OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 11 September 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 11 September 2018

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HEALTH AND SPORT COMMITTEE
22nd Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Keith Brown (Clackmannanshire and Dunblane) (SNP)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Emma Harper (South Scotland) (SNP)
*David Stewart (Highlands and Islands) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Rachel Cackett (Royal College of Nursing Scotland)
Patricia Cassidy (Chief Officers Group for Health and Social Care in Scotland)
Dr David Chung (Royal College of Emergency Medicine Scotland)
Dr Sally Gosling (Chartered Society of Physiotherapy)
Kim Hartley Kean (Allied Health Professions Federation Scotland)
David McArthur (NHS Orkney)
Professor Alex McMahon (Scottish Executive Nurse Directors Group)
Dr Mary Ross-Davie (Royal College of Midwives Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 11 September 2018

[The Convener opened the meeting at 10:30]

Interests

The Convener (Lewis Macdonald): Good morning and welcome to the 22nd meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that mobile phones are switched off or set to silent. You are very welcome to tweet or do other things of that sort, but please do not record or film the meeting; that is being done for us by the Parliament's broadcasting department.

Agenda item 1 is a declaration of interests. In accordance with section 3 of the "Code of Conduct for Members of the Scottish Parliament", I invite Keith Brown, as a new member, to declare any interests that are relevant to the committee's remit.

Keith Brown (Clackmannanshire and Dunblane) (SNP): I do not think that you are asking me for a list of health conditions but, in any case, I have no interests to declare.

The Convener: Thank you. We will take that as a declaration of your having no interests rather than medical testimony. I welcome Keith to the committee. We will be getting another new member next week.

I also take this opportunity to thank Ash Denham, Kate Forbes, Ivan McKee and Alison Johnstone for their work while they were members of the committee, and to congratulate those who have gone on to ministerial office. Clearly the Health and Sport Committee's work provides many opportunities for issues to be addressed and taken forward, and the work of all four members has been much appreciated by me and, indeed, by the whole committee.

Deputy Convener

10:32

The Convener: Agenda item 2 is to choose a new deputy convener. Parliament has agreed that members of the Scottish National Party are eligible for nomination as deputy convener of the committee. I invite nominations for the post.

Keith Brown: I nominate Emma Harper.

Emma Harper was chosen as deputy convener.

The Convener: I congratulate Emma Harper, and I very much look forward to working with her as deputy convener in the months and years ahead, and to her contributing, as she has done so much already, to the committee's work.

Subordinate Legislation

National Health Service (General Ophthalmic Services) (Scotland) Amendment Regulations 2018 (SSI 2018/212)

10:33

The Convener: Agenda item 3 is consideration of subordinate legislation. No motion to annul this instrument, which is subject to negative procedure, has been lodged, and the Delegated Powers and Law Reform Committee has made no comment on it.

Do members have any comments on the instrument?

Members *indicated disagreement.*

The Convener: Does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: Thank you very much.

Health and Care (Staffing) (Scotland) Bill: Stage 1

10:33

The Convener: Agenda item 4 is two evidence-taking sessions on the Health and Care (Staffing) (Scotland) Bill. I expect the sessions to last roughly an hour each to give committee members the opportunity to ask our witnesses about aspects of the bill.

I welcome to the meeting Dr Sally Gosling, who is assistant director of practice and development at the Chartered Society of Physiotherapy; Kim Hartley Kean, who is the head of the Royal College of Speech and Language Therapists Scotland and is representing the Allied Health Professions Federation Scotland; and Patricia Cassidy, who is the chief officer of Falkirk health and social care partnership and is representing the chief officers group for health and social care in Scotland.

We will go straight to questions. First, I ask the witnesses to kick things off by briefly outlining their main concerns about and considerations with regard to the bill's proposals. Who would like to start?

Kim Hartley Kean (Allied Health Professions Federation Scotland): I am happy to start, if I could have the opportunity to sort out my papers.

Thank you for the opportunity to speak to the committee this morning. I represent 12 allied health profession bodies, so I provide real value for the committee—you are getting 12 for the price of one. I represent music therapists, art therapists, drama therapists, occupational therapists, dieticians, orthotist-prosthetists, orthoptists, physiotherapists, paramedics, speech and language therapists, podiatrists and radiographers. I am representing a lot of professions.

We account for more than 11,500 staff, which is 8.3 per cent of the NHS workforce. That compares well with the 8.9 per cent of the workforce that is made up of medics and dentists. We work in health and social care—OTs are employed by social services—from birth to palliative care, in public health preventive services and in primary, secondary and community care. It would be challenging to find a care group in which AHPs do not work.

I have five key points that I want to make; I will do so as quickly as possible. We believe that the bill will not achieve its objectives and is not future focused. We have several significant fears about it and none of the 12 professional bodies that I

represent can support it as it stands. We will offer some solutions.

First, the bill will not achieve its objectives. Only the right staffing team can provide the highest quality of care that leads to the best outcomes. In that sense, legislating for the right staffing presents a great opportunity, so in principle we like the bill. However, it is not outcome focused but is focused instead on a restricted range of inputs, which is its big challenge.

The bill is not future focused and plays to the old unidisciplinary siloed model of health and social care that seems to go against the grain of modern models of health and social care that are promoted in the general practitioner contract, the national clinical strategy and, most recently, in "National Health and Social Care Workforce Plan: Part 3—improving workforce planning for primary care in Scotland".

The bill does not reflect the reality of multidisciplinary working: some parts of the bill seem specifically to exclude AHPs. AHPs work in all 11 types of healthcare that are listed in proposed new section 12IC of the NHS (Scotland) Act 1978, which would be inserted by section 4 of the bill. The list of employees in section 12IC, however, identifies only registered nurses, midwives and medical practitioners, along with people who work under the supervision of those staff groups. Allied professions do not work under the supervision of any of those staff groups. For 40 years, we have been autonomous clinicians. The bill does not cover that.

The bill says that it is multidisciplinary, but the financial memorandum is disheartening. It seems to indicate that it will be 10 years plus before we see any multidisciplinary tools. The bill is also not needs based: people need AHPs, but the bill is all about doctors and nurses.

Our fears are shared by the AHP directors who are working in the health service already, trying to run AHP services. The bill will create unintended consequences and will skew resources from the current dire financial distribution. Directors are likely to say: "Sorry, we can see what you mean about needing more AHPs or multidisciplinary teams, but my hands are tied by the legislation."

Our fears are grounded in reality. No one is saying that the £500 million-plus that has been announced for primary care should not have happened, but compare that to the £3 million that was announced for AHPs in 2015: we have not heard about any more money for AHPs since then.

There is a sense that we have been forgotten; we were excluded from the process of writing the bill, which is indicative of organisational habits. There is one reference to AHPs in the bill papers, in paragraph 93 of the policy memorandum. I am sure that everyone can remember what that says.

The Scottish Government nursing directorate itself says that:

> "The potential for resources to be diverted to nursing and midwifery to meet the mandatory requirement could be to the detriment of other professionals' contribution to the care of patients."

It is recognised that that is a problem.

As I said, none of the professional bodies that I am here to represent can support the bill, as introduced. We would like there to be an outcomes focus in the general principles and a general presumption that quality and safety are best supported through multidisciplinary teams. We want the list of tools in proposed new section 12IC of the 1978 act to be replaced with a new section that would establish a statutory duty on, for example, Healthcare Improvement Scotland, which would be equivalent to the duty on Social Care and Social Work Improvement Scotland, to annually or biennially review and improve the common staffing method, including the tools to reflect the developing evidence base on multidisciplinary staffing. That same body should make annual or biennial recommendations to the minister on improving the tools.

The Convener: That was a comprehensive answer.

Dr Sally Gosling (Chartered Society of Physiotherapy): I will add to what Kim Hartley Kean has said. As she said, the CSP is part of AHP Federation Scotland. I will briefly outline some additional issues that relate to our concerns about the bill as it is currently couched.

First, we believe very strongly that a multidisciplinary team approach to staffing levels must be taken. There will be risks to the quality of patient care, in terms of experience and outcomes, unless a multidisciplinary team approach is taken.

The bill also risks focusing on staff levels in one part of the workforce and potentially depleting other parts of the workforce, which would add to staff workload in unhelpful and unintended ways. We think that the bill assumes that looking at staffing levels in isolation will make a difference to the quality of patient care, in terms of experience and outcomes. We strongly believe that looking at staffing levels in isolation cannot address needs. That risks a partial approach being taken that would not look at outcomes for patients; at best, it would look at avoiding negative outcomes or negative incidents.

There is also a risk that the bill would build in rigidity and inflexibility when, as Kim Hartley Kean said, there is a need to focus on future service delivery models. We need to ensure that staffing is

responsive and able to meet current and future staffing service delivery models, rather than it being grounded in historical models.

The bill risks being a distraction and creating bureaucracy. Staff groups that come under the legislation would need to invest their time in gathering data about activity, but there would be no real focus on the benefit of that work. The survey that the Scottish Parliament information centre undertook recently seemed to affirm that a lot of time is invested in looking at how the tools are used currently, but that there is no clear sense of how use of the tools impacts on analysis of staffing issues or on accountability for decisions.

On that basis, we think that the existing nurse staffing level tools and workload management tools are an odd place on which to base legislation. Embedding those tools in the legislation would build in rigidity, inflexibility and a lack of responsiveness to changing population and patient needs and service delivery models. Again, that view seems to have been borne out by the survey feedback that has been obtained. Nurses who use the tools reflected that how they are working and contributing to patient care is not being captured. That risks the bill being grounded in historical issues.

We are also concerned that the tools are not in the public domain. We are not able to see—as I understand the committee will not be able to see—what the tools are at the moment. We do not understand how the tools have been evaluated, so we have some concerns on that front.

We believe strongly that a whole-system approach to staffing levels must be taken that reflects changing models of delivery, moving care closer to home, integrating health and social care and delivering the Scottish health and social care delivery plan. The grounding of the bill, as introduced, could work against delivery of Scottish Government's "Health and Social Care Delivery Plan". The grounding of the bill, as introduced, could work against delivery of health and social care policy through the bill, for example, taking only a partial approach to staffing.

The bill would also generate the risk of unintended consequences and create perverse incentives and unintended activity. Again, that is because the bill is grounded in a singular approach to one staff group, albeit that it is a very important group.

The bill could also divert resources in order to meet its requirements while not meeting service delivery needs or patient needs. Our strong concerns about unintended activities are borne out by some evidence that, in states where such legislation has been introduced, particularly for nursing its impact has not been what was intended. We are concerned about that.

