The Royal College of Nursing response to the Scottish Government consultation on Safe and Effective Staffing in Health and Social Care.

Question 1: Do you agree that introducing a statutory requirement to apply evidence based workload and workforce planning methodology and tools across Scotland will help support consistent application?

We note that this question comes under the heading "purpose". As such (and given there is no other space to provide general responses), our first comment is that this opening question does not adequately set out the purpose of this important legislation in achieving safe and effective staffing and care for people using services. The consultation generally focuses only on one aspect of delivering safe and effective care through the technicalities of implementing workforce and workload planning tools and methodologies.

The RCN is supportive of the Scottish Government bringing forward legislation to ensure safe and effective staffing levels in health care environments because of the opportunities it presents to impact positively on the safety and quality of care and the outcomes for individuals using services by ensuring that the right staff with the right skills are in place to deliver care in all settings and at all times. This piece of legislation is key to addressing the recommendations of the Francis Report and the Vale of Leven Inquiry with regard to staffing and quality. As the Scottish Government has noted in the new National Health and Social Care Workforce Plan (Part 1): "There is growing evidence about the relationship between registered nurse staffing and educational level, quality of care and patient outcomes" (see also: https://www.rcn.org.uk/employment-and-pay/safe-staffing). The Bill should also help to guard against organisational cultures where poor standards, as a result of insufficient staffing levels and skill mix, become accepted as custom and practice. This legislation is an important step forward in ensuring public protection, and the right to safe, quality care, for all those using services. We accept that, in the first instance, legislation may cover nursing care in NHS settings, but believe that in time it should be expanded to cover care from other professions and in other settings.

The RCN has recently concluded a consultation with nurses and health care support workers on issues of safe staffing. The consultation received over 30,000 responses, with over 3,300 from Scotland. This is a subject of great importance to nursing staff who see the consequences of staffing decisions on patient care and staff morale and wellbeing every day. The Scottish responses have helped to inform this submission, and we offer some preliminary headlines from the survey in it. The RCN will publish a more detailed analysis of the many quantitative and qualitative responses later in the summer to continue our work to inform and shape this legislation constructively.

Consistent application of tools is not the end point the RCN is looking to – important though this may be. Tools and frameworks are simply a means to a far more important end of safe, high quality, care and better personal outcomes. The RCN urges the Scottish Government to set out guiding principles in primary legislation on safe and effective staffing. There is important precedent in recent Scottish legislation to put principles – focused on people and rights-based care – at the heart of legislation, which far more clearly set the shared goals for

all those involved in delivery and provide a marker to measure person-centred success. Landmark Scottish mental health and integration legislation are prime examples of this.

Looking again at the integration planning and delivery principles in the Public Bodies (Joint Working) (Scotland) Act 2014, many of these principles could be helpfully applied, with little if any amendment, to a Safe and Effective Staffing Bill. These principles already have support across sectors following significant previous engagement. Using these quality-based principles as a basis for new safe and effective staffing principles would also aid delivery agencies across health and social care by providing coherence of purpose in both service planning and delivery and setting workforce plans to meet assessed needs.

Though the RCN would prefer to see quality mentioned before sustainability, the aim set out in the new workforce plan, to which this legislative work must be clearly aligned, also gives a helpful means of expressing intent that is more in line with the RCN's aspirations for this Bill:

> *Getting the right people into the right place, at the right time, to deliver sustainable and high quality health and social care services for Scotland's people.*

This leads to a linked issue. The current Nursing and Midwifery Workforce and Workload Planning Tools provide a baseline nursing establishment to meet the average workload in any setting, but a raw number does not equate to safe, effective and quality care. In particular the tools do not set out the mix of skills, experience and competencies required to provide effective nursing care to any patient or patient group. And the tools do not mitigate 'making up the numbers' of nursing staff through use of agency, bank or the loan of nursing staff from other specialties - all of which can have an impact on the quality of care any nursing team can provide.

