STAGE 2 PROCEEDINGS: HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

The RCN welcomes many of the amendments lodged ahead of stage 2, which it feels would improve and strengthen the Bill. In particular, the shift to a multidisciplinary focus is welcome.

Ahead of the publication of the Bill, the RCN set out six key tests which the legislation should meet if it is to have a positive impact on patients and staff in practice. A number of amendments lodged for stage 2 would, if agreed to, mean that the six tests (set out below) would be reflected in legislation. Many of the amendments would also address areas of concern which the RCN expressed at stage 1.

Positive outcomes: Positive outcomes for people and staff must be at the heart of decision making. A number of amendments in the name of Alex Cole Hamilton MSP are relevant:

- ***Amendments 1 and 2*** *seek to include the health and wellbeing of service users in the guiding principles.*
- ***Amendments 3 and 7*** *would include the health and wellbeing of staff as well as that of patients in the general duty on NHS boards and care service providers.*
- ***Amendment 4*** *would include the word 'safe'. As drafted safe is not included in the general duty on NHS boards although it is a guiding principle.*
- ***Amendment 5*** *would extend the general duty to cover services. High quality care and services are different. The latter, would ensure that staff are working in high quality- and safe if amendment 4 is agreed to- environments, in addition to patients receiving high quality care.*
- ***Amendment 6*** *would allow for areas for improvement to be identified through the training and consultation of staff in relation to the common staffing method.*

A strong professional voice: Nursing leaders, whether at a ward, team or governance level, should be able to exercise their professional judgement about whether there are the right number of nursing staff with the right knowledge, skills and experience, in the right place and at the right time.

- ***Amendment 123*** *would mean that NHS boards must consult and have due regard to the professional advice of the designated persons, and it would allow designated persons to note any decisions which are made by the Board which go contrary to that professional advice and judgement. This model provides the opportunity to ensure that professional judgement is central to all staffing decisions, whilst maintaining accountability at Board level. The RCN believes that it fulfils the Committee's wish to have 'an accountable person' and that this builds on the Cabinet Secretary's amendment 17.*
- ***Amendment 122*** *looks to embed the professional judgement of a nurse of appropriate seniority when a provider is using the staffing method in deciding the staffing establishment required for a care home service for adults where nursing care is provided. This amendment is nursing specific because the amendment focuses on the particular clinical care required by residents which is, largely, delivered by nursing teams. As such, residents and the public should be assured that there is professional input from a senior nurse in deciding whether the staffing establishment is appropriate.*
- ***Amendments 97, 99, 100 and 101*** *seek to ensure that the common staffing method is truly triangulated by giving patient need, professional clinical advice and risk identification/ mitigation equal weight to issues such as vacancies.*
- ***Amendments 102, 104, 105 and 106*** *all seek to ensure that professionals and their judgement are embedded through decisions about staffing; that they are supported to give their views; and that they have time to undergo training in the common staffing method and any risk protocols.*

Informed decision making: All decisions about staffing for nursing teams must be based on data and evidence, which is robust, up to date, and used appropriately. A number of amendments in the name of Miles Briggs MSP are relevant here.

- ***Amendment 93*** *designates the Common Staffing Method solely as the establishment setting process for Part 2.*

- ***Amendment 98*** *includes feedback from real-time assessment arrangements and risk escalation to be included in the Common Staffing Method so that learning from practice is taken into consideration in setting a staffing establishment.*

- ***Amendments 94 and 95*** *seek to include relevant guidelines published by professional and improvement organisations as well as peer reviewed evidence as things which can be taken into consideration as part of the common staffing method. 120 seeks to do similar in Part 3.*

- ***Amendments 115 and 119*** *seek to ensure that methodologies for staffing will be developed for care services set out in Part 3.*

- ***Amendment 116*** *makes clear that any staffing method used in care home services for adults (and future services which may be included here) would be evidence based and would be used to set a staffing establishment.*

- ***Amendment 117*** *would require SCSWIS to develop indicators of clinical quality for, in the first instance, care home services for adults. Amendment 118 would ensure that such indicators are developed in collaboration with the relevant partners.*

Responsibility, accountability, real-time action and long-term planning: Organisations must take responsibility for providing the right number of nursing staff. Staff should have the right knowledge, skills and experience and be deployed in the right place and at the right time to provide safe, high quality care to patients.

- *The RCN welcomes the spirit of* ***amendment 17*** *in the name of the Cabinet Secretary for Health and Sport which seeks to make the Bill work in real time by monitoring staffing and escalating risk as appropriate. There are a number of challenges in the amendment as drafted which amendments 17A-I in the name of David Stewart MSP seek to address.*

  Including, in particular, a change from the idea that there is one individual with lead clinical professional responsibility, to recognise that there are different leads for different clinical professions. As drafted, amendment 17 could mean, for example, that all risks are flagged through a consultant in a ward setting. If amendment 17 is agreed to then the RCN would ask that amendments 17A-I are also agreed to. See also notes on amendment 123.
- ***Amendment 107*** *sets out a different risk management and escalation process which also has merit. Amendment 123 would ensure that clinical leadership was taken to NHS Board level.*
- ***Amendment 113*** *in the name of David Stewart MSP seeks to place a duty on care providers to have a risk management procedure which is important for parity across Part 2 and Part 3.*

Scrutiny and sanction: There must be public scrutiny of staffing for safe and effective care and sanction if the law is not met. Amendments lodged by Monica Lennon MSP are important here:

- **Amendments 85, 89, 108 and 109** all relate to reporting duties. This is a positive step in ensuring that clear information is collected which accurately reflects any challenges being faced by those placed under duties by this legislation.