10:45

We absolutely recognise the spirit in which the bill has been introduced and we recognise that it is intended to enhance patient care and to address issues of staff wellbeing, but we do not believe that, as it is couched, it will do that. It needs to be much more responsive to changing population and patient needs, much more in line with health and social care policy and much more focused on being integrated into that.

We are looking for legislation that is much more strategic and integrated in its approach, does not sit in isolation, and introduces a much stronger sense of accountability. Rather than just accountability for demonstrating use of the tools, we need accountability for integrating a strategic approach to workforce planning, workforce deployment and so on.

Patricia Cassidy (Chief Officers Group for Health and Social Care in Scotland): I welcome the opportunity to come and speak to the committee. I preface my comments by saying that we must remember that the focus of everything that we do is to ensure that we have person-centred care that is flexible, responsive and safe, as well as being of high quality.

I am here representing the 31 chief officers for health and social care across all the integration authorities in Scotland. Our response to the initial consultation in July 2017 made it clear that we did not support safe staffing tools that would protect only one element of the health and social care workforce. Conversely, however, that did not imply that we were in favour of tools being extended to other parts of the workforce. When we responded to the second consultation, we stated that, although we understood both the political and public desire to ensure that our health and social care services are appropriately resourced in terms of staffing, our position remained the same: that we would be cautious about supporting a legislative approach, for several key reasons.

There is potential for a significant additional layer of administration and bureaucracy to be added to existing systems. Our challenge in the system is to ensure that, if people do not need to be in an acute hospital, we have sufficient health and social care provision in the community to keep them out of hospital. If they are in hospital, we need to be sure that we can receive them back into the community and support them to be reabled there. That requires us to service acute hospitals and community hospitals across Scotland and to be able to be quick and responsive in anticipating needs and the volume of

care that we need to provide or to commission from other providers. We would be very concerned if the legislative process impeded that as opposed to adding benefit and impact and increasing our ability to respond to that need.

There is a risk that the legislative requirement to use particular tools could stifle innovation. We are in a very exciting policy landscape in health and social care in Scotland, where there is a big transformation in developing community-based needs. The health and social care partnerships are not solely about national health service boards and the councils, although they are important partners. Our key partners are communities—the individuals themselves—and the third sector.

We would be concerned if we became preoccupied with a tool when existing legislative and inspection frameworks are in place, along with the new health and social care standards. That could preclude our innovation and our developments at locality level in working with families, communities and third sector partners to develop a range of supports in communities to enhance people's wellbeing.

It is not just about providing care and support. Isolation is a main issue in Scotland and we need to work with other providers and communities to provide solutions for that. Any tool that is developed needs to be sufficiently flexible and dynamic to allow the developments that we will lead in the next few years to meet local need. It is very much about that.

We are talking about diverse communities, geographies and landscapes across Scotland. I know that colleagues in the islands and rural areas are concerned about any restriction to their ability to respond to local need appropriately and—I must emphasise this—with safety and quality of service at its heart.

We are concerned that legislation is still quite restrictive. Colleagues from AHPs have laid out their concerns on that, and we are equally concerned. In the health and social care service at the moment, there is quite a lot of development of advanced roles to support general practice and the delivery of out-of-hours and other services. We would like to continue to look at that and to see that nothing is dropping off the end of nursing and other roles. We need to look at the workforce that we need. Is it a blended workforce? Is there a baseline workforce for which we can create pathways to a variety of health and social care professions by offering ground-level opportunity?

We are all facing significant recruitment and retention issues across every element of health and social care. We all face a demographic challenge and we need to be able to develop services that respond to that reduction in the availability of employees and recruitment opportunities and develop innovative solutions to attract people, to retain them, and to develop them into more senior or sophisticated roles to meet need across the whole system.

To sum up, legislation should not create a rigid compliance framework that undermines the new integrated environment for health and social care. Each partnership is expected to work at locality level to identify local needs and then meet those needs. We need to be responsive.

Part 2 of the bill, which is focused on staffing and the NHS, does not take cognisance of the significant overlap of governance responsibilities between health boards, integration joint boards and local authorities. That would require clear guidance.

There is tremendous diversity in the workforce in health and social care across care at home, care home provision and intermediate care. The one-size-fits-all approach to workforce planning simply will not work. We have a potential legislative framework, but it needs to be contextualised within that much broader national workforce plan that is happening nationally across all the professions and, looking forward, with our colleagues in schools, colleges and universities around what could be innovative health and care careers that we could feed people into through various pathways into the professions.

Thank you for the opportunity to speak to the committee and I am happy to take any questions.

The Convener: I thank all three witnesses for laying out your concerns in some detail. Questions and answers will henceforth go through the chair. You do not have to respond to every question, but please do respond when you wish to comment.

Sandra White (Glasgow Kelvin) (SNP): You have already given me some answers to the questions that I was going to ask about health and social care integration, but I want to tease the issue out a bit more. The bill is meant to enhance the work that is being done with health and social care and integration. You talked in great detail about the effect that the bill will have. What effect will it have if it is passed without due care and diligence in looking at the integration of health and social care? What will happen if we do not change the bill to take cognisance of what you have said today?

Patricia Cassidy: It could drive resource to focus on being compliant with the bill's requirements, and that could add more administration and avert resources from front-line care. Every day in social care, we receive referrals directly from emergency departments, from hospital discharge teams, from general

practitioners, from families and from social workers.

That can involve quite a significant volume of work, and we need to flex our system to make an assessment, to provide that care, to link with allied health professionals in order to provide a rounded package of care and to provide equipment, and to do that across a range of several thousand people on a daily basis. That might require us to commission additional provision from one of our providers if we cannot meet the demand internally. We would need to be assured through a commissioning process that that supplier was also compliant, and we would need assurance in that regard. The thrust of outcome-based care involves an assessment of need with the service user and their family and an identification of what their personal outcomes are, and then agreeing a way in which we will jointly work towards those outcomes.

We already have in place checks and balances to ensure that we are commissioning and employing sufficiently registered and high-quality trained staff and that there is coverage across the people receiving care, but the proposals would bring in another dimension.

Kim Hartley Kean: Our central concern is the outcomes for service users. That skewing of resources towards the professions that are covered by the tools has already resulted in significant cuts for AHP service users. My radiography colleagues say:

> "at present departments are running with gaps in the rota due to unfilled vacancies, maternity and sick leave, leading to delays in examinations, reporting of results and radiotherapy treatment as well as increasing stress on the radiographers".

At present, those absences are treated differently in AHPs from how they are in other professions. Colleagues in another professional body have said that, basically, the situation will mean fewer AHPs on all those patient care pathways. For example, multidisciplinary teams delivering rehabilitation in community settings, which prevents hospital admissions and readmissions, reduces length of stay and restores function, which increases people's independence, would be in jeopardy. They are the new models relating to prevention and self-management that enable people to live in a homely setting. That is what is threatened.

Dr Gosling: To add to what colleagues have said, the situation risks the issues of skills mix and job-role reconfiguration across health and social care not being addressed. It also risks the assurance being given to the public that staffing-level issues are being addressed when, in reality, the legislation would not address workforce needs in line with population, patient and service demand or deal with the need for increases in workforce supply. It risks appearing to provide a solution while not doing so, which would distract attention from more strategic approaches in line with policy.

Sandra White: I would like to maybe get a one-word answer to this question before moving on to my next question. Are you saying that, if a set of workforce planning tools for nursing were put on a statutory footing, that would have the adverse effect that you are talking about?

Kim Hartley Kean: If you are a director, you might see that there is a need for multidisciplinary team planning. However, if only the needs of the service users of nursing are statutorily protected, the interests of people who are using the other members of the multidisciplinary team will not have the same legislative protection. That means that people will ensure that they have the nursing staff in place first rather than thinking about the necessary skill mix.

Sandra White: Patricia Cassidy mentioned integration joint boards. We know that they do not have a statutory duty to produce a workforce plan, as basically they are not employers. How do you see things working from the point of view of the IJBs? You mentioned that you work with them. Do they need flexibility? Do they need to be involved in the plan and in the bill?

Patricia Cassidy: Integration joint boards are required to produce a workforce plan as part of the integration schemes. We are working very closely with colleagues in the council and the health service. The employees remain their employees, but we jointly create a workforce plan.

11:00

Sandra White: I apologise; I missed that wee bit.

As the bill stands, do you think that it gives IJBs less or more authority?

Patricia Cassidy: The bill does not add or detract from the authority of IJBs. It has no significance in that way. We are cited in the bill and we are obviously key stakeholders, but we will always work with our colleagues in the NHS and the councils.

I have some experience of working in education, and I would be concerned if, as my colleague described, one or two professions had legislative protection of their numbers, because we have seen that in education, where classroom assistants, bus escorts and so on are subject to cuts against the backdrop of protecting the pupil to teacher ratio and the teacher numbers in schools. I would like us to learn from that and recognise that there is a complexity of skills required to meet need and that each of those skills is valid. Consideration would have to be given, using

professional judgment, as to what combination of those staff members and skills is needed. That is much more subtle than a legislative tool might allow.

Sandra White: Absolutely. If the bill is passed, whose responsibility will it be to ensure the adequate supply of workforce? Who will have a say in that?

Patricia Cassidy: I would need to bow to colleagues who have more detailed knowledge of the legislation to answer that. The integration joint boards, health boards and councils work very closely together and currently share that responsibility.

Dr Gosling: At the moment, it is not clear how the bill would address the workforce planning issue. There is, as yet, no workforce planning process in place in Scotland for the allied health professions. What is important and fits well with the integration agenda is to look at the workforce needs across the whole system—not just NHS workforce need, but workforce need from any part of delivering care to patients, as well as leadership, management, education and research capacity. The bill as drafted does not address that.

However, it is imperative that, above and beyond the legislation, a much more strategic approach is taken to what workforce is needed, how that is best delivered and produced and how investment is made to develop the workforce appropriately to meet changing population and patient needs. That can be done only in a multidisciplinary way in order to meet the blended skills mix that is required.

David Stewart (Highlands and Islands) (Lab): I thank our three witnesses for their excellent contributions. I would like to drill down into the detail of staff planning outwith nursery and midwifery. The committee frequently hears about major problems in Scotland with recruitment and retention. To what extent will the bill aid your difficulties in dealing with recruitment and retention?

Dr Gosling: I am not clear that the bill as introduced would address those issues, because it is not premised on them, but is concerned with staffing levels of the body that is already in place—in just one profession. We are keen that the broader issues around workforce planning, development and investment are considered, such that recruitment and retention are addressed across all staff groups. As I said, there is currently no strategic process to address those issues for AHPs.

