

SUBMITTING EVIDENCE TO A SCOTTISH PARLIAMENT COMMITTEE

DATA PROTECTION FORM

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| Organisation: (if required) | The Royal College of Nursing |
| Topic of submission: | The Health and Care (Staffing) (Scotland) Bill |

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FINANCE AND CONSTITUTION COMMITTEE**HEALTH AND CARE (STAFFING) (SCOTLAND) BILL FINANCIAL MEMORANDUM****SUBMISSION FROM THE ROYAL COLLEGE OF NURSING**

1. The Royal College of Nursing (RCN) was a member of the Bill group, but that group did not discuss any of the financial assumptions surrounding the Bill and reflected in the Financial Memorandum. The RCN provided responses to both of the Scottish Government's written consultations on the legislation, neither of which considered financial implications of the legislation.
2. The RCN did not make comments on the financial assumptions made and there are therefore no comments to reflect. The RCN has, however, had numerous discussions with the Scottish Government on the need for further investment in health and care services particularly in relation to workforce supply and recruitment and retention.
3. The RCN felt that there was sufficient time to respond to the consultations to which it provided responses.
4. The RCN does not anticipate direct costs to the organisation as a result of the Bill.
5. The Financial Memorandum estimates a total cost of £13.7 million over the six year period 2018-19 to 2023-24, with a recurring sum of £1.4 million per annum thereafter to implement the provisions of the Bill. As noted at paragraph 20 in the Memorandum, these estimated costs are 'the direct costs associated with the legislation, the development and implementation of staffing level tools and methodologies'.

There are two general points, which relate to the direct costs, that the RCN would raise as concerns. Firstly, there is no sense in the Financial Memorandum that work will be done to ensure the ongoing validity of the tools. That is to say that there are no costs calculated for a review of ongoing data, best practice and evidence to ensure that the methodologies used are continually relevant. As noted at paragraph 25 of the Memorandum, the Nursing and Midwifery Workload and Workforce Planning Programme (NMWWPP) is already 11 years old.

Secondly, as the RCN has stated consistently, NMWWPP does not in itself deliver staffing nor care, which is safe, effective and high quality. It is therefore, a concern that the case studies set out at Annex 1 focus solely on implementation of NMWWPP, rather than in addressing other integral elements, such as the use of professional judgement systems which allow for more responsive and dynamic decision making and local resolution to staffing challenges on a day-to-day basis.

On nursing specifically, the Memorandum makes no mention of the significant challenges already facing the workforce (although the Policy Memorandum does note issues around recruitment and retention of nursing staff).

The last ISD NHS Workforce statistics to be published (June 2018) identified a 4.5 per cent vacancy rate in nursing and midwifery in Scotland's NHS, with over 2,812 whole time equivalent (WTE) posts vacant. Over 850 WTE posts had been vacant for three months or more – a 27 per cent increase on the 2017 figure. In a Scottish Care survey in 2017, 91 per cent of the care providers surveyed – largely nursing homes – indicated that they were having difficulties filling nurse vacancies. Scottish Care data from November 2017 found that the average nurse vacancy rate in care homes was 31 per cent.

Last year the RCN carried out a survey of over 3,300 members in Scotland. Fifty-one per cent of those 3,300 respondents said that their last shift was not staffed to the level planned and 53 per cent indicated that care was compromised as a result. Fifty-four per cent of respondents reported that they did not have enough time to provide the level of care they would like and 34 per cent said that because of a lack of time they had to leave necessary care undone.

Taken together these statistics and survey responses show, without ambiguity, that Scotland does not have the nursing staff it needs to care for everyone who requires it in a safe and effective way.

It is questionable, therefore, whether this legislation can be implemented fully, and in a way which will improve the quality of care that patients receive, without significant investment – particularly in the workforce – and without recognition of the reality of the current workforce situation, and with the likely future increased demand on services.

As a result the RCN would challenge the 'current resources' basis of the Financial Memorandum, set out at paragraph 8.

The RCN would also highlight that, contrary to paragraph 8, the Memorandum does not set out the potential financial impact on wider staffing levels and associated costs. In fact, paragraph 20 indicates that such costs will not be considered.