Many nursing staff responding to the RCN survey described bank and agency staff being part of the staffing on their most recent shift/day of work. From nursing staff responding in Scotland, just over a third reported the use of bank and agency staffing during their most recent shift, with supplementary staffing on average accounting for around one in eight of the workforce on that particular shift. Respondents also reported insufficient staffing and the impact of this on patient care with half of those responding in Scotland reporting that patient care was compromised on their last shift. When describing what had impacted on the ability to deliver high quality care, one third reported not enough registered nurses and a quarter reported there were not enough health care support workers. Nearly half reported they had concerns about the skill mix (which may also include staffing beyond nursing) on their last shift/day of work.

In light of all of this, the RCN is keen to explore with the Scottish Government how legislation based on patient-focused principles, including rights to safe, quality care, would support the delivery of appropriate skill mix. Relevant organisations must evidence how they have specifically accounted for the registered nursing establishment appropriate to deliver equity of outcome based on acuity, dependency, complexity and caseload in any given setting and at any given time. This must also take account of requirements on registered nurses to, for example, supervise non-registered staff, mentor students and undertake their own continuing professional development.

In a linked point, we understand that there is some discussion in Scotland – as there was in Wales – about the use of the words "safe and effective" in the proposed title of the Bill. The RCN is keen to see these words retained in the title of the draft Bill, or at the very least in the key explanatory paragraph that sets the scope of the Bill, given the importance of keeping a clear focus on the greater goals of ensuring safe and effective care for people using services

through workforce and workload planning to improve outcomes. Again, in reference to the integration principles, the RCN would note that words such as “safety” are included within the Public Bodies Act.

In answer to the specific question asked: legislation – in and of itself – will not automatically improve consistency in application, even if that were the primary goal sought. The Scottish Government mandate on the tools has not yet been fully delivered. How the additional lever of legislation will direct effective application of the tools will depend on the detail and scope of the draft Bill – but the RCN is clear that a sophisticated legislative approach will be required to increase leverage, in a proportionate manner, over and above the current NHS mandate of the Nursing and Midwifery Workforce and Workload Planning Tools. We do not expect this to be a very short piece of legislation, given the complexities to be captured.

The RCN is keen to support legislation which will improve the safety and quality of care, and health and wellbeing outcomes, by providing a robust legislative framework for safe and effective staffing that will support the very best practice and drive improvement where needed. At this time it would be helpful to have clarity on the scope, membership and timetable for engagement forums to influence the progress of this legislation, and, in particular, links to the new National Workforce Planning Group. Early engagement across stakeholders as legislation is drafted will be key.

Question 2: Are there other ways in which consistent and appropriate application could be strengthened?

The Bill must address the different levels of planning which impact on any organisation’s ability to provide safe and effective staffing for people using services if consistency in provision over time is to be ensured. These include:

- The inclusion of real time data provision and decision making in existing services to ensure quality and safety at the point of care.
- The use of tools and methodologies to support service planning, particularly given the significant transformation agenda now in play from localities to regional and national services. Plans to resource future services must be based on robust workforce and workload methodologies.
- Duties on the Scottish Government (and in future, other education commissioners) to use robust methodologies from organisations to project future workforce need and commission pre-registration places, as well as post-registration education and training. The RCN is clear that neither organisations nor nursing leaders can guarantee safe staffing for the future if the national supply of nurses and midwives working at all levels is not forecast and resourced robustly.

Linked to this, the Bill will need to be sensitive to the different spheres of responsibility within professional structures around workforce and workload planning. So, for example, in the NHS a Senior Charge Nurse or Community Team Leader holds responsibilities around safe staffing within a given setting on a day to day basis. A nurse member on an Integration Authority board holds responsibilities around providing advice on planning for and resourcing safe nursing staffing across community services. The Executive Nurse Director on an NHS board holds an organisational responsibility for ensuring nursing and midwifery staffing levels. The Bill requires a sophisticated response to ensure professional leaders in each sphere are supported by this legislation to assist organisations to discharge their duties to provide safe and effective staffing.

Given the place of NHS Education for Scotland in and around workforce and their frequent mentions in the new National Health and Social Care Workforce Plan (Part 1), we would welcome further clarity on expectations around their future role in ensuring safe and effective staffing and how duties and powers to effect and support change could be best reflected in primary legislation.