It is possible that there is insufficient data to understand the recruitment and retention issues for AHPs. Just one example from a workforce supply perspective is that, for a number of the AHPs, the workforce comes through postgraduate pre-registration education routes. Those are well established—in physiotherapy, they have existed in Scotland for well over 20 years—but they are not funded, so the students who go through those routes are self-funded. If those routes were funded, that could be a useful way of expediting workforce supply. At the moment, the mixed-economy approach and the lack of data make addressing that issue difficult, but I do not think that the bill that we are considering really touches on those issues, so it needs to be integrated into a more strategic approach.

Kim Hartley Kean: The question touches on the clash between other policy and the bill. On recruitment, part 3 of the national health and social care workforce plan talks about considering increasing or controlling the numbers going into some of the AHPs and increasing the number of paramedics in training, but there is nothing in the bill that will enable jobs to be created for those people to go into. On retention, because the bill is focused on one discipline, investment in continuing professional development and the career structure in others is in doubt. The workforce data that is available across the professions shows that there has been very small growth in the AHPs, and that has primarily been at band 5, which is where new graduates go. There is really nowhere to go, and the bill does nothing to address that.

Patricia Cassidy: To be fair to the bill, it does not purport to be a workforce plan, but there is nothing in it that gives assurance that it will contribute to improving the situation with recruitment and retention.

David Stewart: I will move on to planning tools, which Sandra White touched on briefly. Obviously, that is a big element in nursing and midwifery, but when do you envisage multidisciplinary tools being created for other areas, such as the social care sector? If you think that they will be created, can you give a timescale within which those tools will be of practical use to those in the industry, and particularly to the clients who get the service across Scotland?

Kim Hartley Kean: The only clue in the bill as to the answer to that question is in the financial memorandum, which details the plans for the development of tools in the next five years. It states that the tools take a minimum of three years to develop and will be focused on nursing. Therefore, going by the financial memorandum, we believe that there is a risk that we will not see any multidisciplinary tools for up to 10 years, which will be 10 years behind current policy.

David Stewart: That is a long time.

Kim Hartley Kean: That is 10 years for people to wait for adequate AHP services and for us to establish the vision that we share of prevention, self-management and enabling people to stay and be cared for at home. It goes totally against the grain of what we are trying to do.

David Stewart: Would anyone else like to comment?

Dr Gosling: I agree that it seems a long timescale in which to develop those tools. It might be helpful to make the point that, as the professional bodies for AHPs, we have quite a lot to contribute to the development of multidisciplinary tools. A number of us have done a lot of work on safe and effective staffing levels, which has involved taking a more nuanced approach to the complex issues that are bound up with that. We have done work that we could contribute to the development of a much more multidisciplinary approach.

Kim Hartley Kean: Absolutely. Many of the professional bodies have something. In addition, it is important to point out that AHPs are already using multidisciplinary tools. There is not the same level of publicity about, or knowledge of, those tools, and they do not have the same level of investment as the tools in the bill. There are the six-steps methodology and the Balanced System, which the Scottish Government has recently piloted and which concerns AHP provision in children's services. Therefore, there is something to build on. It could take 10 years to implement the bill but it does not have to be like that.

David Stewart: If I can come back—

The Convener: Patricia Cassidy wants to respond to your previous point.

Patricia Cassidy: The Government and the Convention of Scottish Local Authorities co-produced "National Health and Social Care Workforce Plan Part 2" in 2017. One of the recommendations in that proposes the development of multidisciplinary workforce planning tools. I am not sure what the timeframe for that work is but I understand that it is under way. The plan also proposes the development of a dependency tool, which considers the acuity of need in the care sector. That work will help to inform staffing models and the national care home contract.

David Stewart: Patricia Cassidy has partially covered my next point. We talk about multidisciplinary teams in hospitals and in the community. How is staffing calculated in reality? It is a complex and dynamic issue. I ask the witnesses to say a little bit more about the tools that can currently be used.

Kim Hartley Kean: I cannot say anything about them as a practitioner. To be clear about your question, are you asking about the tools that people are using, such as the Balanced System?

David Stewart: Yes.

Kim Hartley Kean: Children and young people need services at several levels. They need universal provision so that we develop all children's capacities; children who are at risk of having poor outcomes need targeted services; and children who have identified disabilities or additional support needs need specialist provision. The Balanced System is a way of considering the assets that are available in the school, the family and the community as well as among all the AHPs so that we can decide together how many AHPs we need in a particular population—for example, in Ayrshire or Lothian. That brings us back to Patricia Cassidy's point: it is about starting workforce planning by considering population need, not how many AHPs we have.

David Stewart: Some people have asked me why we need legislation to have good workplace tools because good management would normally involve such tools. That question has also come through in submissions to the committee. Although it is probably a simplistic general point about the bill, it would be useful to hear the three witnesses' views on it.

Patricia Cassidy: I reiterate that, as our submission says, there are tools in place and we do not see the need for legislation. However, we embrace the need for good workforce planning for multidisciplinary teams.

Kim Hartley Kean: We must introduce consistency in the intelligence that we need to produce a staffing complement for any particular community. If the approach were more multidisciplinary, it would support the delivery of the new model. The common staffing method in the bill contains many good things that people need to take into account. Because workforce planning is complex, it will be difficult ever to reach perfection, but we want to move away from a wet-finger-in-the-wind approach and people making decisions based only on what their knowledge happens to be and move towards a system that reassures the public that the services that they need and might need in future are being planned for and are not down to some random decision making.

11:15

Dr Gosling: Adding to what colleagues have said, I think that the question whether legislation is what is needed or is what will meet the spirit of the bill is very valid. What seems to be missing from the bill as it is couched is accountability. However,

if there is going to be stronger accountability for ensuring safe and effective staffing levels to deliver safe and effective care to patients, any such move must be predicated on integrated and strategic approaches that are robust and which focus on the whole system, not just one part of the workforce. I think that the question whether this is the right thing to do is a multilayered one.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, and thank you very much for your presentations.

I want to pick up on the impact of the proposals on integration. The committee has done a lot of work on the integration agenda—indeed, we have had an inquiry on that issue in the past year—and, with the bill's introduction, I have a niggle that it might fly in the face of the good work that we have been doing through integration by creating a silo in which primary care gets a different set of rules and is considered in a more focused way than AHPs, social care and all the other arms of integration. Could we remedy that in the bill by including AHPs and social care provision, or should we just tear it up and start again?

The Convener: That is a very good question. Who would like to answer it? Does the bill provide a platform or is it going in the wrong direction?

Kim Hartley Kean: First, AHPs work across health and social care. The bill's general principles would be okay if they were extended to cover outcomes, and it could create some kind of foundation. As far as the specifics are concerned, however, I would remove the list of tools and, as Sally Gosling has suggested, set up some strategic way of continuously improving the way in which we plan for staffing that reflects the evidence base and new models. The bill provides a foundation, but it needs to be changed radically. I hear what my colleague Patricia Cassidy has said about not having legislation at all, but I think that the bill could be significantly improved instead of its being chucked out altogether.

Patricia Cassidy: It is helpful to think about the bill's origin, which was about having a uniprofessional model for nursing, and it is to be lauded for that and its aim to secure safe staffing across all care groups in the NHS. Indeed, my colleague, the nurse director in NHS Forth Valley, is a real supporter of the bill.

I think of this as a train that began on a journey; integration happened, and we joined that journey. The development of the tool started about 10 years ago, before the current policies on integration and health and social care were put in place. In an ideal world, we would start from the other end of the telescope by visioning our workforce needs, the services that we want to provide across health and social care and the skill mix from a very low to a very high level, striking a balance across the system and then looking at how we get from where we are now to having a blended, multidisciplinary workforce. Obviously, this is not an ideal world, but that would be one way of finding a solution, and it would not come at the cost of the long and hard work that nursing colleagues have put into the tool. The fact that things have been extended has raised a whole series of questions at this meeting.

Dr Gosling: I agree with my colleagues that the bill is an odd place to start. The introduction of the bill as it is framed seems an odd contribution the delivery of Scottish health and social care policy. It would be helpful and important to take stock of the available evidence about what works and how legislation that is introduced in good faith may have an unintended impact. The perverse impacts of other legislation should be carefully evaluated to take account of other healthcare systems. I highlighted an example that showed that legislation has led to more reliance on agency nursing staff rather than increasing nursing capacity; reduced opportunities for nursing staff to exercise professional judgment when making decisions; and services deciding to incur the penalty fee for non-compliance with the legislation. None of that was intended by that legislation. We should take strong account of the changed context for what the bill seeks to achieve and recognise everything that has been done in nursing. The risk is that the model is outdated, as the nursing staff survey results reflect. The legislation needs a thorough review to ensure that it is not going in the wrong direction.

Alex Cole-Hamilton: You are all in professions that work cheek by jowl with nurses with regard to integration in hospitals and other care settings. Taken in isolation, does the bill achieve what it set out to do? Is it needed?

The Convener: On the back of the previous questions, panellists may be able to give brief answers to that question. If Alex Cole-Hamilton has a tiny follow-up, this is the moment for it.

Alex Cole-Hamilton: We learned this morning about an horrific case in NHS Highland, where a gentleman has had his social care package removed. He is paralysed from the neck down and has been waiting for the package for months. That case is symptomatic of problems across the health service. Should we use our legislative time to tinker with something that is not badly broken—at least in terms of the nursing profession—or should we bring in legislation that overhauls our approach to social care? That is not a little question, is it? [*Laughter.*]

The Convener: If any witness wishes to respond to that very broad question, they can feel free to do so.

Kim Hartley Kean: The answer to your question whether the bill is needed is yes. Things are broken and we need massive improvement in how we plan our workforce. The fact of one, two and three workforce plans indicates that there is a lot of work to be done.

Brian Whittle (South Scotland) (Con): A lot of information is flowing in this direction that we need to gather together. The theme of multidisciplinary working comes up every time that we take evidence and the bill could impact positively or negatively on that. I would like to drill down further into the role of allied healthcare professionals in multidisciplinary groups—specifically, their distinctive and crucial role in bridging the two sectors of health and social care. I am interested in how AHPs play into the preventative agenda. For example, how do they ensure that there are fewer unnecessary admissions into hospitals?

Kim Hartley Kean: I can talk in detail about my profession of speech and language therapy. I hope that the AHP colleagues whom I represent will forgive me, but that is what I know most about. I am sure that Sally Gosling will talk about physiotherapists.

Let us talk about people with dementia. Everyone who has dementia will have an eating, drinking or swallowing difficulty at some stage in the progress of their disease. An impairment of the ability to swallow safely is one of the first things that happens to someone with dementia, so they cough and choke, start aspirating, get chest infections and possibly pneumonia. Speech and language therapists work with the individual, their spouse and home-care staff to assess where the swallow is going wrong. They do that in partnership with radiographers, doctors and the screening and monitoring that is done by our nursing colleagues. The speech and language therapists will make recommendations about how to eat and swallow safely, so that the person is not choking or aspirating and needing to be admitted to hospital. That is an example of the work done in speech and language therapy that prevents people from becoming undernourished, from having unpleasant and traumatic experiences every time they try to eat and drink and from having to go into hospital and have lots of medication.