Paragraph 13 of the Memorandum sets the tone for where savings are estimated to be – that is to say, through more effective application of the staffing tools and methodologies.

In addition, whilst acknowledging the difficulties some NHS boards face with staff shortages, the Memorandum states that this Bill will not directly address shortages. That statement the RCN believes to be at odds with legislation which places NHS boards under a duty 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'. (12IA Health and Care (Staffing) (Scotland) Bill).

Paragraph 23 reads 'no significant additional costs are anticipated in respect of increased staffing levels in health or social care.' The phrase 'no additional costs' is mentioned several times in the Memorandum. This would appear to pre-empt the outcome of the running of any tools and methodologies and somewhat tie the hands of NHS boards.

It also assumes that the resource currently available for running NMWWPP, which, to some degree, may sit outside of the nursing teams, is sufficient. The RCN would challenge this view. Some aspects of NMWWPP are immensely complicated, and coordinating the information required across workforce planning and finance is a time-intensive process.

The 'no additional cost' message is echoed again at paragraph 50 which states that: 'Overall, it is not, therefore, anticipated that the introduction of the Bill will significantly increase overall staff costs but may in fact provide the opportunity to reduce spend on supplementary staffing, enabling a reallocation away from supplementary staffing towards funded establishment.'

The agency costs set out at Table 6, although not insignificant in cash terms, are small when compared to the overall nursing and midwifery spend excluding bank and agency. For 2016-17 the total agency spend was equivalent to just 1 per cent of the total nursing and midwifery spend excluding bank and agency. ISD NHS Workforce statistics report annually on agency use and in 2017-18 ISD stated it was equivalent to an average of 257 WTE posts across Scotland. The current vacancy rate is 2,812 WTE in the NHS alone.

It is a concern to RCN Scotland that the crude measure of diverting agency spend into full-time posts is emerging as a solution to a complex problem. In looking solely at agency spend, the Memorandum does not take into consideration whether there are actually the number of nursing staff working solely in agencies to redeploy to substantive NHS posts. The Scottish Social Services Council publishes annual workforce data which includes estimated numbers on nurses employed by agencies. The latest data was published in September 2017 and estimates that 1,800 nurses were employed by agencies in 2016. The data does not distinguish if agency is their only job.

The 2017 RCN Employment Survey found that 20 per cent of respondents from Scotland had taken an additional job over the last year. But when asked about the employer for their main job, only 3 per cent reported NHS Bank and only 2.8 per cent reported that an independent/private health care provider was their main employer, with numbers for agency not reported separately. Nevertheless, from the general trend on the amount spent on agency against the amount spent on bank, it can be assumed that the number of nurses with an agency as their main employer is low.

The RCN is also conscious that in focusing in on agency spend and the potential efficiencies found there, there is a danger that financial drivers become more imperative than addressing some other factors which have a direct impact on safety and quality, such as high nurse caseloads in community teams.

The training requirements and costs set out in the Memorandum are insufficient. For staff in care homes, for example, budget has been allocated to train two staff members per care home in 2020-21 and 2021-22. Staff turnover in these settings means that the ongoing training need and associated costs may be significantly in excess of the £150,000 budgeted for each period.

With the financial pressures already on integration authorities and the care home sector, the RCN is concerned about who would be expected to absorb any additional costs.

It is assumed throughout the Memorandum that nursing staff already have access to sufficient time to use the tools. This argument is set out at paragraph 37 of the Memorandum. Likewise, paragraph 39 states that 'much of the infrastructure, knowledge and experience required to support this legislation is largely already in place'. Paragraph 41, however, indicates that there has been 'low uptake' of online training and 'significant turnover of those staff who were initially trained'. The estimate is that 50 per cent of all Band 7 and above nurses and midwives would require training. The RCN believes this to be a modest estimate of the training need.

Throughout the parliamentary process, the RCN will make the case for senior charge nurses and community team leaders to be non-caseload holding to ensure that they have adequate time to manage their teams safely and effectively in line with legislation. This is something which the RCN set out in its 2016 manifesto ahead of the Scottish Parliament elections and which numerous MSPs supported. In 2008, 'Leading Better Care', published by the Scottish Government, stated that while senior charge nurses should monitor and ensure quality and consistency of care for all patients, they should not have a direct case load, nor have their attention diverted from their role in clinical coordination by spending significant amounts of time on administrative duties.