Staff to care for people across Scotland: This legislation is a starting point. Work must continue to ensure that Scotland has the health and care staff it needs across nursing and other disciplines. The Scottish Government must take responsibility for ensuring a supply of nursing staff that meets demand. A number of amendments in the name of Alison Johnstone MSP seek to ensure that this legislation will deliver the staff to care for the people of Scotland.

- ***Amendment 90*** *would place a duty on Ministers to ensure that, where they have commissioning powers, enough student places are being offered to train a workforce to allow health care and care providers to staff appropriately. If amendment 90 was accepted an equivalent amendment relating to Part 3 would seem sensible at stage 3.*

- ***Amendment 91*** *seeks to ensure that non-caseload holding status of senior charge nurse, and their equivalents in community teams. These senior nurses are integral to the daily delivery of safe care and successful implementation of this legislation. They must be given the time they need to fulfil their clinical leadership role by not being counted in the number of nursing staff required to provide direct care to patients.*

- ***Amendment 124*** *would place a duty on NHS boards to ensure that employees received time to carry out CPD. As drafted, this exists in Part 3 at section 7. This would give equivalence in Part 2. NHS Governance Standards do already state that employers will give time to staff for CPD but, in reality, CPD time is often lost because of the high demands on staff time.*

Amendments 84 and 86 in the name of Miles Briggs MSP and **amendment 110** in the name of David Stewart MSP are also important here in that they relate to duties on commissioners and the ability therefore of providers to be able to meet the duties placed upon them under this legislation.

Opposition to amendments

The RCN has serious concerns with the following Scottish Government amendments and would ask MSPs to oppose them:

- **Amendment 9**. This dilutes the original principle of having the right staff, in the right place at the right time. The RCN supports the original wording of the Bill.

- **Amendments 15 and 67**. These focus on the wellbeing of staff only when patient care is compromised. This would mean that the wellbeing and safety of staff is not a concern where patient care is deemed to be satisfactory. This is a significant concern to the RCN. There may, for example, be sufficient staff to provide safe patient care but not enough staff to assist a staff member who suffers abuse and needs assistance. The RCN supports amendments 3 and 7 in the name of Alex Cole Hamilton.

Areas for clarification

- **Amendment 11** seeks to define multi-disciplinary services. The RCN and AHPFS believe that such a definition is helpful. The inclusion of the word 'together' is, however, ambiguous. If it is taken as meaning in a collaborative manner then that would be appropriate. If, however, it means in close proximity or with then that would be problematic as not all multi-disciplinary services are delivered together in the latter meaning. RCN and AHPFS would ask MSPs to be cognisant of this point.

- **Amendments 66 and 82BB** in the name of the Cabinet Secretary for Health and Sport. There has been significant discussion around the tools which are used as part of the common staffing method, and those which are yet to be developed which would form a part of the common staffing method. The Health and Sport Committee's report indicated that a multi-disciplinary approach should be taken to the development of future methodologies and tools. The multi-disciplinary approach is a principle which has the support of those across professional disciplines.

  It is, however, important to highlight that a multi-disciplinary approach is different to a multi-disciplinary tool. A multi-disciplinary approach requires potentially numerous tools which can take in to account the different roles, work patterns etc. of the different professionals involved in any given care pathway.

  The RCN and the AHPFS agree that there should not be an assumption that the development of a single tool for use by everyone to measure workload is equivalent to taking a multi-disciplinary approach.

Likewise, RCN and the AHPFS agree that each professional discipline must be equally supported to develop an approach to workload and workforce planning which is focused on their contribution to care. That would lead to the development of a multi-disciplinary "tool box", made up of different tools, as necessary, to reflect different roles, work patterns etc. of the different professionals involved in any given care pathway.

Amendments 66 and 82BB in the name of the Cabinet Secretary for Health and Sport are a concern in relation to the above as they both imply a single tool for use across disciplines. It would be helpful to have clarification at stage 2 that the meaning is not a presumption to one single tool in all cases, with a view to an amendment at stage 3.

- **Amendment 66** in the name of the Cabinet Secretary for Health and Sport relates to HIS and the RCN is supportive of its inclusion. The RCN would ask MSPs to note, however, that:
  - 12IH on monitoring and compliance could also usefully cover encouraging improvement.
  - HIS is under no duties to consult or collaborate with representatives of services users and carers which may be an omission.
  - The power to require information should include the power to require information from Integration Authorities
  - The Care Inspectorate and Integration Authorities also need to have regard to Ministerial guidance on staffing functions.

- **Amendment 79** in the name of the Cabinet Secretary for Health and Sport. This amendment refers only to methods and not to tools. Tools can form part of a staffing method, as per the common staffing method. It would be helpful to have clarification as to why tools are not referenced. It should also be noted that the amendment does not require collaboration with stakeholders in reviewing methods. . This is different from the duty in relation to HIS (included in amendment 66) which states with whom HIS must collaborate in reviewing the common staffing method.

- **Amendment 90** in the name of Anas Sarwar MSP aims to limit the fee which agencies can charge. This is a principle which the RCN agrees with. There are, however some concerns over the mechanism set out in the amendment:
  - How will the authorisation process from Scottish Ministers work in real-time?
  - What would the impact be if a senior nurse cannot get agency staff at short notice because of the cap - both on the clinical service and on that individual's NMC registration?
  - Would the 150% include the agencies fee? If yes, would there be a knock-on effect to what individual agency staff take home in pay?
  - Will the 150% take into account overtime/out of hours being paid at a higher rate?
  - Will there be any unintended consequences on agency use in the social care sector, if agency spend is capped in the NHS?