Dr Gosling: A key development in physiotherapy across the UK is physiotherapists playing a much stronger role in delivering care within primary care and general practice settings, particularly to address musculoskeletal disorders. The evidence is growing that the front-line, first-point-of-contact role is helping to ensure more timely care for individuals and avoids issues becoming worse before the individual can gain treatment. It reduces unnecessary referrals and admissions to hospital, as well as unnecessary tests and medications. Physiotherapists can also develop and support patient self-management.

As Kim Hartley Kean said, there is much potential within each of the allied health professions to build on such preventative, more timely, closer-to-home care for patients, which keeps people out of hospital when they do not need to go into hospital. Those kinds of service delivery models are at risk of not progressing under the approach in the bill, because, as we have said, the bill is predicated on old models of service delivery and does not capture the multidisciplinary team approach. We need to consider how primary care teams work collaboratively in the patient's best interests and the best interests of the service, as well as how we tackle workforce development to meet those changing service delivery model needs.

Those issues of integration and taking a more strategic approach to meeting changing population patient needs are at risk of not being addressed by the approaches in the bill, which, as Patricia Cassidy suggested earlier, are quite rigid.

Patricia Cassidy: I will build on the theme of dementia. Where we have a person at home with dementia, working with speech and language therapists, physiotherapists and community psychiatric nurses, through joint planning and communication we can really improve the level of care that we are able to provide and the consistency of that care.

If someone is being cared for in a care home, it is really important that the care home staff are aware of the level of care that is required. Community psychiatry can be really helpful in coming in and giving training on how to cope with a particular service user's manifestation of their illness, how to de-escalate situations and how to work around and retain the consistency that that individual requires.

It is about considering how we can blend and work together, rather than having layers of services going in to meet needs. We want to be clear and agree on the need that an individual has at that point in time and who is best placed to co-ordinate that and who is best placed to deliver it. People will come in and out of that care delivery package, but there will be a joint and shared assessment and multidisciplinary discussions about that patient's progress or otherwise.

Keeping people in care homes or at home, if that is where they want to be, and avoiding unnecessary hospital admissions, is key. If providing nursing care is challenging for colleagues in a care home, we look at how district nurses and others can go in to provide such care and keep a person in a care home who is at the

end of their life and wants to be in a homely setting of their choice. Care is very much blended and planned around the person, and that should be done not in a siloed way but in a shared space.

I point out that the allied health professionals who are directly employed in social care, as well as in the healthcare setting, are occupational therapists.

11:30

Brian Whittle: So we should start with quality care that brings quality of life. Who should lead such a methodology? Who should be involved in developing that under the bill? The bill says that the Care Inspectorate will lead the development of new methodologies for social care and that Healthcare Improvement Scotland will lead on new healthcare tools. Do you share my concern that that poses a danger of divergence in development?

Patricia Cassidy: I would be concerned about such an approach, because the integration space is about how we plan integrated care together and how we plan the workforce together. That is key to our success in cutting across areas. People care about getting high-quality responsive services, but they do not necessarily care about whether someone's uniform represents an external provider, the council or whoever.

People want to know that the members of the team who are working with them are working together and can meet their needs. It should not be the case that no conversation takes place in teams; if district nurses and carers go in, they should speak together and plan the care together. Integrated teams provide that approach, because staff speak to each other daily, work together, do joint planning and assessing, and, when it is required, they adjust care or pull in other professionals.

Previously, the GP was often the point of entry for care workers and social workers, so they had to go back to the GP for someone to have access to a service. That took up a lot of GP time. When we establish the shared understanding among professionals of limitations and responsibilities, that takes a lot of the obstacles out of the way of delivering responsive care in a timely manner.

Kim Hartley Kean: The AHP Federation suggested in our submission that HIS should be given an equivalent role to that of SCSWIS. That would offer the potential for consistent integrated planning across health and social care. Having that equivalence and ensuring that we work together, as Patricia Cassidy described, would be innovative and transformative across the two agencies in planning services. Beyond those statutory sectors, the integration joint boards have clear relationships with service user forums and the third sector.

Such an approach offers opportunities for much better integration. It would be good for the bill to enable and facilitate joint working.

Emma Harper (South Scotland) (SNP): The discussion has been really interesting, and a lot of it has focused on allied health professionals. The Nurse Staffing Levels (Wales) Act 2016 focused only on medical and surgical acute care, but the bill goes further than that by including the community.

My background is 30 years in nursing. The bill says that the guiding principles are

"that the main purpose of staffing for health care and care services is to provide safe and high-quality services"

and

"that, in so far as consistent with the main purpose, staffing for health care and care services is to be arranged".

The bill goes on to refer to service users' needs and abilities and all that.

Yesterday, I had a conversation about an upside-down triangle of health and social care, where the broad part at the top represented care that is provided in the community and the pointy bit at the bottom represented acute care. Some care is delivered in acute settings, but most of it should be delivered in the community.

The bill needs to be good at focusing on the differences in communities that require allied health professional input. I agree that we should not be working in silos in health and social care, and that the bill has come about after 10 years of implementing tools, and we have seen a patchy approach to the way that the tools are accessed and used across the whole of healthcare, even in the NHS. Does the bill not support better training and enablement of the use of tools, and could not the professional judgment tool and the quality tool be used as part of that, feeding in to allied health professionals' contribution to whatever we see as the best way to staff and plan our workload?

Kim Hartley Kean: The short answer is no, it does not feel as if that is going to happen. If we look at what is happening already around attention to the needs of AHP service users, we see that we could not be confident that there would be some kind of hoped-for trickle-down effect, if that is what you mean. It is important to point out that AHPs work in both acute and community provision. The bill as it stands would allow training and enabling use of those specific tools for those specific staff groups.

As Patricia Cassidy noted, the survey that has been published on how the tools are used has noted their patchy use. Patchy use might indicate

a lack of training, which is one of the messages, but it might also just indicate that the tools are not any good. We all have a kitchen drawer full of bits and pieces, but we use only the tools that work. I do not mean to be flippant, but are those the right tools? Sally Gosling has made it clear that there is no evaluation of those tools. In fact, none of us can tell how good those tools are, because they are not publicly available to anyone. The CSP has worked hard to get hold of them and we cannot, so you are in danger of putting into legislation something that nobody knows about.

Dr Gosling: It is possible to see the Scottish bill as progress from the Welsh legislation, from the point of view that it is not just focused on nursing in acute adult in-patient wards. As you would expect, we had and continue to have concerns about the impact of that in terms of the risks of staffing resources being focused on meeting the legislation and not on being in line with the direction of health and social care policy.

It is progress from that point of view, but the tools that we understand underpin the legislation are predominantly acute-care focused, and the feedback in the survey results was that nurses who are currently using them found them particularly limited in relation to community-based service delivery and did not seem to have a huge amount of confidence in them. However, as I said, we are not aware that an evaluation of those tools has been undertaken.

As Kim Hartley Kean said, if the legislation were to be progressed, we would want to have some direct involvement, as AHP professional bodies, in how that is done, given the work that we have done around safe and effective staffing levels, on which we have done quite a thorough appraisal of different approaches. We feel that we have a lot to add to how it could be done differently that would be in line with a whole-system approach and could add to a multidisciplinary approach. At the moment, we would be sceptical about the starting points as couched in the legislation.

Patricia Cassidy: For the avoidance of doubt, there is no evidence base to show that those tools will work across health and social care, and no evidence base has been applied to other professions such as social work or social care provision to show that they would work. We need a more thorough evaluation of the success and the evidence base within nursing. We also need to be sure that the impact of any legislative tool is to improve outcomes for people who require our care and support services.

Emma Harper: As far as I am aware, the tools are being revised, because they have been used—or not used—and obviously there needs to be further education on their implementation and use. The tools have been developed by clinicians involved in the specialty areas such as community, mental health and maternity. I agree that any legislation needs to be based on evidence—that is the number 1 priority. I look forward to having clearer evidence, if it is not already out there, to use as the basis for supporting or changing the bill. For me, allied health professionals, especially those who are working in the community, need to be included in the bill. The allied health professional teams are working together with nurses in the community and need to be considered as part of the bill.

The Convener: I see assent from all the witnesses. I think that what is being said is that we need the evidence first.

Miles Briggs (Lothian) (Con): I want to carry on from Emma Harper's point and from Brian Whittle's point about capturing quality, because that is one thing that we have kind of lost. Given that we are told that the idea is to have two speeds for the bill, how do you capture information on quality, outcomes and impact at present without the tools, especially in a community care setting?

Kim Hartley Kean: We are not doing it without tools, but it is left up to the professional bodies. Obviously, we are here for people who use our services and we want the best provision possible. My professional body has developed outcome measurement tools and tested them across the UK, and I am sure that a number of other professional bodies have done so. We have set up a platform that allows speech and language therapy services to record and report the outcomes that they deliver. Therapy outcome measures are a common tool that people use, and we have adapted those to be used by all our speech and language therapy services in reporting.

Rightly, all AHP leaders have to make the case for investment in AHP services, and they will use the data that is developed through those outcome measurement tools to make that case. One of the main drivers of the development of those tools is the need to create a case based on outcomes. There are outcome measures.

Dr Gosling: As we have said throughout, our key focus is on the quality of patient outcomes. As Kim Hartley Kean said, AHPs use tools to appraise, evaluate and demonstrate the quality of their outcomes for patients. To go back to the example that I cited on physio roles in primary care relating to musculoskeletal conditions, with other key stakeholders, we are undertaking a thorough evaluation of the impact of that new model of first-contact practitioners.

Professional bodies have a strong focus on demonstrating value and impact in taking forward

service improvements for patients. As currently couched, the bill is focused much more on issues of input and activity of staff than on quality of outcomes or, potentially, quality of experience for patients. We are talking about different aspects of quality. The issue is how we ensure that the bill is focused on quality of patient experience and outcomes and not on input and activity, which is what staffing level tools have traditionally tended to focus on. We have done work to shift that and to focus more on patient outcomes than on things such as inputs, tasks and activity.

Patricia Cassidy: The current legislative framework for social care is set out in regulation 15 of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, which has regulations and a scrutiny framework. The Care Inspectorate inspects all the services that are provided and the new health and social care standards that came in this year, which are a key focus of inspections, very much focus on outcomes, particularly outcome 3, which is:

"I have confidence in the people who support and care for me".

Care homes began to be inspected against the health and social care standards in July this year. That is a whole new filter that is very much outcomes focused.

