolved to Scotland, but I do not see why we should not follow best practice that we might see in other parts of the United Kingdom.

It is right that the Scottish Government act to limit that spiralling spend. Workforce tools might well encourage more use of agency staff in understaffed wards in order to avoid their being shut down or beds being closed, but it is important that some protections be built into the bill. One of the primary reasons for the overspending in boards, including mine in the Highlands, is spend on agency staff.

I accept that there are wider issues to take into account, but amendment 80 would represent a start by putting in place a limit or cap on agency spending.

I move amendment 80.

Miles Briggs: I am very sympathetic to amendment 80. I appreciate that the member who lodged it is not with us this morning, so before we vote on it, I must seek clarification. Specifically, does the 150 per cent limit that is proposed include agency fees? If so, that might have an unintended consequence for, or a knock-on effect on, individual agency staff's take-home pay. Does Mr Stewart have any information on that?

The Convener: Before I ask Mr Stewart to wind up, I must ask the cabinet secretary whether she wishes to comment on amendment 80.

Jeane Freeman: I thank Anas Sarwar for lodging amendment 80, and I agree with him that it is not appropriate for private companies to make such profits at the expense of our national health service. However, the Scottish Government and NHS boards have given much thought to the issue, so I have to disagree with Mr Sarwar's proposed approach. I will outline some of my concerns in that respect, but at this stage I ask that amendment 80 not be pressed, and suggest that Mr Sarwar and I look at whether we can reach agreement on an amendment for stage 3.

Currently, by the time that health boards go to an agency, that action will have been processed through existing enhanced governance arrangements. That means that other options, including use of overtime and bank staff, will have been exhausted and that the only way to provide cover is through use of agency staff. Decisions about agency use will always be signed off by a senior member of clinical staff. If the decision is

taken to use agency staff, that will have been because the advice from a senior clinical professional was that patient safety was likely to be compromised if an appropriate staff member was not secured. Patient safety has to be the cornerstone of our approach.

We already have a preferred-supplier contract that the agencies that we use most are invited to join. Agencies on that contract supply NHS Scotland staff at rates that are similar to NHS rates of pay, which means that pay rates are capped for those who are on the contract. That also caps the commission rates that agencies on the framework contract receive in order to ensure that they cannot make exorbitant or surplus profits for supplying the NHS with key front-line staff. NHS boards have been instructed by chief executive letter to source, in the first instance, only from agencies that are on that contract, but we know that if a nurse cannot be supplied through the contract, one will need to be sourced from an agency that is not on the contract.

The amendments that I have lodged to create duties to have in place real-time staffing assessment and a risk-escalation process will reinforce the position that appropriate clinical advice needs to be sought as part of the risk-mitigation process, including if the risk is being mitigated through use of agency staff. Guidance will set out more detail on that, including on the circumstances under which it will be acceptable to resort to use of agency staff, and on the board-level sign-off process that I expect to be in place for procurement of agency staff, and monitoring of same.

The proposed break-glass provision in amendment 80 sets a potentially very high bar. What circumstances would be classed as "exceptional"? If the bar were to be set too high, that could undermine the principles of the bill with regard to safety, and it might lack the flexibility that is needed to ensure safe staffing. Let us be honest: if a board comes to me with a request to pay over the cap because it urgently needs a nurse in an intensive care unit, I will defer to the clinical opinion of the nurse or medical director. I am sure that members would expect me to do precisely that. I would prefer that a board spend its time sourcing an agency nurse and doing everything in its power to ensure the safety of the service, to its going through an additional bureaucratic process to seek my approval.

I note that a similar approach has been taken in England, although not through legislation, with the recognition that there needs to be a break-glass clause to ensure safety and continuity of service. That break-glass clause is used extensively, and nursing agency spend is around three times higher per head in England than it is in Scotland.

