REF NO.

SUBMITTING EVIDENCE TO A SCOTTISH PARLIAMENT COMMITTEE

DATA PROTECTION FORM

Name:	**Theresa Fyffe**
Date:	
Organisation: (if required)	**The Royal College of Nursing**
Topic of submission:	**The Health and Care (Staffing) (Scotland) Bill**

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REF NO.

HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM THE ROYAL COLLEGE OF NURSING

1. Since the Scottish Government announced its intention to legislate for safe staffing, the Royal College of Nursing (RCN) has worked to highlight areas where legislation has the potential to make a positive and lasting change for nursing teams, and crucially for the people that they care for. The RCN is supportive of a legislative approach because of the opportunities it presents to ensure that the right staff with the right skills are in place to deliver care in all settings at all times. This approach is key to addressing the recommendations of the Francis Report and the Vale of Leven Inquiry with regard to staffing and quality. There is also a body of established evidence which demonstrates the link between better nurse staffing and improved patient outcomes.

   The RCN has maintained that legislation solely to create a statutory footing for the previously mandated Nursing and Midwifery Workload and Workforce Planning Programme (NMWWPP) was insufficient, and could not be deemed as legislating for safe staffing in nursing teams. Consistent application of NMWWPP, important though this may be, is not the end point the RCN is looking to. The RCN has championed a process which takes into consideration, with equal weight, the use of tools (such as NMWWPP) and methodologies, professional judgement, and patient acuity/need. This triangulated approach can help to deliver what tools and methodologies in themselves cannot – safe, high quality care and better personal outcomes.

   The Bill as introduced is more substantial than putting NMWWPP on a statutory footing and therefore goes further than the Scottish Government had initially intended. By setting out principles which apply to all health and care settings, the Bill is rooted in a drive to ensure positive outcomes for service users and staff. The inclusion specifically of the word ‘safe’ in the guiding principles for health and care staffing, set out in Part 1, is critical in legislation which is to address staffing for safe and effective care.

   The duty on health boards to ensure appropriate staffing at all times, set out at Part 2 section 4 of the Bill, is important for areas where NMWWPP do not exist and cannot therefore be used at present. This duty means that an approach taking into account professional judgement, any relevant guidance and patient acuity and dependency should still be used ‘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.’ The RCN also sees this duty as a possible driver to develop tools and methodologies which can add to the triangulated approach where NMWWPP does not exist at present (it is currently used in around 98 per cent of clinical areas).

   The application of the Bill across the health and social care sectors is vital in a system where health and social care are integrated. It should, however, be noted that the RCN’s interest in social care settings is about clinical care need and the delivery of clinical care through nursing teams.

The RCN believes that the Bill as introduced has the potential scope to meet its policy objectives as set out at paragraphs four and five of the Policy Memorandum. That being said, the Bill would, in the RCN's view, require some significant amendments in order to fulfil this potential.

The RCN would, however, question 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 current workforce pressures, and with the likely future increased demand on services.

Throughout this document where the RCN refers to an 'NHS board', the assumption has been made that the Public Bodies (Joint Working) (Scotland) Act 2014 would extend all provisions of the Health and Care (Staffing) (Scotland) Bill to Integration Authorities should it become an Act of Parliament.

2a. Although not in Part 2, the RCN sees Part 1 section 2 as crucial in the provision of safe, high-quality services in communities, through Integration Authorities, and where services are commissioned from third parties. The RCN believes that Part 1 section 2 will need to be strengthened to ensure that people using services have confidence that the guiding principles must be met by service providers and to ensure that both commissioners and providers have sufficient resources to meet any obligations placed on them. It would also be helpful to see Part 1 section 2(2) revised to give some points which must be considered when reaching a decision on what constitutes 'appropriate staffing arrangements'. Section 6 in Part 3 of the Bill could be replicated here to set a determination for 'appropriate', and the RCN would also want to see professional judgement being included. Nevertheless, the inclusion of Part 1 section 2 is important and demonstrates an ambition to ensuring safe, high quality services at every level and across health and care services.

It is right that the legislation will cover acute and community settings. For many nursing teams the reality of delivering the Scottish Government's 2020 Vision means delivering highly complex clinical care which would previously have required hospital admission. It would therefore be remiss to introduce legislation where staffing for safe, high quality services did not extend beyond ward walls.