Notwithstanding our question on whether "consistent" application is our ultimate goal, *effective* application of tools will require the following, at a minimum, to be addressed in primary legislation:

- Duties in the Bill are organisational and not placed on individuals.
- Provision is made for a nurse in all relevant ward[1]/theatre/community teams to be appointed by the relevant organisation and supported to: run tools; exercise professional judgement; provide advice on safe and effective staffing; have authority to act to ensure safety of people using the service, and, *in holding this function, to be non-caseload holding*. This is line with the aspirations set out in *Leading Better Care.* The RCN survey explored with nursing staff whether, throughout their whole shift, their Senior Charge Nurse or Community Team Leader was non-caseload holding. In Scotland, the majority reported Senior Charge Nurses and Community Team Leaders were counted in the staffing numbers (i.e. caseload holding), with variance by clinical setting. For example only one quarter of those working in adult acute care reported that the Senior Charge Nurse was not counted in the nursing staffing (i.e. non-caseload holding) throughout their whole shift.
- Provisions are included to set out the organisational duties to support an organisational nursing leader (the Executive Nurse Director in the NHS or the Nurse Member of an Integration Authority for example) to be assured, and provide assurance to the board, on safe and effective staffing levels and to have clear routes to act where safe and effective care as a result of staffing issues is, or could be, compromised. We emphasise that accountability for safe and effective care must be held corporately by the organisation. The RCN thinks there may be merit here in considering what could be learnt from guidance around the statutory role of the Chief Social Work Officer in Scotland (see: http://www.gov.scot/Publications/2016/07/3269).
- Duties are placed on organisations to seek, record and have regard to the advice of professional leaders with workforce and workload planning responsibilities.
- Duties are placed on organisations to provide all information required to those who are responsible for making workforce and workload decisions, as well as providing education and necessary support.
- Provisions are made for workforce and workload planning to be used effectively:
    - In real time,
    - In planning future services, and
    - In commissioning education places for relevant professionals.
- Duties are placed on organisations to run the tools in all wards[1]/theatres/community teams. This would avoid organisations running a specific tool in one ward, for example, and extrapolating results to all other wards in that specialty without acknowledging different contexts.
- Duties are placed on organisations to run tools with the frequency set out by individual tools included in secondary legislation/guidance.

[1] Our definition of a "ward" in this instance includes, for example, individual EDs, critical care areas and outpatient clinics. This list is not exhaustive.

- Duties are placed on organisations to develop, publish and implement risk plans, in a timely manner, in collaboration with staff (including those with workforce planning responsibilities, such as Senior Charge Nurses/Community Team Leaders, and trade union representatives), where there may be a gap between the safe and effective staffing levels required and the ability of the organisation to fund or recruit to those levels.
- Duties are placed on organisations to ensure staff can raise and record concerns, and for the organisation to respond to those concerns in a timely way.
- Duties are placed on organisations to provide frequent governance reporting of safe staffing.
- Provisions are made to develop and implement nationally agreed reporting mechanisms to support benchmarking, improvement and national scrutiny of safe and effective staffing.
- Provisions are made for the Scottish Government to regularly review nationally agreed tools and methodologies in line with emerging evidence and in partnership with professional and trade union organisations.
- NHS Healthcare Improvement Scotland is appointed (in relation to nursing and midwifery provisions in the NHS in the first instance) to publish an annual national overview of safe and effective staffing and provide improvement support where required.

The financial memorandum would need to reflect the impact of these duties on organisations.

Question 3: Our proposal is that requirements should apply to organisations providing health and social care services, and be applicable only in settings and for staff groups where a nationally agreed framework, methodology and tools exist.

3A: Do you agree that the requirements should apply to organisations providing health and social care services?

In principle, yes, the RCN is clear that this legislation should be written in such a way as to permit extension, through future regulation, to other settings and professions beyond NHS-employed nursing and midwifery staff covered by existing tools. The Scottish public should expect care in any setting to be provided with assurance that services have the right numbers of staff, with the right level of skill and competence, to meet their needs safely and effectively. However, we also acknowledge that nursing and midwifery has gone through a long and funded process to reach a place where there is significant support for the development and application of national tools and frameworks for the workforce. And the RCN notes that, even now, application of these tools to determine this specific workforce has yet to guarantee the correct numbers and levels of staff in all areas.