At a more local level, across the multidisciplinary teams, there are a range of outcome measures. People's person-centred plans are developed using their personal outcomes and with their carers. Under the Carers (Scotland) Act 2016, we are required to do planning with carers as well.

A range of checks and balances are in place to measure outcomes, safety and quality across the services.

The Convener: I thank our witnesses for their informative contributions, for answering a wide range of questions and, of course, for their written submissions.

We will now take a short break and resume at 11:50 with our second witness panel.

11:46

Meeting suspended.

11:51

On resuming—

The Convener: We resume our evidence taking on the Health and Care (Staffing) (Scotland) Bill with our second panel of witnesses: Rachel Cackett, policy adviser, Royal College of Nursing Scotland; Dr Mary Ross-Davie, director for Scotland, Royal College of Midwives; Dr David Chung, vice-president, Royal College of Emergency Medicine Scotland; Professor Alex McMahon, executive nurse director, NHS Lothian, who is representing the Scottish executive nurse directors group; and David McArthur, director of nursing, midwifery and allied health professionals, NHS Orkney. I welcome all of you to this morning's meeting.

As you might know, we have already taken extensive formal evidence on health and social care and allied health professionals and on the tools that are a focal part of the bill. I ask each of you to comment briefly on your overall view of the bill and what it brings to objectives for health and social care. Perhaps Rachel Cackett can start.

Rachel Cackett (Royal College of Nursing Scotland): I am happy to do so, convener, and I thank you for the opportunity. It has been an interesting morning, and I am sure that the discussions that you have already had will give us a lot to build on.

The Royal College of Nursing has submitted extensive evidence and has been working with the Government—and now through the parliamentary process—to develop the bill for the past 12-plus months. We have heard a little bit about this already this morning, but the first point that I will make is about how far the bill has moved from where it began, as a means of simply putting certain tools in legislation. It is important to note how far things have gone and how complex the bill now is, and there is still work to be done.

There are six areas where the RCN is particularly keen for the bill to be improved. First—and we have heard a lot about this already—the bill must be rooted in positive outcomes for patients and staff, because if we have an overstretched staff and workforce, the members of staff who go the extra mile every single day will struggle. Indeed, that is the situation that we are in. The first panel giving evidence was asked why we need this bill, and that is certainly the reason. There is clear evidence of a link between patient outcomes and nursing staff, and, if it helps, we are certainly happy to provide some of that evidence to the committee.

There is work to be done to increase the level of the strong professional voice in the bill—and I stress that term "professional voice". I am speaking today for the Royal College of Nursing; as nursing forms our remit and mandate, it is important that nursing has a voice in all of the bill's elements. That is what we hope to see by the time the bill completes its parliamentary passage. That does not mean that we are trying to exclude other professions; it is just that that is the mandate that we are speaking to.

It is important that decision making about staffing is informed, which means using the best available evidence and data. Obviously, the duty to follow the common staffing method in the bill is limited to emergency medicine as the only area in which there is a multidisciplinary tool, and to nursing and midwifery. The RCN is clear that we have spent a lot of time in Scotland developing a series of tools for the largest workforce in the NHS, which provides 24/7 clinical care. It is often high-risk clinical care and we have to be aware of the patient safety elements that the bill affords us the opportunity to address. However, that does not mean that those tools are set in aspic. They are not and it has never been our position that they are. It was mentioned that the tools are being reviewed. Even for us, not all elements of nursing are included in the available tools. For example, prison nursing—an area on which we have done a lot of work—does not have a tool attached to it.

We would like the evidence to be developed for nursing and other professions, but we do not want what we already have to be dropped, because that would be a retrograde step. Kim Hartley Kean used a helpful phrase when she talked about not wanting to put a wet finger in the air. For a significant part of the workforce, the tools give us the starting point and the opportunity to learn and develop more. It would have helped had provisions for how the methodologies will be developed in the future appeared clearly in the bill—we certainly seek for that to be the case—and had the financial memorandum given a greater, timed commitment to the extension of those tools for nursing and our colleagues.

We want responsibility, accountability, real-time action and long-term planning to be a part of the bill. The paper that the Government shared last night was helpful and clearly sets out areas for development. The common staffing method is a means for setting establishment. It goes beyond the current tools to include far more data about how professional data will inform that establishment. However, it does not deal with real-time risk, which our members need it to do and patients should expect it to do. What happens if a nurse turns up on shift and there are not enough staff, or not the right staff, to deliver the required care? In our submission, we provided a schematic for how that could be better dealt with. My understanding is that the Government's thinking is that it will be linked to the general duty to provide appropriate staffing. However, we must remember that that duty is for all staff, not just nursing, midwifery and emergency medicine.

There is no scrutiny or sanction in the bill and we would like that to be added. We do not want another measure like the 12-week referral to treatment target to be put into legislation that can be breached as many times as we like without it making any difference. The bill must have teeth. It is a crucial patient safety issue and we need to ensure that there is accountability in the right place.

One issue with the bill is that, in part 2, which focuses on the NHS, accountability is put on to boards to deliver the general duty. That is important, but it needs to be linked to a scrutiny methodology. HIS is reviewing how it undertakes scrutiny to include that, which provides a great opportunity, but there also needs to be an opportunity for public scrutiny when things repeatedly go wrong or something very serious happens. We need to ensure that staff on the ground are enabled to undertake that scrutiny in real time and that the Parliament and others have a role in doing that over the longer term.

We need to ensure that there are enough staff to care. I know that the committee spoke informally to many senior charge nurses this morning. They are crucial to the process. They set the culture for their teams, supervise them and set the staffing to deal with risk. If we do not free up our senior charge nurses and their equivalents in the community, the bill will not be able to do what we expect it to do. It is extremely important to note that, as comes out in the staff survey, they do not have the time to do what they need to do. Therefore, we seek for the bill to make senior charge nurses and their equivalents in the community non-case load holding so that they are freed up from direct patient care to be able to supervise their teams' work and ensure that it is safe.

We also need to ensure that supply is dealt with, but the bill does not do that. We cannot tie the hands of boards and put a duty on them to provide appropriate staffing if the supply, which is held by the Scottish Government, does not come through. We would like that to be added.

We appreciate that part 3 is complex because of the landscape in which it works. However, our interest in that relates to our clinical nurses who provide clinical care in the care home sector. Our stance is that a patient should expect no difference in the clinical care that they receive whether it is in a care home, their own home or a hospital. That is why we support part 3.

12:00

Dr Mary Ross-Davie (Royal College of Midwives Scotland): The Royal College of Midwives believes that the bill might help to establish a consistent strategic focus on the staffing of maternity services. We have been grateful for the focus that our sister organisation the Royal College of Nursing has given to the legislation. We have been working alongside the

RCN to effect change in the nature of the bill and support the developments that are needed to ensure that the planning tools are fit for purpose.

The committee will have heard from some of my colleagues in the pre-meeting this morning that the existing midwifery planning tool has some weaknesses, and there are issues over how effectively it has been implemented. Implementation has been a bit patchy.

We recognise that the preparations for the introduction of the bill have led to greater focus on the need to amend and develop the midwifery workforce planning tool and to increase the support that is provided in health boards to run the tools successfully.

The bill is part of a much wider picture ensuring that we have safe staffing levels and midwives in all parts of Scotland. We have particular challenges in recruiting and retaining midwives in the north of Scotland and in more remote and rural areas. There are a whole raft of supports and changes needed in addition to the bill.

The committee will know from the SPICe survey that was undertaken earlier this year and from our consultations with our members that there is a range of problems with the current midwifery workforce planning tool. I apologise for not having tabled this before today, but I have copies of a paper for the committee that summarises the challenges that have been identified.

Some areas in Scotland have invested significant time and energy in providing dedicated time for completion of the tool and training. In those areas, there have been instances where a staff shortfall has been identified and a business case could be made for more midwifery staff. We acknowledge the significant amount of national activity now under way to ensure that staff are trained to use the tool effectively and to give on-going support.

Dr David Chung (Royal College of Emergency Medicine Scotland): The Royal College of Emergency Medicine is broadly supportive of the principles behind the bill. As others have said, it is important to have oversight and integrated planning of the health and social care system within Scotland. The bill acknowledges that. We have an unofficial motto—if it is right for the patient, it is right for the emergency department.

We are the interface between different parts of social care, primary care, secondary care and public health. We see things quickly and issues manifest for us more acutely than for other areas. Most of the times when we feel that patients may be getting a raw deal—when they are waiting for a long time on trolleys in a department trying to get into a bed or to go somewhere to be processed rapidly and have their needs met in a clinic or wherever—are due to staffing issues elsewhere in the system. While we welcome the emphasis on multidisciplinary care within emergency medicine, it is also important that there is an emphasis on care outwith the emergency department. Staffing levels in other areas need to be adequate for the whole process to run smoothly. We are the canary in the mine or, for younger people who cannot remember that, the indicator light on the dashboard telling you that you have a problem in your engine.

As others have said, the principles are good, but we need to accept that, although the concept of the bill is sound, it will be an iterative process and there needs to be feedback from clinicians of all stripes if they find that bits of the bill are not workable, that the tools do not provide what is necessary or that there is a weakness. There must be the ability to rectify matters as soon as possible. That is the same for any process, whether in health, social care, industry or wherever. If people feel that there has been a mistake, we need to be able to correct that. There is no point in doing the same incorrect thing, just because it has been set in legislation.

It is also important that there is transparency in data recording. When the legislation comes in and various organisations show how they have implemented the tools and reached appropriate staffing levels, the process should be in the public domain. I am not sure whether the bill makes that explicit. It is important because it involves the taxpayer's money and it is important that we are able to say that the process is transparent and open to scrutiny.

In short, the RCEM is broadly supportive. The bill should help speed and provide greater impetus to true integration of health and social care. Although we are making some steps towards that, it could progress at a faster pace. As long as we are mindful of that, it definitely has the potential to benefit patients and staff and improve the human experience of everyone working in health and social care.

Professor Alex McMahon (Scottish Executive Nurse Directors Group): I will build on some of the comments that people have made, all of which I agree with. No one would disagree with the principles of the bill or the aspirations for patient safety and looking after the staff we employ. Most people would agree that although, as they stand, the tools are not perfect, there is a process to review those tools and their implementation. That has a bearing on the infrastructure that would support the running and analysis of the tools and the implementation of their findings—we have not had that before. We want to address those issues with the Government and others.

The principles of the bill also relate to how health boards, councils and integration joint boards work in partnership. There is already a workforce planning process in place and we need to build on that, and not just from a nursing perspective. In my role, I am also responsible for AHPs in Lothian. I have a duty at executive level to ensure that the voice of AHPs is heard at workforce planning level and professional level.

