

HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM Chartered Society of Physiotherapy (CSP)

Introduction

The CSP welcomes the opportunity to make a written submission on the Bill.

The CSP **cannot** support the Bill as drafted. We believe that significant amendments are needed for the legislation to be effective and for its intended purpose to be met.

Our comments relate to Parts 1 and 2 of the Bill. We are not making detailed comment on Part 3, as we recognise other organisations will have the expertise to comment on how it relates to social care provision.

Summary of concerns

The CSP's priority is securing the best care (experience and outcomes) for patients and service users through how health services are designed and delivered.

The draft Bill contains fundamental weaknesses and ambiguities which make it unclear how it can serve its defined purpose. We believe its implementation would create a number of unintended consequences and perverse incentives and serve as a distraction from upholding safe, effective care for patients.

Our main concerns about the Bill are that:

- It risks staffing resources being deployed just to demonstrate compliance without attending to fundamental issues and needs
- It risks staffing levels being looked at in isolation from all the other factors that affect the quality of patient experience and outcomes, such as the mix of multi-disciplinary teams, staff capabilities, population health trends, service delivery models, and specific environmental factors that impact on delivery and quality of care and outcomes
- By its predominant focus on care delivery in acute settings, the Bill risks displacing staff resources from healthcare delivery in non-acute settings, therefore undermining implementation of Scottish government policy priorities
- The Bill risks multi-disciplinary team staffing resources being under-developed and depleted, when these are what are required for safe, effective and sustainable care for patients and service users
- By creating a new demand on time for staffing levels training and reporting, the Bill risks diverting staff time away from delivering care and developing staff and improving services, which will not enhance quality of care
- The Bill seems predicated on an incorrect assumption that legislating for nurse staffing levels will address current nurse staffing shortages; in reality, these shortages stem from problems in strategic workforce planning and recruitment and retention in the nursing profession, which the legislation will not address

- The Bill's express reference to particular workforce planning and workload management tools is inappropriate, given that these are not available in the public domain and do not appear to have been evaluated; they also risk the legislation becoming quickly dated and too inflexible to implement.

CSP proposed areas for amendment

1. Strengthen General Principles

- 1.1 The general principles as outlined in Part 1 of the Bill articulate important duties on health boards and other providers to ensure appropriate staffing levels. The CSP broadly supports these. However, it is important that these are underpinned by an additional principle relating to **optimising outcomes** for patients and service users. This key focus needs to be made explicit.
- 1.2 The general principles use a number of key terms and phrases, which are not defined. We would expect this lack of clarity about intended meaning will make the legislation impractical to implement and open to challenge.

2. Remove mandated use of specific workforce tools in legislation

- 2.1 There is a danger that mandating specific, uni-professional workforce tools throughout Parts 1 and 2 of the Bill will distort decision-making about staffing across the wider-disciplinary team and service delivery. This could result both in under-staffing parts of the workforce beyond nursing and undermining patient care.
- 2.2 For example, multi-disciplinary teams delivering rehabilitation in community settings, preventing hospital admissions and re-admissions and reducing length of stay, restoring function and increasing people's independence are not covered by the listed common staffing methods, the training on data, or the reporting requirements placed on Boards.
- 2.3 Furthermore, because devising quantitative workforce tools and professional judgement tools are far more challenging in multidisciplinary community settings, the tools, staff training and reporting requirements are likely to focus on single profession teams within ward-based care.
- 2.4 All of this risks undermining wider strategic policy objectives regarding deployment of the wider multi-disciplinary teams in new ways and shifting resources into the community. This could tie the hands of a future administration and clinical leaders seeking to transform services to meet future population need.
- 2.5 As well as being uni-professional and, by default, focused on hospital settings, the workforce tools identified in the Bill are untested and are not in the public domain.

We understand that investment in the development beyond nursing has not yet been made.

- 2.6 Providing workforce tools are robust, and evidence-based, they can inform the planning design and delivery of services. However, where the operation of such tools is given *statutory force*, they risk becoming the focus, and seen as the chief indicator of safe and effective care. This undermines attempts to shift the balance of care toward prevention and rehabilitation in community settings.
- 2.7 Given the fact that the staffing tools are not available for MSPs or others to see (including the public and professional bodies), and the risks outlined above, it is inappropriate to mandate the use of tools within legislation. Reference to them should therefore be removed from the Bill entirely.