Our experience in the developing integration agenda demonstrates that imposition of one staff group's or sector's norms to others is not a constructive way forward, particularly given the different spheres of democratic and contractual control over services. We would hope that the Scottish Government would first invest in engagement and collaboration to build collective support for development of new tools applicable to other sectors and professions to assure public safety and quality of care. It will also need to adequately fund the development of any new, evidence-based tools and methodologies, before legislation is extended. We will be interested to see how the potential extension to other sectors and professions might be reflected in the financial memorandum to the Bill.

Aspirations for extension will provide some complexity in setting the scope of this Bill effectively now, whilst ensuring it is also future proofed. The RCN understands that, within this consultation response, there are proposals that fit easily within the scope of large NHS organisations, but could have far more significant consequences for other providers, such as small care home providers, in the future.

However, we are also clear that, as major providers of front-line clinical care, constituting the largest proportion of the NHS workforce and with significant impact on the outcomes of service users, this legislation is required now for the nursing and midwifery workforce. The Bill cannot weaken the potential positive impact of this legislation by diluting provisions in order to remain theoretically inclusive for the future.

We ask the Scottish Government to define, *in primary legislation*, that provisions will relate to the nursing and midwifery workforce and NHS functions from enactment, but allow each significant provision to be extended, individually, by Ministers in the future by regulation. We believe this would balance the need for robust legislation now and proportionate extension of relevant sections of the Act in the future as new work is developed and other professions and sectors are engaged. Clarity on this approach from the start would have a significant impact on drafting.

We would hope that statements accompanying the Bill when published would set out some timescales for extension so as not to lose momentum from the task.

3B: Do you agree that the requirements should be applicable in settings and for staff groups where a nationally agreed framework, methodology and tools exist?

Yes – see answer 3A.

Question 4: How should these proposed requirements apply or operate within the context of integration of health and social care?

The RCN is clear that the provisions of this legislation must apply equally to Integration Authorities from commencement, at least in relation to nursing and midwifery staff delivering delegated NHS functions. We appreciate the practical difficulties of separating legislative duties on staffing by sector and profession in light of the integration of health and social care. This is the same dilemma faced by the Scottish Government in attempting to produce a unified health and social care workforce plan. However, the evidence on the impact of nurse staffing on patient outcomes means Scotland should not delay primary legislation which will guarantee safe nursing staffing to the public.

Decisions being made by Integration Authorities are already having a profound effect on the shape of the nursing workforce in many areas as they reconfigure services and/or are making savings in the nursing workforce. They now, in practice, determine nursing numbers and skill mix in the NHS, across all community and significant parts of the acute sectors - though they are not currently employers. This legislation should place equal duties on Integration Authorities and NHS Boards, from the outset, on all elements of ensuring safe and effective staffing in real time services, in planning new and redesigned services and in planning the future workforce. This will include consideration of the role of nursing leaders within both governance and delivery functions of Integration Authorities.

Whilst delivery of integrated care is becoming clearer, with those structures set out in legislation, we are far less clear about the structures, governance and plans of emerging regional approaches emerging in the NHS. The RCN is clear that the legislation must apply

to these new structures too; but without further information on regional approaches it is hard to suggest how this might be best drafted.

Question 5: A triangulated approach to workload and workforce planning is proposed that requires:

- **Consistent and systematic application of nationally agreed professional judgement methodology and review of tools to all areas where current and future workload and workforce tools are available**
- **Consistent and systematic consideration of local context**
- **Consistent and systematic review of quality measures provided by a nationally agreed quality framework which is publicly available as part of a triangulated approach to safe and effective staffing.**

Do you agree with the proposal to use a triangulated approach?

Yes, we agree that triangulation is key and is one way to mitigate the limitation of the Nursing and Midwifery Workforce and Workload Planning tools in providing a single number for the total staffing required for average workload without, for example, identifying the skill mix required to address acuity and demand. Triangulation should support real time workforce decisions to be made far more responsively, given that many workforce and workload tools are run relatively infrequently but acuity, demand and staffing availability (due to sickness for example) change frequently. Of nursing staff in Scotland responding to the RCN survey who said that care was compromised on their last shift, 50% reported that increased patient acuity and/or dependency had impacted on their team's ability to deliver high quality care on their last shift, and two fifths (40%) reported higher patient demand than expected/planned had impacted the ability to deliver high quality care.

However, the wording in the proposals does require some adjustment.