As the tools progress, I want them to become much more multidisciplinary, because we need to ensure that patients get access to the right staff, across the spectrum, and not just in the nursing profession.

It is important to consider the process around escalation from a public scrutiny point of view, but it must not become bureaucratic and interfere with the daily business of health boards.

David McArthur (NHS Orkney): I will give an outline of the scale of NHS Orkney, which is the smallest health board in Scotland. A head count of our AHPs gives the princely sum of 40. We have 62 whole-time equivalent community nurses and we have 135 WTE hospital nurses.

Although we are not talking about huge numbers of people, we run into challenges when we apply the staffing tools, for example in our lack of resilience. Our bank nurses are already wholly employed by the board, so there is no spare capacity. We tend to staff up by working towards a worst-case scenario. The tools will be helpful for us because they will provide transparency and will, we hope, support our approach, particularly the professional judgment tool.

I entirely support what my colleagues have already said. It is about transparency and being able to demonstrate that we are doing the right thing and have the appropriate amount of staff. I have some concern about the lack of specificity in the bill on the impact on remote and rural areas. That goes back to earlier comments about the Scottish Government holding the supply. We need that supply coming on to the islands and we need that flexibility in the workforce.

In support of my AHP colleagues, I will say that we need to build a very strong multidisciplinary workforce that can work across barriers and professional boundaries.

On any caveats that we may have about the bill and the tools, I see the bill as a huge opportunity that we can utilise to build that multidisciplinary workforce and to ensure that the workforce tools are utilised properly. One of the issues that we have with the workforce tools is that there is a lack of knowledge in their application. We need to ensure that that educational piece is out there. Where the tools are not working for us, as professionals, we need to put our hands up and say so, but we also need to provide an answer to those questions.

Sandra White: Good morning and thank you for your presentations. As others have said, things have moved on, but it seems that you are saying that you would like the tools to move on a bit more, and for there to be more of them.

I have a question that was raised by the previous panel of witnesses, who said that the bill and the tools are acute-service based. Do you agree? Your answer could be a quick yes or no, but please expand on that if you want to.

Dr Ross-Davie: I can certainly speak from a midwifery perspective. In the original research to develop the midwifery workforce planning tool, some observations were apparently undertaken not just in an acute labour ward setting but in community settings. However, when we speak to colleagues in the service, they make it clear that they feel that the tool is more effective in the acute setting—in other words, in labour wards or antenatal and postnatal wards—and less so out in community settings.

One key problem is that the tool's community elements allow community care to be provided only in working hours. Obviously, not all babies born out in the community come between 9 o'clock and 5 o'clock, Monday to Friday. There are a significant number of home births and births in midwife-led units all over the country, and there have been real issues with acknowledging that care and ensuring that it is being recorded correctly. That key element is not well covered in the midwifery workforce planning tool, and we hope that the look that will be taken at this issue will improve things.

We are particularly concerned about the issue because, as a result of "The Best Start" review recommendations, maternity services will definitely become more community based over the next five years, with many midwives moving from hospital settings out into the community. As a result, the tool must be robust and fit for purpose to ensure that we have safe staffing levels in the community, particularly in remote and rural areas, where midwives sometimes have to drive four hours there and back just to make one postnatal visit. That needs to be taken into account, and colleagues in remote areas have certainly said that they feel that that is not done effectively at the moment.

Professor McMahon: Many of the tools were developed at a time when many of the services that we currently deliver were not being delivered by healthcare professionals. For example, prisons and police custody have been mentioned. We have only recently delegated to IJBs responsibility for community mental health, learning disability

and substance misuse services, and as time progresses, there will be a greater need to look at how we provide that care to people in different settings and the workforce requirements in that respect. There is now much more scrutiny of that issue, and we need to rebalance some of the tools to ensure that we take as much cognisance of the community elements as we do of the acute elements.

For me, the issue is the pathway for patients. Patients are not quite linear—they do not just go into one bit of a system. Instead, they cover many pathways, and we need to ensure that we have synergy and connectedness.

Rachel Cackett: The tools that are currently in the bill include community ones. They are not comprehensive and, at this time, do not cover all areas of community nursing, but they are there. There are more tools that sit in specialties in the acute sector; however, they are not just for that sector, which is to be welcomed.

One area that will be covered in the review of the tools, which the Scottish Government has begun, relates to the fact that the services that nursing is providing in the community are now very different from what they were 10 or 12 years ago. As we change the way in which we deliver services and as new options come online, people will now receive in the community the sorts of services for which they would previously have gone into hospital. That certainly needs work, because there are areas of the community that are not covered.

A linked issue that the committee discussed earlier is the multidisciplinary approach and what that might look like, particularly in the community. We need to pick that apart a little. I do not think that there would be a single person around this table, including me, from the RCN, who would not promote the need for multidisciplinary teams if they are exactly what is required by patients and service users either in the community or the acute sector. The team has to be multidisciplinary where that is the right approach to take.

However, when you come to set your establishment and understand your workforce planning, you have to know how many of each individual profession you require in your team to meet the needs of individual patients. For example, you need to know how many paramedics you need in the back of an ambulance to run an ambulance service, and that might or might not be done on a multidisciplinary basis. Moreover—this brings me back to the discussion about what the changes might look like in the care home sector—you need to know how many district nurses you need to deliver your multidisciplinary community service. It is therefore really important to bear in mind that, when you set establishments—particularly when you think about the number of bodies needed on the ground in one day or, at Scottish Government level, the supply that you are planning for—you have to know how many nurses you need. Of course, that does not mean that that will not then be applied to a multidisciplinary setting.

Often one tool might not be appropriate. For example, I would be surprised if someone who ran a 24/7 nursing service that had sessional input from our AHP colleagues used exactly the same tool to work out whether they had enough physios or OTs as the one that they used to work out whether they had enough nurses. However, they would use a multidisciplinary workforce planning process. We must bear it in mind that the bill does not necessarily deal with everything that has been described.

12:15

Dr Chung: It is important to try to lose the distinctions between community and acute settings, because they are part of the problem. More staff might well be needed in the community, which would ameliorate negative effects on acute care, and vice versa. As the tools become better developed with feedback, we hope that the outcome measures will be decided, which will allow us to know whether the tools are working. The community tool should not look only within the community or at the average level—it would be a mistake to use the average to plan capacity, because that would mean that the supply was not enough for half the time.

We support the principle, but we are talking about what we want to happen. Will the community tool mean that no delayed discharges occur? More important, will it enable people to have assessments at home, as they do in East Ayrshire, so that they do not get anywhere near a hospital, which is good for them? Will the tool mean that there are enough acute staff so that, if patients need to come into hospital, they will stay there for the time that they need to, rather than go out into the community? That will ensure that the two sides do not create a constant merry-go-round for patients, which they do not need, because the capacity is not right on either side.

I emphasise that, whatever the tools are, we cannot afford for them to be seen in the next five to 10 years as a community tool or an acute tool. All the tools should be integrated; that is how the system should be developed.

David McArthur: I wholly support that. We mentioned the challenges in midwifery. We support home births from our central base in Kirkwall out to Papa Westray, which can involve a helicopter or a boat ride of a couple of hours.

While we wait for a midwife to arrive and for the team to get to the location, we need the ability to provide care, which is where our multidisciplinary piece comes in.

I agree that the workforce tool needs to be based on a holistic view that provides continuity and a continuum of care; otherwise, we will end up siloed and lose the ability to flex. Such an approach also allows the IJB to commission appropriately and to provide the correct services.

Sandra White: Looking to the future, the tools as they stand do not seem to be fit for purpose. The witnesses might not agree, but will they say something about that? All the tools are based on the Scottish standard time system, which deals with pay and staffing. It is difficult to look beyond that to the upside-down triangle that my colleague Emma Harper described. How do we fix that? Everyone wants the bill to work and to do so for the community. Are the tools that are based on the SSTS fit for purpose? How do we get round that to include other issues?

Professor McMahon: The SSTS is simply an e-payroll system; it is not necessarily fit for purpose, because it involves a lot of entry of information and duplication of effort by staff to triangulate information from the system for workforce planning. The Scottish Government is leading a piece of work with NHS National Services Scotland to review the system and consider a better platform and information system.

That is one element; another element is education, training and awareness about the tools and the implementation of their outputs, whether that involves a desktop exercise or running information through an e-system. Latterly, an issue has been the expert capacity in the system to work with people such as me to ensure that the outputs from tools are being interrogated, analysed and turned into robust plans.

All those elements are being addressed. If we have got them right by the time the bill is enacted, that will put us on a better playing field.

David McArthur: I reiterate what Alex McMahon said and emphasise that, when the tools were first established, there was a huge training effort to support them. That cohort of trained people has changed and moved out. We have not kept as up to date as we should have on the tools. The tools provide us with a starting point, and the direction of travel in the way that they are being introduced is correct. That is recognised by the chief nursing officer's office, which has provided the boards with an expert resource, both from within that office and to be recruited from within the boards, to provide continuity and additional input.

Rachel Cackett: As I said, no one wants tools that are set in aspic, because the world moves on. It is encouraging that the Government has put in a process to review the tools. That process should be on-going; we cannot let the dust settle on the tools at any point. They must be fit for purpose.

That is why the bill should be amended to include a duty to have in place an on-going method of review. We must be able to say when a tool has come to the end of its life and we need a new one, and we need to be able to keep the tools that we have up to date. That important process is missing.

Under the social care provisions, the Care Inspectorate has responsibility for developing new methodologies, but again the bill does not go far enough, because it does not say that the Care Inspectorate needs to keep the tools up to date and set out the process for doing that. Those are important issues that we need to look at to make the bill more fit for purpose.

I go back to the survey and the discussions that we have been having with our members. When you want to run the tools, you need the education, the time and the expertise to do so. Those things matter and have to be in place, and we need to look at where the levers are in the legislation to get that right.

Brian Whittle: This is probably an appropriate time to mention my entry in the register of members' interests, which states that I have a close family member who is a midwife.

I want to follow on from Sandra White's questions on the technology. If the bill is going to succeed, it is fundamental that the technology that underpins it will support the tools that are required. I have heard in evidence and again at our pre-meeting this morning that a wide variety of tools are used by midwives and nurses. This morning, some did not recognise the names of the tools that other areas use.

As Alex McMahon mentioned, the SSTS platform was not built for purpose and is therefore not fit for purpose. Are you suggesting that, before the bill can go anywhere, we need a platform that is developed specifically to deliver and better regulation of the tools across the profession?

Professor McMahon: I know that NSS is looking to procure a new system and I believe that it hopes to have that by the end of the calendar year. There is then the issue of how that can be developed and implemented. One would hope that that could work at the pace at which the legislation goes forward.