Given the amendments that I have lodged on real-time staffing assessment and risk-escalation processes, and the need to ensure that we take an effective and proportionate approach to reducing agency spend, I ask the committee to reject amendment 80 on the understanding that I will work with Anas Sarwar to explore whether there is a way in which we can agree the best approach to addressing the issues, including the associated escalation and governance of the process at board level in order to ensure that staffing decisions are taken at the highest level.

David Stewart: I agree with the cabinet secretary that the issue is vital. However, on the basis and understanding that she will meet my colleague Anas Sarwar, I will not press amendment 80.

Amendment 80, by agreement, withdrawn.

The Convener: The next group of amendments is entitled "Duty to ensure appropriate staffing: sufficient number of healthcare professionals". Amendment 90, in the name of Alison Johnstone, is the only amendment in the group.

Alison Johnstone (Lothian) (Green): Amendment 90 would ensure that, where ministers have commissioning powers, enough student places are offered to train a workforce that will better ensure that we deliver the healthcare that will meet Scotland's changing needs. I imagine that we are all agreed that the bill is a starting point. Any Scottish Government must, and will surely, want to take some responsibility for ensuring that Scotland has the right number of registered nurses, midwives and medical practitioners to deliver the healthcare that Scotland needs.

In September last year, more than a third of all nursing and midwifery vacancies had been vacant for three months or more. Although I accept that there has been some improvement, in June last year, the nursing and midwifery vacancy rate was 5.3 per cent, which was more than 3,000 whole-time-equivalent posts, and was the highest number of vacancies ever recorded. ISD Scotland tells us that turnover has been increasing for several years due to the increasing number of leavers in each year.

Amendment 90 would also require the Scottish ministers to take into account NHS boards' reports when commissioning places. It is clear that ministerial decisions have an impact on providers' ability to have appropriate staffing. The amendment would also require ministers to report to Parliament on commissioning of nurses, midwives and medical professionals.

I move amendment 90.

Alex Cole-Hamilton: I thank Alison Johnstone for lodging amendment 90. I considered lodging a similar amendment, so she has the Liberal Democrats' enthusiastic support.

Jeane Freeman: To ensure appropriate numbers of health professionals, there needs to be robust evidence of the workload that will be required to provide high-quality care, and evidence of the appropriate staffing levels and skills to deliver that. The bill's purpose is to create a framework through which health boards can generate and use that evidence consistently. Once boards are using the common staffing method effectively and consistently, and reporting on it, that will—of course—inform national planning.

Later, I will speak to an amendment that will require the Scottish ministers to report on how the information that boards generate as part of that process has been taken into consideration in setting national staffing policies. That is the proportionate way to link the bill to wider workforce planning.

The commissioning of student intake in relation to nursing and midwifery already takes into account the available data, and is agreed by consensus by the nursing and midwifery stakeholder reference group. The Scottish ministers do not have the power to direct universities to take specific numbers of students. Once we have agreed, with the reference group, what is required, we provide funding for that number of places at universities throughout Scotland, and that funding is then allocated to individual universities by the Scottish Further and Higher Education Funding Council. Universities receive funding only for the places that they fill, which incentivises them to offer the maximum number of places, but we do not have the power to make them do that.

The process requires a projection of what might be needed. Of course, improving the data that we use to do that will help, but I say with the best will in the world that we cannot project for every possible circumstance. Ensuring that we have the right number of staff available is a complex issue that is not just about setting the number of student places: it is also a recruitment and retention issue, and there is an onus on employers to seek to incentivise and grow their staff, as is happening in health boards across Scotland.

The cumulative effect of the bill's provisions will help us to address the issue. The bill recognises that the Scottish ministers, health boards, integration authorities, universities and colleges all have roles. I am happy to commit to working with Alison Johnstone and others to ensure that the reporting duties that will be placed on health boards and the Scottish ministers will create the transparency that is needed for effective workforce planning. On that basis, I ask her not to press amendment 90.