The lack of specificity around tools and methodologies is important in future-proofing this legislation. The current NMWWPP was developed some time ago and should be open to review, particularly around whether general assumptions built into modelling, such as bed occupancy and staff absence rates, are correct. In future, different methodologies and tools may be developed which will further enhance the ability to provide safe care. It is crucial that this legislation does not tie Scotland to a moment in time through a specific set of tools and methodologies. The RCN would want to see a role for Healthcare Improvement Scotland in the development of new tools and methodologies in Part 2, in line with the role for the Care Inspectorate set out in Part 3. Both Healthcare Improvement Scotland and the Care Inspectorate should have a role in maintaining tools.

It is imperative that this legislation is taken as a starting point to promote safe, effective care through a robust triangulated process. At present NMWWPP means that nursing has the tools and methodologies to underpin triangulation. The RCN does not believe that this legislation should be delayed because it covers, with the exception of accident and emergency, the nursing and midwifery workforce alone. Neither does it think that in the long term nursing should be the only discipline to be covered by this legislation. Work must continue to ensure that Scotland has the health and care staff it needs across staff groups. It is crucial therefore that Part 2 is drafted in a way which is non-prescriptive on exact tools and methodologies as this will allow for development and extension to other health professionals. It is disappointing that no funding has been identified to develop this work beyond the care home sector.

The duty to ensure appropriate staffing set out in the Bill is a strength. This duty is key to ensuring that where NMWWPP is not used in an area, NHS boards still have a responsibility to ensure that there are the right staff, with the right skills, in the right place and at the right time. The RCN also sees this as a strength for other professional groups which do not currently have tools and methodologies to assist with workload and workforce planning. The RCN has written to the Scottish Government to seek clarification on how 'health' is to be interpreted in the duty. Is it unclear whether the phrase 'are appropriate for the health' is being used as an indicator of acuity and dependency, or whether this is a longer-term view of health and the maintaining of it. The RCN would wish to see the health, safety and wellbeing of staff included in the duty.

The inclusion in the Bill of training and consulting staff is important. In setting out a need for training and consultation, the Bill recognises the vital part that staff, in particular senior charge nurses, community team leaders and other nursing leaders who have a role in workforce and service planning and delivery, will need to play in the implementation of this legislation if it is to be a success. The RCN questions the need for the section 'Training and consultation of staff' to be linked solely to areas where the Common Staffing Method can be applied. There would, for example, be value in supporting NHS board employees to give views on staffing arrangements, and ensuring that they had time to exercise professional judgement in the small number of areas not covered by NMWWPP. This would also recognise the value of colleagues working outside of nursing teams.

The RCN is pleased to see a measure of reporting set out in the Bill. Reporting will be crucial for improvement and public scrutiny. Its inclusion in the Bill means that there is the possibility for these measures to be strengthened if the Bill progresses to Stage Two.

2b. As set out in response to question one, the RCN's main focus is to ensure that clinical need can be identified and met in care settings. As such, the RCN is pleased to see care settings being included through Part 3 of the Bill.

The inclusion of a number of issues which are to be regarded when making decisions about what constitutes 'appropriate numbers' of staff, set out at Part 3 section 6(2), is considered by the RCN to be helpful in setting out a method by which 'appropriate' can be measured.

This is something which the RCN believes could be replicated in Part 2 section 2(2)(b) to set out a similar process for NHS boards to consider when commissioning services with 'appropriate staffing'.

Section 7 'Training of Staff' is something which the RCN would like to see mirrored in Part 2 of the Bill, to ensure that staff have time for training and for obtaining further qualifications.

3a. The RCN has identified three areas which must be reflected in legislation if it is to make a positive and lasting difference to nursing staff and patients. At present, the Bill's provisions across these three areas are either insufficient or absent altogether.

Responsibility, accountability, real-time action and long-term planning
The responsibility to provide the right number of nursing staff with the right knowledge, skills and experience, in the right place at the right time, must be organisational. Likewise accountability for discharging the duty to ensure appropriate staffing must be seen as organisational.

The Common Staffing Method set out in Part 2 will be used to determine nursing staffing in the NHS where tools are available. The Common Staffing Method set out is, in almost all cases, an annual or biannual process to look at the nursing establishment. It does not work in real-time to monitor staffing issues, nor help nursing leaders to monitor 'hotspots' where staffing issues or quality of care indicators may show patterns of concern. The Common Staffing Method does not assist with day-to-day risk assessment, mitigation and, therefore, the delivery of safe, effective care.