In addition, paragraph 42 states that 'time for continuous professional development is included in current nursing and midwifery establishments and it is anticipated that training could be completed within this'. The result is that no additional resource will be required for nurses to undertake training. The RCN is concerned that, at present, nursing staff getting time to complete even mandatory training such as moving and handling and infection control can be a challenge. The RCN would also draw to the Committee's attention the last NHS staff survey (2015) which showed that time for continuing professional development (CPD) is not prioritised, with over a quarter of staff not even having an appraisal or development review meeting in the last 12 months; and the 2015 RCN employment survey which found that 37 per cent of members in Scotland reported not receiving any CPD in the last 12 months.

It may be helpful for the Committee to know that from April 2016, nurses must undertake revalidation every three years to remain on the NMC register. As part of this they must have undertaken 35 hours of CPD over three years. CPD also features in the NHS Health Care Support Worker Codes of Practice, NHS Scotland Staff Governance Standards and the Scottish Social Services Council Codes of Practice. But, in reality, there is a tension between what staff are required to undertake around CPD and what in reality they are able to do. Employers struggle to release staff because of day-to-day service pressures.

6. As at question 4, the RCN does not anticipate that there will be any direct costs to it as a result of the Bill.

7. The margins of uncertainty are arguably in the costs associated with what the application of the methodologies find about need for staffing. The RCN is concerned that the Memorandum assumes a static level of demand, and fails to take account of current unmet needs. The assumption throughout the Memorandum is that no additional staff will be needed and therefore, there will be no additional staff costs. The RCN believes that this at best a naïve understanding of the current state of the challenges facing nursing across Scotland.
8. As drafted, the reporting duties on NHS boards are minimal and scrutiny is entirely missing. In its evidence to the Health and Sport Committee on the Bill, the RCN has made the case for more significant and transparent reporting which would have cost implications for NHS boards. The RCN believes that if this legislation is to work that there must be the resources, and the time, for robust reporting. NHS Orkney has recently been subject to a Healthcare Improvement Scotland Quality of Care Review. The Committee may be interested to consider NHS Orkney's experience. The RCN wishes to see a change of remit for Healthcare Improvement Scotland to allow it to provide a scrutiny function in relation to this legislation. This would have cost implications for Healthcare Improvement Scotland.

While the Financial Memorandum makes reference to 'Excellence in Care' in Table 4, the RCN is concerned that there is not sufficient funding agreed to fully develop, implement and support the ongoing use of 'Excellence in Care' across NHS boards. At present there is partnership work with Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, Scottish Government and others to develop an assurance framework – called 'Excellence in Care' – but it is unclear where funding for work beyond 2019-20 will come from. A care assurance framework must be complete and able to be embedded across nursing services ahead of commencement.

Without a care assurance framework, there would be a lack of consistent data on indicators of care quality – which in acute adult inpatient settings may cover things like pressure ulcers and trips and falls, as well as workforce staff data such as bank and agency use and skill mix – making decisions about whether nursing was delivering safe and effective care very difficult and not evidence based, meaning that this legislation would fail to deliver positive change.

There is also a lack of funding for NHS boards to ensure that they have the IT systems in place to enable the real-time monitoring and risk assessment element of workload and workforce planning which is essential to ensure safe, high quality care. Some NHS boards do already have systems in place; NHS Lothian, for example, uses a system called SafeCare. But where NHS boards have not been able to invest in such systems, it is crucial that funding is available in order for this legislation to be implemented in practice.

9. Further to what the RCN has stated above about the need for investment to review, maintain and, if necessary, develop new nursing and midwifery tools and methodologies, no funding has been set out in the Memorandum to provide for the extension of tools and methodologies to other settings and professions beyond the initial work with care homes. Extension would have significant cost implications.

REF NO.

The RCN believes that, if there is an appetite, each professional group should have the opportunity to develop methodologies which will allow for improved workforce planning and deployment. This is, of course, a matter for each professional group to discuss.