Alison Johnstone: We all agree that workload and workforce are absolutely inextricably linked. The fact that we are debating amendment 90 shows that it is within the scope of the bill.

11:30

However transformative or efficient workforce planning tools might be, we cannot apply them adequately if we simply do not have in place appropriate numbers of staff. I appreciate the cabinet secretary's point that the tools will help us to ensure that we have appropriate numbers of staff in place in the future, but I think that the two issues go hand in hand. We cannot continue to put all the focus on the providers. If we want a partnership approach, it is clear that the partnership involves the Scottish Government. Our health boards cannot ensure that enough staff are in place if not enough nurses, midwives and doctors have been trained. We are all aware of what has happened previously, when ministers have decided that X nurses will be trained. There is a knock-on consequence. The more the decision is a joint one, the better.

In a 2017 iMatter survey, only 27 per cent of nursing and midwifery staff agreed that there were enough staff to enable them to do their jobs properly, so it is an important issue. It takes 13 years to make a general practitioner, so we must get a grip on the issue now. We cannot afford to wait until we have more information. The information that we have in front of us—we all hear from constituents who simply cannot get an appointment with a GP—is such that we must act together, and we must act now.

It is right that the Scottish Government should play as large a part as possible, and take the responsibility for ensuring that Scotland's NHS has an adequate supply of appropriately trained nurses and medics. Therefore, I intend to press amendment 90.

The Convener: The question is, that amendment 90 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 90 agreed to.

The Convener: The next group is entitled "Duty on Health Boards to ensure appropriate staffing: senior nurses". Amendment 91, in the name of Alison Johnstone, is the only amendment in the group.

Alison Johnstone: Amendment 91 seeks to ensure that senior charge nurses and their equivalents in community teams have the time that they need to carry out their important clinical leadership role. Senior charge nurses are key to the on-going delivery of safe care—indeed, they are key to the successful implementation of the bill. The Royal College of Nursing supports amendment 91 whole-heartedly. It has told me, and I am sure that it will have advised colleagues, that senior charge nurses must be given the time that they need to fulfil their clinical leadership role by not being counted in the number of nursing staff who are required to provide direct care to patients.

Amendment 91 seeks to ensure that the non-case load holding status of nurse leaders—senior charge nurses—is fully realised in practice.

I move amendment 91.

Alex Cole-Hamilton: I thank Alison Johnstone for lodging amendment 91, and I absolutely agree with what it seeks to do. It speaks to the dynamic nature of the theatre of operations that our nurses work in. In the past, we have expected far too much of our senior charge nurses when it comes to case load holding. As a result, they have not been able to take a strategic overview of the health, safety, cleanliness and wellbeing of their patients and their staff. For that reason, I support amendment 91.

Emma Harper: I support the approach that senior charge nurses and the management team take to workforce planning. As somebody who has worked on the front line, where senior charge nurses have the flexibility to support patient care, to carry out their clinical duties and to support student nurses and mentoring across the board, I believe that, because of the dynamic differences in case load that exist—in some places, senior charge nurses work across health and social care—amendment 91 would be too prescriptive.

We need to allow senior charge nurses to be empowered and flexible and to make decisions in their individual areas, for example, in relation to chemotherapy or the operating room. In my experience, sometimes, senior charge nurses have to step in because, at that moment, they are the person who has the experience. I support the ability to be flexible in the approach across health and social care, allowing senior charge nurses to be empowered and make individual choices based on their clinical expertise.

Brian Whittle (South Scotland) (Con): I am generally supportive of amendment 91, but I seek some clarification, which Alison Johnstone might be able to provide when summing up. To follow up on Emma Harper's point, I believe that the amendment would not preclude a senior charge nurse from taking on case load in certain circumstances, given that, as Alex Cole-Hamilton said, it is such a fluid environment. Perhaps Alison Johnstone can clarify that point.