The legislation should not limit professional judgement to the use of a nationally agreed methodology alone, but the RCN acknowledges that professional judgement should be based on clear evidence. We note in other parts of this response the importance of the legislation setting a framework of duties on any relevant organisation to seek, record and respond to the advice of nursing leaders with workforce and workload planning responsibilities. In developing that credible advice nursing leaders with workforce and workload planning responsibilities must be able to use the most up-to-date evidence available to them and which is appropriate to their context. This should include the use of real time data on, for example, acuity, dependency, caseload, available staffing numbers and skill mix, as well as the use of professional guidance from bodies such as the RCN itself.

The RCN is clear that primary legislation should not name specific tools and methodologies as this would severely limit the long-term relevance of the Bill which would not reflect developments in the field. We would expect to see this detail in secondary legislation or statutory guidance.

Bullet point 2 requires much more clarification to ensure that this is not used as an excuse to provide services at staffing levels at ongoing sub-optimal levels because of, for example, financial or recruitment pressures. As noted elsewhere in the response, where context unavoidably results in sub-optimal levels or skill mix in staffing the organisation should be under a duty to prepare a risk plan to manage the difference safely and effectively and address the reasons for the gap within an agreed timescale. In relation to nursing, this plan should be developed with nursing leaders with workforce and workload planning responsibilities and wider staff groups, including partnership representatives. We are also

not quite sure what “local” means in the context of nursing services planning at locality, partnership, board, regional and national levels.

The development of national quality measures for nursing and midwifery are key and we understand that the Cabinet Secretary noted the positive work in this area in Forth Valley at her recent visit when this consultation was launched. Delivery of the Chief Nursing Officer’s Excellence in Care programme is important and it will be essential that all the tools to support sound judgements are available to nursing and midwifery leaders with responsibility for workforce and workload planning for all NHS settings at the point of implementation.

As noted above, it will be important for the principle of triangulation to apply equally to real time service, service planning and student commissioning decisions.

Question 6: Are there other measures to be considered as part of the triangulation approach to workload and workforce planning? If yes, what measures?

See answer to question 5.

Question 7: Given existing staff governance requirements and standards are there sufficient processes and systems in place to allow concerns regarding safe and effective staffing to be raised?

The complexity of the scope of this legislation is again evident in this section of the consultation. Whist the Staff Governance Standard already applies to the NHS, it does not have currency beyond it and, in our experience of working with partners across integrated health and social care, there is resistance to an assumption that the NHS Staff Governance Standard will apply to other sectors. As noted above, it will be important to collaborate with partners to deliver the aspiration of extending the provisions of this legislation.

In addition, given our call for the purpose of this legislation to be focused on ensuring safe, effective, quality care through provision of appropriate staffing, far greater emphasis must be placed on the role of care and clinical governance structures within the legislation to provide appropriate, and equal, oversight from staff and clinical governance perspectives.

The legislation and guidance relating to NHS partnership arrangements will continue to stand and be applicable to workforce planning in the NHS. Nothing in this Bill should undermine existing provisions, including PIN policies. But given experience to date, we suggest that, rather than simply extending these provisions on the assumption of wider acceptance, this Bill sets out bespoke principles for staff engagement, in keeping with the ethos of the Staff Governance Standard and built through dialogue with partners in the drafting of the legislation. We would call, for example, for provisions to ensure that any organisation is under a duty to ensure that staff are able to raise and record concerns in a timely way and that the organisation has a duty to consider these concerns, document their response and act, where appropriate – also in a timely manner.

Question 8: If not, what additional mechanisms would be required?

See question 7.

Question 9: Do you agree with the proposal to require organisations to ensure that professional and operational managers and leaders have appropriate training in workforce planning in accordance with current guidance?

Whilst education to support implementation is a crucial element of any Bill the wording here is not sufficient to ensure that organisations can provide evidence of the competence of those given responsibility for workforce and workload planning, including professional

judgement. This should be reflected in the draft Bill. Implementation of a full education and training programme should also be included in the financial memorandum to the Bill, much as resource was allocated some years ago when the Nursing and Midwifery Workforce and Workload Planning tools were first established.