It is not just about having a system in place; it is about having people trained and educated to use the system. There is a lot of work to be done. The

systems also have to be tested. Not to have a new system in place and then to introduce one after we have introduced the provisions in the bill would cause confusion and more work for people. I am not saying that one should prevent the other from progressing, but in an ideal world it would be nice to see both coming in at the same time.

Dr Ross-Davie: The introduction of the bill has focused people's minds on what is not working. That has certainly been the case for the midwifery workforce planning tool. Views were sought from the heads of midwifery on how effective the tool is. It is clear that implementation was patchy, and at least half of the health boards felt that the tool did not reflect what they needed. The introduction of the bill has helped to move things forward and the work on the new platform is well progressed. It helps to do this in tandem.

Rachel Cackett: What we are hearing and the information that you got back from the survey shows that there is not a uniform picture. Things are working more fluidly in some areas than in others. That is part of the work that the Government is now doing with its additional support. As Dr Ross-Davie said, it will certainly focus minds in boards and elsewhere on rethinking how the tools are implemented. I would certainly be reluctant to say, "Let's hold off until everything's perfect" because, as we said earlier, it is an on-going improvement process that should never stop. The health service is built on an improvement focus, as is our social care service.

There are other platforms that we are looking at. The care assurance system that the CNO is developing through the excellence in care approach will give us really important indicators about the quality of care that is being provided and the outcomes for people, and that is being developed in tandem with the bill. It is really important that we do not forget that there are other indicators and platforms out there.

We must remember that the common staffing method is more than just the tools. The RCN lobbied hard for that to be the case and the Government listened. In setting an establishment, it gives those with professional judgment a variety of other means to come up with what the establishment should be. It is not limited to the tool alone; we will look at other things. For example, we would like to see the addition of professional guidance from royal colleges or from peer-reviewed international evidence, which could be brought in by those who have the professional judgment to make decisions on what an appropriate staffing level would be for any particular setting.

David McArthur: I reiterate what Alex McMahon said. Ideally, we would see the new platform and the bill come together—that would be the perfect solution. In my previous employment, it was made clear to me on many occasions that we needed to go with the best current solution rather than holding up the plan, because we will never get the perfect plan, and we need to know whether is it going to survive first contact.

Professor McMahon: I want to pick up on what Rachel Cackett said. I guess there is potential to run with systems that do not necessarily all collect the same data and are not defined in the same way so that we start to select things as we wish in order to try to make the argument. However, what we really need is a like-for-like or an apples being compared to apples situation, not the situations that we might have had in the past, whereby we got different outputs depending on what day of the week it was or what question we asked. We need absolute clarity and consistency.

Alex Cole-Hamilton: Good morning to the panel. I have a large narrative question and then a couple of more detailed questions, which are perhaps more for those who deal with the nursing profession daily.

Dr Chung, I was struck by your reference to the canary in the mine. You described coherently and in great detail how the problem in social care is causing an interruption in flow that is manifest in accident and emergency services. You cannot release people into the wider hospital because there are no beds to receive them. Are we missing a trick by not including aspects of social care? Will that cause us problems for the whole integration experiment because the bill is so siloed and focused on primary care?

Dr Chung: You have summed up quite nicely the points that I was making. It is essential that social care is involved, because that is where a lot of the capacity is. A lot of this is aimed at what is best for the patient, and if patients are getting the right care it should also turn out to be what is best for the staff. The two have to go hand in hand.

As I have indicated, the bill needs to account for integration and the fact that the different parts of the system cannot afford to plan in isolation from one another. They will have to work together. We hope that the effects will be positive, but they could be negative if one bit does not get it right. Whatever tools are developed and whatever planning occurs in a particular area, we must ensure that there is a broader scope and some overview to say, "That's all very well, but is it going to have a negative unintended consequence somewhere else?" Planning is littered with such considerations. If we make the system one where rapid assessment is possible, we will be able to change and update the tool to ensure that that does not happen.

Your analysis is correct. It is imperative that all parts of the health and social care system are involved. Emergency medicine is called "emergency", but a lot of it is social medicine as well, in some ways. People come to us because there are issues in their lives and we are available, but we are often not the best place to solve their problems.

Increasingly, we are seeing some very good work in Scotland about using other staff groups to help and signpost people to the right places. For example, there are navigators in big hospitals, including in Arran and Ayrshire, and there are roles such as community connectors and adult support and protection. Those are all integrated groups that can get to the root of the problem. If we apply that to the likes of paediatrics and adverse childhood experiences, that will solve the problem for the next 20 years. If we can get to grips with the early childhood stuff, there will be less work for us to do in accident and emergency.

It is difficult to nail this down with the tool that we have at present. It is easy to look at a defined group but, as the tool develops, it needs to become more sophisticated to reflect where the system is going to get the biggest bang for its buck, for the patients' benefit and for value for money for the taxpayer.

12:30

Alex Cole-Hamilton: Thank you for that. My second question is a bit more detailed. With the toolkit and the other provisions in the bill, it is clear that this is about better workforce planning. I have been struck by the focus in our background briefing on head count and being sure that we have capacity, but it is not always necessarily clear whether that is the right capacity. Should we specify the need for an appropriate skills mix within the staffing that we are planning for?

Rachel Cackett: There are a few points to make in answer to that. First, the duty to provide appropriate staffing is clear that the staff need to be competent and qualified. That is the way in which the bill attempts to deal with the issue of skills mix.

The nursing tools as they stand will not give a skills mix. They will give a number for the average workload. That will give a baseline, and professional judgment will then be applied to work out what the staffing should look like. Going back to a point that was made earlier, I note that, because of the way that the common staffing method is written, it focuses on a number for the average workload based on a certain set of assumptions such as bed occupancy, which may be well off the current situation for the NHS in Scotland. It does not deal with risk, and that is the big bit that is missing in the bill, for us, along with the other things that I set out earlier.

On the risk management process, we can have a number and a skills mix, but if there is a sudden outbreak of flu that affects both the staff group and the acuity of the patients who are coming in, we need to be able to adjust that and do on-going risk assessment. Only part of this is about an evidence-based number. We need that for workforce planning and to get the finance right, but we need to have professional judgment in place, with the support for that, in order to consistently, every day, adjust that according to patient need, whether that is in the community or in the acute sector.

Alex Cole-Hamilton: Is there sufficient provision for that in the bill?

Rachel Cackett: No. It needs to be added. I know that the Government is looking at work to do that. We will not see what that looks like for a while, but discussions are going on, and we have put forward proposals on how it could look. That would address many of our members' concerns. It is fine to set a number and get the budget right for the establishment—that is an important process and it needs to be based on the best available evidence, which is why we need the tools—but there is also a need to be able to deal with risk in real time.

Dr Chung: Like all issues, this tends to get more complex the more we look at it. It is just one of those things. That's life. Using an average to plan capacity is a fool's errand because, by the law of averages, there will not be enough half of the time. There are certain ways to plan. The perfectionist would say that we need to plan to have enough reserve to cope with 95 per cent. That is probably not far off, and maybe 85 per cent is the minimum. However, using the average will cause problems because it is not going to work. People will be unhappy half of the time and will lose engagement. There needs to be some modification around that.

Head count is too crude a measure in itself because of differences in skills mix. The time of day, day of the week and season of the year all create different pressures. Most tools and workforce planning appear to have been based on historic numbers of staff and how to divide them to put them where they need to be. We need to do some work on how many staff we need, and the Royal College of Emergency Medicine can certainly give some help on that.

On national benchmarks, we should ask what kind of health service model we are aiming for. In Australia there are not twice as many, but certainly 70 or 80 per cent more beds, more doctors and probably more nurses. We are at about the level of

the United States. Compared with our European neighbours, our levels are lower than those of many countries. I have the figures here. I mentioned the issue to the committee last time I was here, and I have the figures to hand.

We could ask whether the tool will reflect the need for certain numbers of different staff on, say, a Monday evening, which is the busiest time in an emergency department, compared with the need at a less busy time, which might be a Saturday morning. Does a paediatric assessment area need a different number of staff in the middle of the bronchitis season? Every area has different peaks and troughs and different advantages to having different staff levels. A certain volume might be able to do stuff, or having more senior people who can move from one task to another might be more efficient, although they might appear to be more expensive.

As I have said, the position is complex. Thought is needed about how the tools can adapt to give more detail and reflect complexities, which might vary from area to area or according to the time of day, the day of the week or the season.

Unexpected pressures are another aspect. We have done a lot of work to create a very efficient system—by international measures, the NHS in the UK and in Scotland is very efficient—but an increasing body of thought, which is starting to be backed by evidence that is not just in healthcare but more to do with industrial processes, is that getting very efficient means becoming more fragile. That might be what we see when we are squeezed in periods when there are pressures on the system, as in winter.

When we do workforce planning, we must decide where the balance will lie. At the moment, it is very much about efficiency, but perhaps we need to think about our reserve and the level that we need to plan for. I say for the third time that using the average would be the wrong approach.

Professor McMahon: We must remember that such tools are run at best once a year, so they give a snapshot at a point in time. As Rachel Cackett said, they do not deal with the skills mix or the risk element, which we address day to day in a ward or a community setting. We often start a day by asking whether we are safe to start; there are huddles and discussions about patient and staff safety, and none of that should be taken away. The issue is how we plan that into a process that involves the tools; another issue is the frequency with which the tools are run. We will need to marry the day-to-day activity with an annual process, if that is the way that we decide to go.

Many submissions on the proposals support giving band 7s a supervisory role. That is an important conversation that we should have. It should not be the case that everything falls to them, but they have a key role to play in day-to-day staff and patient safety. They could also become experts in running the tools and educating and training others in the tools.

I stress that we look at risk day to day—and hour to hour in some departments—but it is a key element that needs to be built more rigorously into the overall process.

Dr Ross-Davie: We support the thoughts about risk and the use of averages. In maternity care, we have peaks—one is often nine months after Christmas—that we cannot necessarily plan for. As has been said clearly, basing the workforce on averages would mean that midwives were running short a lot of the time.

Midwifery workforce planning tools were some of the first such tools to be developed, to try to cope with the peaks and troughs that we see. The rest of the UK uses a workforce planning tool that is called Birthrate Plus but, in about 2010, it was felt that that was not appropriate in Scotland, because it did not take into account some of our remote and rural issues. People down south are trying to evolve that tool; they are looking at new models of care that involve continuity and have realised that the tool needs to develop to reflect the new ways of working.

As Rachel Cackett clearly said, we will need to continue to develop tools as services change so that they reflect new practice. We do not know yet what that will look like, because that model of care has never been applied at scale—it has been used only in small research projects and randomised controlled trials. The tools cannot replace day-to-day risk management.