Jeane Freeman: I understand that the RCN is keen for the role of the senior charge nurse to become non-case load holding and I have had several discussions with the college on that point. However, my view is that, to put such a provision in primary legislation, which is what amendment 91 would do, would be inappropriate. It would be inflexible and would not recognise the multidisciplinary approach or the different local contexts in which healthcare is provided across Scotland.

Although it might be appropriate for a senior charge nurse in a large ward to be non-case load holding, it might not be appropriate for someone in the same role in a small ward with very few staff. I saw that for myself on Friday, when I visited my local community hospital, where the senior nurse was very definite that she believed that her clinical leadership and case-load roles are complementary.

In addition, as I have said before, the bill is not only about nurses; it covers a variety of professions. Although the majority of the current tools for use as part of the common staffing method cover nurses and midwives, that will change over time. Amendment 91 applies only to nurses and does not provide a mechanism to include other staff groups in the future. I cannot support such a narrow nursing-only provision in a bill that takes a multidisciplinary approach to staffing by covering all staffing groups, and for which we have already accepted amendments that define what that multidisciplinary approach should be, as promoted by Alex Cole-Hamilton.

To illustrate the kind of problems that such a narrow nursing-only provision might cause, I want members to consider the evolving multidisciplinary nature of teams. For example, in rehabilitation or re-enabling services, the clinical team leader is not necessarily a nurse, but might be a physiotherapist, or anyone from a team that

comprises nurses, physios, occupational therapists and speech and language therapists. Surely there should be flexibility to ensure that the appropriate person is given time to undertake the leadership role?

Another potential unintended consequence, which is important and worth mentioning, relates to the ability to maintain clinical competence. It is essential that senior charge nurses maintain their clinical competence in care delivery in order to maintain clinical credibility and to provide effective supervision and oversight of clinical care. It would be much harder to do that if they were entirely non-case load holding.

The issue of senior charge nurses being non-case load holding has been discussed with the Scottish executive nurse directors group. I understand that, at the group's meeting last Friday, it discussed the amendment and indicated that it did not support it, for the reasons that I have described. It is important to listen to those nurse directors from across our health boards.

The Scottish Government has lodged amendment 20, which we will discuss when we come to group 11, with the aim of achieving a position that is consistent with our multidisciplinary approach, by setting out an additional step in the common staffing method, requiring consideration of the role and professional duties of lead clinical professionals, which covers all professions, and not just nursing. Given that the committee will vote on amendment 91 in Ms Johnstone's name before we reach group 11, I will take a minute to outline what amendment 20 does, so that members are aware of the alternative before we come to the vote.

Amendment 20 aims to recognise the unique roles and responsibilities that are placed on all clinical team leaders. It ensures that, in carrying out the common staffing method, health boards and the agency must take into account the role and, in particular, the professional duties of any individual with lead clinical professional responsibility for the particular type of healthcare whose staffing levels are being set. The Scottish executive nurse directors group supports that approach, because it believes that it clearly articulates the role of the clinical leader in the common staffing method.

Guidance will set out the detail of what that will mean in practice but, in essence, it means that boards will have to carefully consider whether, in their circumstances, and given the other duties that they are expected to carry out, it is appropriate for clinical team leaders to have a case load. The decision that is reached on that will then have to be factored in when the health board sets out its staffing establishment for the coming period.

It is worth noting that, as part of the common staffing method, account is to be taken of appropriate clinical advice. That clinical advice is to cover all the steps in the common staffing method, not just the final output. Senior clinicians will therefore always be directly involved in decisions about whether it is appropriate for clinical team leaders in their area to hold case loads.

For those reasons, I ask Ms Johnstone not to press amendment 91, and if she does, for the committee to reject it, knowing that we will come to amendment 20 in group 11, which I hope the committee will support.

Alison Johnstone: I thank colleagues for their comments and questions.