Question 10: Do you agree with the proposal to require organisations to ensure effective, transparent monitoring and reporting arrangements are in place to provide information on how requirements have been met and to provide organisational assurance that safe and effective staffing is in place, including provision of information for staff, patients and the public?

Yes. We have included our answer to questions 14 and 15 here.

The consultation covers much of what we would expect to see. However, we note that professional leadership in nursing and midwifery is absent from the groups listed here and should be included explicitly. The voice of senior nurses, who have workforce and workload planning responsibilities, in reporting and monitoring safe and effective staffing must be underpinned in the legislation. Again we note the guidance related to the Chief Social Work Officer and their reporting functions. More could be done to learn from this for nursing in relation to safe staffing legislation.

As noted above, the RCN would also like to see equal emphasis placed on the role of care and clinical governance committees and on staff governance committees, given that we wish the Bill to be rooted in issues of safety and quality. We note here that the provisions as included in the consultation document relate only to NHS-focused structures and would need to be revised and re-drafted if the Bill is to remain open to future expansion.

As also noted in earlier answers, the RCN would wish to see a national reporting template developed for nursing and midwifery to allow benchmarking of performance – including quality outcomes and weighted to particular context, such as service user needs or configuration of available space – to direct improvement support effectively. This could build on early work to this end which was not taken forward.

We have also noted a role here for NHS Health Improvement Scotland in providing scrutiny of safe and effective staffing which could build on their inclusion of workforce considerations in the scrutiny of older people's care and in quality of care review proposals for health care services. Further discussions on the best way to reflect these scrutiny functions in the Bill would be welcomed. This would also link to our response to question 16.

Finally we note that there is greater clarity required on how, where and when transparent and accessible information on safe staffing is presented to the public.

Question 11: Do you agree with our proposal to consider extending the requirement to apply nursing and midwifery workload and workforce planning approach to other settings and / or staff groups in the future?

A: If yes, which staff groups / multi-disciplinary teams should be considered?
B: If yes, which other clinical areas / settings should be considered?

This has been answered in other parts of the response. The support of other staff groups and care providers is key.

Question 12: Are there any risks or unintended consequences that could arise as a result of the proposed legislation and potential requirements?

As currently proposed, this Bill risks putting in place legislation that will not improve the staffing available across Scotland to provide safe and effective care through a too narrow focus on technical process. A solution to this would be to rethink the scope of the Bill, as the RCN proposes, to ensure it underpins existing activity in the highest performing organisations, as well as providing support and direction to those requiring improvement around safe care and staffing. The Bill is unlikely to help to improve patient outcomes if it is not designed explicitly to do so. This could be easily remedied in the drafting process.

However, we are also aware of the consequences inherent in the RCN proposals to make this a more robust and effective piece of legislation. In particular:

- NHS Board employers are in very different places in terms of their current nursing staffing provision. Creating a Bill with teeth to ensure patients have access to the right staff in the right place to deliver safe and effective care risks creating a downward spiral for poor-performing organisations if this starting point is not acknowledged. The support available through the financial memorandum for organisations to improve their capacity and capabilities – alongside a clear timetable for enactment – will be key. The Scottish Government must also ensure coherence between this Bill and implementation of the new National Health and Social Care Workforce Plan which is intended to improve recruitment and retention. We appreciate that giving additional investment to organisations with insufficient staffing may be perceived as effectively penalising organisations which *have* chosen to build in numbers, skill mix and ongoing education and development of staff over recent years. However, everything possible must be done to ensure a level playing field in terms of safety and quality across Scotland. The cost of bringing all boards up to par may be significant.
- Many issues affecting staffing numbers are outwith the direct control of commissioning and delivery organisations. For example, determination of national supply and the barriers to employment in some areas (such as high housing prices or lack of work for partners of nursing staff) can hamper the ability of organisations to deliver the numbers indicated through triangulated workforce planning processes. Our proposals address this in part by ensuring the tools will be applied to defining student numbers and (re) designing services. Our proposals (see question 16) regarding the role of NHS Healthcare Improvement Scotland and applying the model of a Section 22 financial report to Parliament for safe staffing, would also call on Scottish Ministers – and others – to be transparent and open to public scrutiny in how they have discharged their responsibilities in ensuring safe, quality care through appropriate staffing. This would avoid all duties and risks being held, unfairly, by NHS bodies, Integration Authorities and, in future, other delivery and commissioning organisations. This leads to another point:
- There is a risk – and a fear among nursing staff – that this Bill could place accountabilities on nursing leaders who may not hold the power and authority to effect change. The RCN is clear that our members cannot be exposed to such risks, which would not only be unfair, but could also impact on their Nursing and Midwifery Council registration. We have made a number of proposals to address this. Accountabilities for delivering safe and effective staffing must be organisational. The Bill must reflect different spheres of influence of professional leadership at different levels (with lessons from the role of the Chief Social Work Officer considered in this context). And the Bill should ensure that Senior Charge Nurses/Community Team Leaders are non-case holding as well as ensuring organisations provide them with the education and support they require.