David McArthur: I wholly support that view and I will pick up on the skills mix. We have 23 beds in an acute ward in the Balfour hospital in NHS Orkney, which can at any time accommodate acute surgery, acute medicine, renal, gynaecology, ear, nose and throat, and orthopaedics patients—and the list goes on.

We are very much in the business of being the specialist generalists. I fully support the approach, but we need to ensure that any skills mix package takes due cognisance of the fact that not only do we need to be able to provide those specialist generalist people, but also that we do not have the critical mass to call on. For example, when I was theatre manager of Glasgow royal infirmary, I could call on colleagues from the intensive treatment unit and any one of the 27 operating theatres that we had. We lack that critical mass in remote and rural areas.

For us, there is not only the question of assessing skills mix and managing that risk, but also the knock-on training element and training

margin. Those margins should be increased as well.

Emma Harper: I welcome our second panel of witnesses.

Alex McMahon talked about not having another level of bureaucracy, as it would lead senior charge nurses to say, "No way—this will impact my clinical supervision abilities." I support there being no more pieces of paper that simply reflect an additional workload.

The letter from Fiona McQueen, the chief nursing officer, includes information from NHS Lothian on the number of rosters and staff that have applied the tool, which suggests that it is pretty successful. Can you tell us about the success of applying the tool and what you have done in that respect? After all, training will be key to engaging the staff in taking on board something like the workforce tool.

Professor McMahon: As with any data, there are always more questions than there are perhaps answers. That information came from the CNO late last evening.

I have been in my post for only two years, but I am very fortunate in having a deputy director who is steeped in the tools and has been involved with them right from the very beginning. The deputy director is an expert and works with associate nurse directors, clinical nurse managers and charge nurses across the system. However, that does not negate the fact that more education and training need to be done.

During a recent internal audit of our own processes, we found that, although it feels like we use the tools—and use them well—we are not as good as we could be in the implementation of some of their outputs. Sometimes there is an issue with closing the circle. As I have said, it is about using and building on what we have.

Picking up on the SSTS issue, I think that my deputy director would say that the current system makes implementation clunky and cumbersome. She has to spend a lot of time working with others to try to get the data out of the system. We might want to use it more often, but many of the things that are in her way relate to infrastructure and having the time and expertise to be able to do that. That said, I welcome the Scottish Government's commitment on the adviser posts; they will help her, and they will work with us to build up that awareness, education and training.

We are all in slightly different places. Some people might use the tools, but they might do so as a table-top exercise, or it might be that they sit outwith the reporting system in Ayrshire. When I saw the information that you mentioned, I thought that it raised more questions than we know the answers to at the moment.

Emma Harper: E-rostering was mentioned as something that could pick up the competence or skills required. Depending on who is on shift, you might need someone who is central-line trained, intravenous trained or catheter trained—the list goes on—and is able to give competent care wherever needed. After all, IVs are now delivered in the community, too. Is that part of the development process?

Professor McMahon: Absolutely. NHS Lothian has almost completely rolled out the electronic rostering system, but it has not been without its challenges. Bedding in a new system always creates challenges.

E-rostering allows us to see the acuity of the patients and the skills mix that is required for any particular shift, but it does not mean that you can always respond to that as effectively as you might want. However, it gives the charge nurse and others the ability to see on a day-to-day basis whether the staffing and skills mix meets patients' needs at that point in time.

The bit that sits behind all that is called SafeCare. As we have said, there are different systems in use; NHS Lothian uses SafeCare, and it is proving to be successful, but not without challenges.

David Stewart: I thank the witnesses for their contributions. I am particularly interested in rural, remote and islands issues, so I will address my questions to Mr McArthur.

Your submission contains the stark conclusion that the philosophy behind the Islands (Scotland) Act 2018 is not fully reflected in the bill. Will you say a little more about that?

12:45

David McArthur: The 2018 act refers to having

"regard to the distinctive geographical ... and cultural characteristics"

of the islands, and I would ask whether that is wholly reflected in the bill. I think that a clear reference would be useful—that reflects the opinion of my IJB and council colleagues, too. It is a crucial element in our move to a new hospital, which you are probably aware of. The philosophy behind that is that we will roll out more and more to our community and use all the facilities that are out there, including Attend Anywhere and other video systems.

Our perspective is that the bill must give due recognition to the fact that some things will differ. We are asking not for allowances to be made but for that kind of recognition, so that we can test and

adjust systems. For example, although our staffing tool might tell us to have X staffing for a given period, perhaps the figure should be X+1, because we do not have the same resilience.

David Stewart: The philosophy behind the 2018 act is about island proofing, so every piece of legislation needs to be conscious of the islands. Your submission says that the existing tool is not sufficient for use in small hospitals. Does that represent a lack of island proofing?

David McArthur: I am sorry—I meant small wards rather than small hospitals. The tool applies nationally across the country, and I wholly support the approach in the bill. However, for the remote and rural element, we need to look at something slightly different. The letter from the CNO that came out last night referred to areas of non-compliance, which are not just in the islands. I know that Shetland has been mentioned; we applied the tools only late last year, when I joined the staff in NHS Orkney. However, there is also non-compliance in remote rural areas such as the Borders. Some areas are taking the view that the tools do not really meet their needs or apply to them; I would counter that by pointing out that some of that arises from a lack of understanding and training. However, it is difficult to apply the concepts to very small units.

David Stewart: I do not want to be flippant, but I note the famous military quote that every plan collapses on first contact with the enemy. Are you suggesting that the plan is not sensitive enough to deal with rural and remote areas?

David McArthur: I think that the quote is that no plan survives first contact, but such tools can be made to work for remote and rural areas. As I have said, the tools are not at their perfect point, but we can make them work by giving people appropriate education and training. We have support from the Scottish Government—and I would ask that you bear it in mind that my submission predated the additional support that was made available. I am confident that we can make the tools work for us, but they need to be nuanced.

David Stewart: You made an interesting point about the tension between using a tool as a financial workforce predictor and using it as a safe staffing predictor. Will you say a little more about that?

David McArthur: I go back to risk and the skills mix. The way in which the tool was used did not produce the skills-mix sensitivity. As Alex McMahon has said, a tool is run once or twice a year, so the sensitivity is not built in for us to make day-to-day changes. We have huddles every morning; in some ways, that is probably easier for us, as it is about half a dozen people sitting round a table, saying whether we are safe. However, the situation is also challenging, because we do not have the critical mass of people to move about. The tool does not facilitate the piece of work that needs to be done on the skills mix and risk.

The Convener: Clearly we have not had time to cover every aspect of the bill in detail, but do the witnesses have any final brief comments on the financial memorandum, particularly the absence of funding for any additional staffing, and on whether there is adequate funding for full implementation of the tools as they exist across health boards? Finally, is there a risk of creating a perverse incentive, in that running the tools might demonstrate that you do not have adequate staffing and that the way to balance the tool might be to reduce the number of beds? Is that a live or real risk in this context?

Rachel Cackett: In our evidence to the Finance and Constitution Committee—I know that this committee is now considering the bill's financial elements—we were critical of, as we read it, the assumption in the financial memorandum that the bill would not necessarily result in more staffing. Our members are certainly under extreme pressure. With the vacancy rate that we now hold, I think that the assumption that the new models of care that are arriving and the greater demand from the public will not result in any change in that rate seems an interesting place to start. After all, the bill is supposed to be about improving the safety and quality of service to people and, from our point of view, where that is delivered by nursing across health and social care.

I would be deeply surprised if that were to be the result of the bill. The submission that we received last night seemed to address some of that by talking about the need for any additional staffing to go into the annual uplifts and for that to be a discussion in the budget process. If that is where we are going with this, that would be helpful, but whether it will be sufficient for the boards to be able to do what they need to do, I do not yet know.

With regard to creating a perverse incentive, I guess that one of the things that we need to say—and which might not have been said clearly enough—is that nurses go into work to do a really good job. That is why they join the profession. It does not matter whether that person is a healthcare support worker or a director of nursing; their aim is to do a good job and to make sure that the safety and quality of the nursing care that is provided, wherever it is provided, are good.

I hope that the bill provides an important balance to the financial positions that boards are under—which brings us back to the governance discussions that we had around this table some time ago. That is crucial, but I certainly hope that

things are not gamed in that way. From a nursing perspective, it is certainly not why nurses go into the profession.

Professor McMahon: We have not really touched on workforce planning. Although the numbers for student nurses and midwives have increased this year—and might increase next year, too—they will not be out for the next three or four years, so there will be an overlap with the legislation coming into effect. There are and will continue to be vacancies, particularly in areas such as where David McArthur comes from, where it is incredibly difficult to recruit staff. From that point of view, more of the same will not do it, so we need to look at the skills mix. That is not about denuding or putting down nursing—it is about how we grow a workforce that better meets the needs in different areas.

We often look to advanced nurse practitioners as a solution to many of those problems. However, sometimes when we do that we are actually robbing Peter to pay Paul, because we are taking them from one area and are not able to replace them. There are also areas of medicine that are difficult to recruit into, and sometimes the answer to that is nursing. From a workforce and skills-mix perspective, we need to look at the issue in the longer term. It should not distract us from the principles and aspirations around the bill, but it is a reality.

As for any unintended consequences, we are aware that there is a need for clarity in the process of escalation. If we have done everything that we can to ensure that things are safe from a staffing view, but we then have to consider putting two wards into one, that has to be supported. It is not that we are fudging things; it is just that nothing else is available to people. The focus must be on looking after patients and staff.

David McArthur: I entirely agree. If we look at beds as currency, the only variable that we have in Orkney—and this is reflected throughout the health service—is the availability of beds and the need to do things safely. We therefore have to be very careful. We have not hit that issue yet but, looking to the future, if we found that we did not have enough staff, would we need to close beds and start moving our patients to the mainland?

I am not saying that that is going to happen, and it sounds like scaremongering, but that is where the Islands (Scotland) Act 2018 and the idea of island proofing come in. We need to be able to attract students to the island. We have issues with affordable housing, transport infrastructure and broadband, and those things, especially communications, are important for young people coming out of training. I therefore agree whole-heartedly with Alex McMahon. I would point to the Islands (Scotland) Act 2018 and put a remote, rural spin on it.

Dr Chung: There is a fear that the tool might be used to justify what many perceive to be inadequate staffing levels. If the bill is to progress, it is important that we replace that fear with the hope that we will provide evidence-based engagement with professionals in order to plan and implement proper staffing and provide proper patient care across the entire health and social care network.

The Convener: That is a strong message on which to finish our meeting, and I thank all the witnesses for answering such a range of questions so succinctly.

We now move into private session.

12:55

Meeting continued in private until 13:06.

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