On Mr Whittle's point, senior charge nurses should not be expected to be case load holding. They should not constantly have to plug gaps because of a lack of other staff.

It is correct that amendment 91 addresses senior charge nurses alone, but we have to take into account the fact that nursing and midwifery staff account for 42.6 per cent of the NHS workforce, and so are the largest group. The title of the proposed new section makes it clear that it is about them and the roles that they are meant to undertake.

I appreciate Emma Harper's personal experience, but the RCN has not presented the amendment on a whim. It has done so after a great deal of consultation and discussion with our nursing and midwifery workforce. Whether in a small community hospital or a bigger ward in a city hospital, from chemotherapy to the operating theatre, rostering should be appropriate anyway, and the unique role of senior charge nurse should be properly supported. Senior charge nurses are involved in things such as complex discharges and other issues around flow. If they have time to spend on that co-ordinating role, that can help to reduce issues such as delayed discharge and improve co-ordination and communication across teams. Senior charge nurses are expected to manage and develop the performance of a nursing team and to manage the practice setting by ensuring the effective use of resources and workforce planning through monitoring workloads.

Sandra White: Will Alison Johnstone take a small intervention?

Alison Johnstone: I will.

Sandra White: From the start of the bill process, the committee has worked hard to ensure that it is multidisciplinary and not just about acute services or nursing. Many people who work in hospitals take on many responsibilities. I do not mean any disrespect to anyone and I give credit to

all the people who work in the health service, but there are many more people than just senior nursing clinicians. That is where I have a problem with amendment 91. As the cabinet secretary said, there are multidisciplinary teams of professionals, so why should we concentrate on just a small part of those?

11:45

Alison Johnstone: The senior charge nurse role applies only to nursing, and nursing makes up more than 42 per cent of the NHS workforce. Such nurses help to co-ordinate inputs from different members of the multidisciplinary team. It is a key role. Having worked with the Royal College of Nursing to ascertain the impact, I will press amendment 91. If the role is properly focused and those experienced professionals are allowed to do their job to the utmost, it could have a positive effect.

Emma Harper: Will the member take another intervention?

Alison Johnstone: Certainly.

Emma Harper: Under amendment 91, it would be mandatory to remove the case load from senior charge nurses. My point is that senior charge nurses should already be empowered and able to be flexible in their choices on how they roster staff.

Alison Johnstone said that, if senior charge nurses do not have a case load, that should allow them to support training. In my experience, they can still support training if, for instance, they are scrubbed and at the operating table to remove a gallbladder, because they can conduct, guide and support people in that environment.

Amendment 91 is too prescriptive. There is such a wide range of health professionals and senior charge nurses in many areas, and those in the senior charge nurse role should be empowered to choose whether to pick up a case or assign it. Wide-ranging skills are required. Senior charge nurses should be allowed to make those informed clinical decisions, so we should not prescribe their role in the bill.

Alison Johnstone: Only a quarter of nursing staff in Scotland surveyed by the RCN in 2017 reported that the senior charge nurse was non-case load holding. The results of a freedom of information request to NHS boards from the RCN show that, of the 911 whole-time equivalent senior charge nurses identified at September 2017, only 115 were non-case load holding. We are struggling to recruit and retain nurses. We should work towards having an experienced professional in charge of a ward, giving leadership and security and helping others to develop their careers.

Miles Briggs: Will Alison Johnstone take a short intervention?

Alison Johnstone: Certainly.

Miles Briggs: I am incredibly sympathetic to what Alison Johnstone is trying to achieve with amendment 91, but none of us wants to write poor legislation. It is important for the delivery of the outcome of the bill that we have non-case load holding staff within its parameters. Given that amendment 20, which the cabinet secretary referred to, aims to develop that, and the overlap with potential work for stage 3 on getting the designated person right, it may be possible to do some work on the issue before stage 3 to ensure that the measures are incorporated in the bill. It is an important aspect, but there seems to be a bit of confusion.