- If the Bill focuses on nursing and midwifery staff and the NHS only from the outset it risks skewing resources for multi-disciplinary, multi-agency teams – particularly in these times of austerity and rising demand. However, the Bill cannot set undeliverable duties on organisations or professions who may not yet have robust workforce tools .Our proposals to name nursing, midwifery and organisations commissioning/delivering NHS functions on the face of the Bill – and ensuring the Bill is drafted to permit future regulation to expand its scope – would create an appropriate balance, as would ensuring the publication of the Bill is accompanied by a timetable for expansion developed with relevant stakeholders.
- This is a changing landscape as new international evidence and decision-making support tools are being constantly developed. There is a risk that, by focusing on current tools, this legislation preserves current methodologies in aspic, which will not serve Scotland well in the long term. This risk could be reduced by not naming tools or methodologies in primary legislation but detailing this through regulation and/or formal statutory guidance; by including duties on Scottish Government to review national tools regularly in line with emerging evidence and in partnership with professional and trade union organisations; and by ensuring that professional judgement decision support is not limited to any single evidence source, methodology or tool.

Question 13: What steps could be taken to deal with these consequences?

See answer to question 12.

Question 14: Do you agree with the proposals to use existing performance and monitoring processes to ensure compliance with the legislative duty and associated requirements?

See answer to question 10.

Question 15: in what other ways could organisations' progress in meeting requirements be monitored?

See answer to question 10.

Question 16: What should the consequences be if organisations do not comply with requirements?

The RCN has been clear that this Bill must have teeth. Scotland has had a legal 12 week treatment time guarantee for some time but this did not stop more than half of all boards failing to deliver this in 2015-16 without any significant consequences. This Bill, with a clear link to ensuring public safety, must do more. However, the RCN is not advocating that punitive consequences – such as financial penalties – are included, as this would simply encourage a downward spiral for those organisations who have not complied.

Instead we would encourage the Scottish Government to consider the Section 22 arrangements for financial performance as a model, with duties placed on NHS Healthcare Improvement Scotland in the first instance (and other regulators/inspection agencies as the legislative scope is expanded in future) to raise concerns in similar ways to the Auditor General through an annual review process. Such an approach would give the Scottish Parliament the information to scrutinise failures to provide safe staffing and ensure that both commissioning/delivery organisations and those setting the context in which they work, such as Scottish Government, can be called to account publicly for failures in safe and effective staffing.

Question 17: Do you anticipate any of the proposed options outlined in this consultations will have a direct or indirect, positive or negative impact on any protected equality characteristics?

Yes. Many of those with protected characteristics – particularly age, disability, pregnancy and maternity – are likely to be frequent users of NHS services and a Bill configured as the RCN is proposing would guarantee to service users both the levels and skill mix of nursing required to meet their particular healthcare needs. The RCN believes this would promote improved equity of outcome.

However, the RCN is concerned that an unintended consequence of this legislation could be a downward pressure on requests for flexible working from women who are pregnant or have caring responsibilities (particularly as the majority of nursing staff are female) given that employers are permitted to refuse requests for flexible working on the following grounds:

- An inability to reorganise work amongst existing staff
- A detrimental impact on quality
- A detrimental effect on ability to meet customer demand

The RCN would expect this to be monitored to ensure equity in access to flexible working once any Act is implemented.

If you require any further information on this response please contact Rachel Cackett, Policy Adviser at Rachel.Cackett@rcn.org.uk or on 0131 662 6180.

The Royal College of Nursing
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