The RCN is content with the inclusion of a Common Staffing Method process, but it should be viewed as an establishment setting process, linked to long-term workforce and financial planning processes.

It is a concern to the RCN that the sequential process created by the Common Staffing Method creates a hierarchy within the triangulated approach, with tools and methodologies holding significantly more weight than professional judgement or patient acuity and dependency. It would be crucial, in the RCN's view, to bolster and embed the professional voice throughout the Common Staffing Method to ensure that there is no hierarchy within the triangulated process.

Provisions should be included within the Bill to set out a process for monitoring, risk assessment and local resolution. This is a process which happens daily across nursing teams, and is integral to the delivery of safe, high quality care. The inclusion of a section on monitoring and local resolution, will ensure that the emphasis is on monitoring and resolving of issues locally where there is a risk that the duty to ensure appropriate staffing will not be met. Without an addition of this nature, there is a significant risk that the Bill is focused entirely on the outputs from the Common Staffing Method, which cannot take into account the daily realities of working in clinical areas.

A section on exception reporting should also be included in the Bill to ensure that, where local resolution cannot resolve issues, there is a means to report that the duty to ensure appropriate staffing will not be or has not been met.

This exception reporting would also allow for the flagging of 'hotspots' which show a persistent risk to the NHS board being able to meet the duty placed upon it. The exception reporting process would ensure that reporting is appropriate and only happens where all steps in the monitoring and local resolution process have been followed and a risk remains.

The RCN thinks that there would be merit in establishing a system which would allow for directors of nursing to formally record, through letters of direction, any instances where the NHS board has chosen to follow a course of action which goes directly against their professional judgement and advice.

Annex 1 sets out how the RCN would see this process working. Exception reports would go to the director of nursing. The NHS board would be under an obligation to receive a report each quarter (at a minimum) on any exception reports made; as well as there being a mechanism for directors of nursing to raise a red flag with the NHS board at any time if they felt that was needed. The RCN believes that this model would ensure that accountability and responsibility to consider risks are held at NHS board level and that directors of nursing are enabled to have their professional judgement sought and heard. This is a key step in ensuring that those professionally responsible for ensuring that care is safe, and of a high quality, have an unquestionable right to raise issues with the NHS board.

It is important to state that whilst the RCN does want the legislation to create a framework for monitoring, risk assessment, local resolution and exception reporting, the RCN would not wish the legislation to be prescriptive on specific systems or procedures which NHS boards must follow. It is important to recognise that each NHS board will have existing systems and processes to monitor clinical care, and that these must work in the local context of each NHS board area.

For section 2(b) of the Common Staffing Method to work in practice, it requires a care assurance framework for nursing to be in place. Without this, monitoring cannot be undertaken. The current iteration of a nursing care assurance framework is '*Excellence in Care',* which is being developed in partnership between Healthcare Improvement Scotland, NHS Education for Scotland, National Services Scotland, Scottish Government and others. The RCN is clear that an appropriate care assurance framework must be complete and able to be embedded across nursing services ahead of commencement. Work is ongoing to develop a care assurance framework for use in acute adult inpatient settings by April 2019. Work is also underway to develop assurance frameworks for mental health and maternity, but these are unlikely to be complete by 2019. Further work will be required to develop assurance frameworks for different clinical settings and specialties if monitoring and risk assessment is to work in practice.

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.

At present there is no Ministerial accountability within the Bill to ensure that there is a supply of nursing staff sufficient to meet demand. The Scottish Government must take responsibility for ensuring that NHS boards have the right funding, as well as access to a supply of nursing staff which is sufficient for them to discharge their responsibilities under this Bill. It will be increasingly necessary to align national budgeting processes, as well as workforce planning processes, to ensure that there is a synchronised national approach. At present, for example, the different timings for local authority budget setting and NHS board funding allocations is problematic because of the joint budget now held by Integration Authorities to deliver integrated health and care services.

Scrutiny and sanction

There must be scrutiny of staffing for safe and effective care and sanction if the law is not met. The Bill does not contain any section for scrutiny or sanction.

The Bill does contain a section on 'Reporting on Staffing' which the RCN deems insufficient to allow for adequate public scrutiny. An annual process by which each NHS board reports to government on its exception reports, what actions have been taken in response to mitigate risk following exception reports, and how it has fulfilled its duties if the Bill is enacted, should be required. The RCN would favour an approach which put a responsibility on government to collate a report covering all NHS boards with a view to this being laid before the Scottish Parliament. This would allow for transparency, consistency of reporting and therefore, full public scrutiny.