Alison Johnstone: I have concerns that we may water down the approach considerably. On that basis, I will press amendment 91.

The Convener: The question is, that amendment 91 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 91 agreed to.

The Convener: The next group is entitled “Duty on Health Boards to ensure appropriate staffing: training”. Amendment 124, in the name of Alison Johnstone, is the only amendment in the group.

Alison Johnstone: Amendment 124 is the third amendment in my name this morning. It aims to place a duty on NHS boards to ensure that employees receive the time to carry out continuing professional development.

NHS governance standards already state that employers will give time to staff for CPD, but as we are all too well aware, that precious time is often lost because of the high demands on staff time.

The “RCN Employment Survey 2017” reported that the main reason that nursing staff feel that there are too few opportunities to progress in their

current job is that there are too few opportunities to access training and development. There are real difficulties in that respect. Nursing staff simply feel unable to take time off for training due to the many demands that they face in their work.

With that, I move amendment 124.

Emma Harper: I will not say a lot about amendment 124, but will just point out that in my former role as a nurse educator, I managed to get NHS Dumfries and Galloway to put in place four educators to support education and facilitate continuing professional development. In my current work, I have been looking at the education that is being provided out there, and I suggest that we do not put what is set out in the amendment in the bill until we can get a real assessment of the education and support that is being provided.

I understand the challenges facing nursing staff in being able to access CPD while they are on the ward and are being pulled in different directions, but I suggest that we have a further look at the situation with education across health boards. I know that in the health board where I worked—NHS Dumfries and Galloway—particular efforts were being made to accommodate more focused CPD for the staff.

Brian Whittle: Amendment 124 is an incredibly important amendment that we should support. With regard to CPD, the committee is very well aware of the pressure being put on paediatric wards in affording all staff the opportunity to have cardiotocography scan training and development, but it is incredibly important not just for the staff themselves and for patient safety but for staff retention that they are allowed to develop continually.

George Adam: I just want to back everything that my colleague Emma Harper has said. On three or four amendments, she has given us her point of view as a professional who has worked on the front line. She provides a valuable resource for the committee, but on each occasion, the majority of the committee has not really taken on board what she has had to say. I simply want to back Emma Harper's position on amendment 124 not for the obvious reasons but because she has been on the front line and knows exactly what is going on out there.

Jeane Freeman: I thank Alison Johnstone for her opening remarks on amendment 124. The amendment itself mirrors section 7, which relates to the care side of things, but I should point out that that section was inserted because the bill seeks to revoke regulation 15 of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 and, in so doing, revokes important provisions on staff training. It was therefore felt necessary to replicate those provisions in the bill to ensure that care service staff still had the same rights to training and development as they had before.

However, health is a different regulatory environment. I am very supportive of amendment 124's aim of ensuring that healthcare staff have similar rights to training, but I have a number of reservations about the amendment itself. The National Health Service Reform (Scotland) Act 2004 inserted into the 1978 act section 12I, on the duty in relation to governance of staff, and the staff governance standard was published to support that. That standard already requires all NHS boards to demonstrate that their staff are appropriately trained and developed and goes on to provide some detail in that respect, and it is, of course, subject to significant scrutiny and work by the partnership forums, which are central to how we work in our NHS. The amendment therefore duplicates, in part, something that already exists in the standard. I gently suggest to the committee that we do not make good law by duplicating what we find elsewhere.

Furthermore, I have concerns about the extremely wide scope of amendment 124. If we take account of ever-changing health technologies and treatments, the legislative entitlement would be open ended and unquantified, so I question how the entitlement would be managed. For instance, who would decide and how would it be decided which staff should get priority for further qualifications that are deemed to be appropriate for work? Do the educational development sectors have the capacity to deliver what would be required? In that regard, the comments that were made by Ms Harper are very pertinent.