3. Rewrite sections on common staffing methodologies and list of employees

- 3.1 The common staffing methodologies listed in Part 2 are presented as '*types of health care*'. The intentions of this section are unclear. This includes in terms of why these types - and not others - are selected for inclusion; why such specific reference is made to some nurse staffing (which are not a type of care; but a component of care delivery *eg 'clinical nurse specialist provision'*); or what inference should be made about the employees included in the descriptors of types of care. It is assumed that this part of the Bill is structured in this way because it reflects the areas in which workforce planning and workload management tools have been developed for and within nursing. However, this is an arbitrary way to legislate for improved healthcare.
- 3.2 As an example, it is not clear whether the reference to '*mental health and learning disability*' provision is intended to include physiotherapists and other allied health professionals (AHPs) within multi-disciplinary teams in mental health.
- 3.3 In the list of employees, the current Bill only identifies registered nurses, midwives and medical practitioners, along with employees working under their supervision or discharging their duties on their behalf (121 C (2) and (3) on pages 4 and 5).
- 3.4 We understand that this means that physiotherapists and other allied health professions are expressly excluded from the scope of the Bill. For over forty years, allied health professions have practised autonomously, with the skills and expertise to assess, diagnose and treat patients, and delegate tasks to AHP support staff.
- 3.5 While we wish to ensure that this autonomous role is understood, we also wish to highlight that not recognising the strong role that physiotherapists and others make to delivering safe, effective care to patients and service users risks only a partial approach being taken to required staffing resources. This forms a fundamental flaw in the Bill's design.

- 3.6 There are numerous examples, similarly not listed, where physiotherapists and other allied health professionals are being deployed in new ways, to better meet growing population need and take the pressure off other parts of the system that are under strain; for example, physiotherapists with advanced practice skills in primary care seeing patients as a first point of contact instead of the GP and providing the assessments for patients presenting at A&E.
- 3.7 We recognise that the Bill allows for change to the *'type'* of healthcare listed. However, it is not clear that this includes the scope to amend the description of *'Employees'* listed to include registered health professionals other than doctors, nurses and midwives, or those who work under the supervision of physiotherapists and others.
- 3.8 The requirements relating to the use of the common staffing methods also specify training and development, and reporting, targeted toward those settings and staff groups where tools have been developed. This risks valuable staff time being spent on activity that will serve no real purpose (in terms of patient benefit, service improvement, or staff well-being). It also risks forming a distraction from ensuring effective staffing levels across all patient care areas and across multi-disciplinary teams.
- 3.9 The CSP therefore believes that these sections need to be thoroughly reviewed and rewritten. It needs to be ensured that their purpose is clear and that they accurately reflect both the range of health care services and environments across which patient needs are met, and the full range of staff who contribute to safe, effective and sustainable care (including in terms of high-quality patient experience and outcomes).

4. Develop multi-disciplinary workforce tools to support implementation of the Bill

- 4.1 Removing the mandatory requirement to use the nurse staffing workforce tools from the Bill would open up the possibility of developing multi-disciplinary workforce tools that are more reflective of how care is delivered and more in keeping with the direction of Scottish healthcare policy.
- 4.2 The CSP would be keen to help develop a more fully inclusive approach and could usefully inform the development of statutory guidance if the Bill is passed. We have undertaken substantial work in this area, with a focus on ensuring safe and effective care to patients.
- 4.3 A shift in approach would need to do the following:
- Give legislation the flexibility to respond to newly-emerging evidence, rather than grounding it in specific tools that will become dated and that have limited parameters
 - Inform how staffing levels, and configurations of staffing, are progressed to optimise clinical and cost-effectiveness and sustainability services.

- Recognise that staffing levels cannot be considered in isolation from all the other factors that impact on the quality of patients' experience and outcomes.
- Have the capacity to be applied across different specialties, settings, services and team configurations, and reflect the roles played by all staff within multi-disciplinary teams to deliver the service in question.
- Underpin quality improvements and the strengthening of the evidence base relating to service delivery models, alongside other initiatives to achieve care that is genuinely person-centred and responsive to individual need.
- Reflect and emphasise the variables that need to inform local decision-making on safe and effective staffing levels, taking account of particular service environments and the needs of particular patient groups at different times.
- Have the capacity to take account of key determinants such as population, demographics and deprivation.
- Be designed to serve the nature of the specialty of services provided, including the complexity of the caseload managed; the specific risks to patient and staff safety; how a service is positioned within the context of broader service provision and patient pathways; and patterns of patients' experience of care and use of additional services.

Conclusion

The Health and Care (Staffing) (Scotland) Bill could present an opportunity to ensure the right procedures and process are in place to support and enhance safe, effective and appropriate staffing in NHS services.

However, we are concerned that implementation of the Bill, as currently drafted, would not serve its defined purpose. Furthermore, we believe it would create unintended consequences that would undermine fulfilment of the legislation's purpose and work against ensuring quality of patient care. In its current format, therefore, we cannot support the Bill.

The CSP would be pleased to help with re-drafting to address the issues raised in this submission.



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