There may also be merit in establishing a system where the Parliament can call in NHS boards which have been highlighted as having serious and consistent challenges in discharging their duties. The RCN believes that this would be a significant opportunity for NHS boards to raise concerns with the Parliament in instances where they cannot fulfil the duties placed upon them because of issues, such as NRAC allocation and workforce supply, which are not within their control.

The RCN would like to see a role for Healthcare Improvement Scotland in the scrutiny of the application of the Bill. This could be achieved by extending Healthcare Improvement Scotland's remit to inspect any service provided under the NHS for a number of purposes, including the extent to which services are complying with the guiding principles set out in Part 1 of the Bill, as well as reviewing and evaluating how far NHS boards have complied with the duty to ensure appropriate staffing and the duty to follow the Common Staffing Method.

As a result of such scrutiny, Healthcare Improvement Scotland could encourage improvement and could also have the power to recommend that the Parliament calls in an NHS board where there has been a persistent and prolonged failure to act on the duties incumbent upon it under this legislation; or where there is a persistent or significant risk to ensure appropriate staffing.

Annex 1 shows how the scrutiny and sanction model outlined above could work alongside exception reporting.

Professional voice

It is essential that this legislation enables and empowers nurses to use the knowledge, skills and experience they have in order to exercise their professional judgement. At present, professional judgement is only mentioned in relation to the consideration of the results from the Common Staffing Method. As previously stated, this means that it is not given equal weight within the triangulated approach.

Without nurses of appropriate seniority (i.e., those ranging from directors of nursing and integration authority nurse board members to senior charge nurses and community team leaders) exercising their professional judgement through each and every step of the process, safe staffing establishments cannot be set; care assurance cannot be monitored; risk assessment cannot be undertaken; local resolution cannot be sought; and effective exception reporting cannot be completed.

It is critical that nurses of appropriate seniority have the time to do what is being asked of them. On any given day these senior nurses will monitor the clinical needs of patients and manage their teams effectively to respond to need whilst also monitoring and managing risk and seeking local resolution. In addition, in order to be assured of the quality of care, senior charge nurses and community team leaders must ensure that the right data is accurately collected and recorded by their teams. The professional judgement of senior charge nurses and community team leaders will also be required for longer-term establishment setting through the Common Staffing Method.

The RCN believes that the only way in which to ensure that senior charge nurses and community team leaders have the time that they require to fulfil their roles effectively is to make them non-caseload holding. This supervisory role was something which the RCN included in its 2016 manifesto, 'Nursing Scotland's Future', which many sitting 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 caseload, nor have their attention diverted from their role in clinical coordination by spending significant amounts of time on administrative duties.

The Francis Inquiry Report made strong recommendations about the importance of clinical leadership with Recommendation 195 stating:

'Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of ongoing nursing provision.'

The evidence shows that having clear leadership is best for patients and staff. The policy intention for this is in place already, but on the ground the story is often very different.

3b. The RCN would reiterate its point that its interest in Part 3 of the Bill, which deals with care settings, is in ensuring that clinical need is identified and met.

The loose wording of Part 3 of the Bill is therefore a concern to the RCN, given that there is widespread recognition of the clinical need identified in some care settings, and in care homes for older people in particular. The RCN would want to see nurses enabled to exercise their professional judgement as in Part 2 of the Bill.

The RCN would want to see the Bill strengthened to ensure that there is extension of this legislation to the care home sector. This intent is acknowledged in the Bill documents, but the legislation is not drafted in a way which is binding.

4. As set out in response to question 1, tools and methodologies, such as NMWWPP, cannot in themselves deliver safe, high quality care. In response to the questions asked by the Committee, particularly question 3a, the RCN has set out additions to the Bill which it believes are required in order to guarantee safe, high quality care. It must nevertheless be recognised that health and care services operate in a high risk sector.

In its written evidence to the Finance and Constitution Committee the RCN has set out its significant concerns around the Financial Memorandum to the Bill. The Committee may be interested to read that submission in conjunction with this.
The Scottish Government has assured the RCN that the Bill as drafted will ensure that duties are placed upon Integration Authorities. The RCN is unsure, however, of whether the definition of 'employee' would be sufficient in the case of Highland Integration Authority where NHS staff, such as health visitors, were transferred to be employees of the local authority.

Annex 1