Staff should receive training and should continue to be developed throughout their careers—I have absolutely no argument with that point. However, making it a legislative entitlement in the way that is suggested is not the correct thing to do. I have serious concerns about whether it will be feasible—or, indeed, possible—to maintain safe and high-quality services if growing numbers of staff are released for an open-ended and unpredictable amount of training and development.

As part of the development of each of the workload tools, the amount of time that staff should spend training has been factored into the tool. For the existing tools for nursing and midwifery, there is an allowance of 2 per cent, which equates to 33 hours each year for a whole-time-equivalent nurse. Since the allowance has been factored into the tools, I expect boards to ensure that staff receive it, and if they do not, I want to know why.

Therefore, I am happy to commit to working with Ms Johnstone, should she wish it, and with the

RCN and others with an interest, to consider what might be done to make the common staffing methodology more explicit about the built-in time for training and the need for boards to meet it. I feel strongly that it is an important issue and one which must be addressed, but the correct way to go about it is not to put what is, in effect, an open-ended proposition into primary legislation.

On that basis, I ask Ms Johnstone not to press the amendment and, if she does, I ask the committee not to support it.

The Convener: I call on Alison Johnstone to wind up and press or seek to withdraw amendment 124.

Alison Johnstone: I will start by addressing Brian Whittle's comments. I agree whole-heartedly that ensuring that our staff have adequate time to develop themselves professionally will empower them and make sure that they are educated in the latest innovations and developments in their field. It will help us to recruit and retain people; it will make them feel valued.

George Adam is absolutely right to say that Emma Harper is a valuable resource to the committee and the Parliament who reflects the experience that she has gained working in nursing. However, it is also true that, in a large workforce such as nursing, there are different views and experiences, perhaps as a result of geography or the management that people experience, so it is important that we try to look at the issue as widely as possible.

Emma Harper: Will you take a wee brief intervention?

Alison Johnstone: Certainly.

Emma Harper: Continuing professional development and education are provided in lots of different ways, off and on the ward, in the community or through self-directed learning as part of a professional nurse's approach. For nurses, it is not often done in work time, but there are other health professionals who might require bedside, on-the-job training.

There is a wide approach to delivery of appropriate learning for developing clinical skills so, again, it is not required to put it into primary legislation when amendment 20 describes a more flexible approach to the training of staff. I support guidance following the introduction of the bill so that we can continue to focus on how we best provide education with regard to recruitment, retention and staff development.

Alison Johnstone: During an inquiry that was conducted when I was a member of this committee, we heard from the chair of the British Medical Association—I cannot quite recall on what occasion that was—and he spoke about the fact that medics have protected time for training. He was favourable to and supportive of the idea that that should be enjoyed by colleagues in nursing as well. The 2017 RCN UK employment survey reported that the main reason that nursing staff feel that there are too few opportunities to progress is that there are too few opportunities to access training and development.

I appreciate Emma Harper's comments about learning in one's own time and self-directed learning, but there is something invaluable about setting aside specific time for such important work—it shows appreciation.

12:00

I appreciate the cabinet secretary's comments too, but, with respect, this is not an open-ended commitment. We are talking about appropriate training, which is what we have in place at the moment.

In the Scotland staff survey in 2015, 22 per cent—almost one quarter—of nursing and midwifery staff indicated that they had not received, and did not expect to receive, the training that was identified in their personal development plan.

It is time that we looked at this issue. Nursing is an incredibly important career—is there a more important one? We should be investing in it whole-heartedly.

I press amendment 124.

The Convener: The question is, that amendment 124 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Torrance, David (Kirkcaldy) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 5, Against 4, Abstentions 0.

Amendment 124 agreed to.

The Convener: We will resume stage 2 next week. Members can still lodge amendments relating to the part of the bill after the part that amendment 124 deals with. The deadline for lodging further amendments is 12 noon tomorrow, Wednesday 30 January.

12:01

Meeting continued in private until 12:23.

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