

Response to Health & Sport Committee Call for Evidence on the Health and Care (Staffing) (Scotland) Bill

About the Scottish Partnership for Palliative Care (SPPC)

The Scottish Partnership for Palliative Care (SPPC) brings together health and social care professionals from hospitals, social care services, primary care, hospices and other charities, to find ways of improving people's experiences of declining health, death, dying and bereavement. We also work to enable communities and individuals to support each other through the hard times which can come with death, dying and bereavement.

Sometimes our field is described as "palliative care" but depending on what people understand by this term, this language can cause confusion. One way of thinking about "palliative care" is to talk in terms of providing "good care" to people whose health is in irreversible decline or whose lives are coming to an inevitable close. However, the work of the SPPC is not synonymous with death – it is about life, about the care of someone who is alive, someone who still has hours, days, months, or years remaining in their life, and about optimising wellbeing in those circumstances.

SPPC was founded 26 years ago and has grown to be a collaboration of over 100 organisations involved in providing care towards the end of life. SPPC's membership includes all the territorial NHS Boards, Integration Authorities, all the hospices, a range of professional associations, many national charities, local authorities, social care providers and universities.

Introduction

Death, dying and bereavement comprise a large part of the work of Scotland's health and care system. Around 56,000 people die annually in Scotland. Of these it is estimated that as many as 46,000 people will have needs arising from living with deteriorating health for years, months or weeks before they die. **Death in hospitals:** 29% of all acute bed days are used by patients in their last year of life. Nearly 1 in 10 of patients in hospital will die during their current admission and 54% of deaths take place in hospital. **Death in care homes:** 33 000 older people live in a care home, their median length of stay is less than 18 months, over 60% have dementia and over 11 000 die each year. **Death in homes:** In 2013 63 000 people aged over 65 received care at home services. **Babies, children and young people:** There are growing numbers of babies, children and young people living with life limiting conditions. **Economics:** Health and care expenditure rises sharply towards the end of life.

"Safety" and "avoiding harm" are both concepts which should be applied even when declining health and death are inevitable. Untreated symptoms and purposeless distressing interventions are avoidable harms at the end of life. Another avoidable harm occurs when relatives are not told by staff that their loved one is so ill that they may die, and so chances to say "thank you" or "I love you" may be lost. How someone dies lives on in those who are left behind.

Much of the work involved in providing palliative and end of life care is relational rather than task-focused: taking time to listen to and engage with someone's hope, fears and regrets; holding someone's hand; being present with a bereaved relative. Approaches to workforce planning need to take this into account the time required to meet such psycho-social and spiritual needs, giving them equal weight alongside meeting physical needs.

SPPC welcomes the good intent of the Bill and the fundamental importance of adequate staffing levels. SPC acknowledges the complexity of legislating in this area given the ambition to create a framework spanning diverse settings, multiple professions, integrated services and team working when evidence-based approaches to workforce planning of this type are not well developed.

- **Do you think that the Bill will achieve its policy objectives?**

The Bill contains a variety of policy objectives. The overarching policy objective of enabling safe high quality care and improved outcomes for service users can't be achieved by the Bill on its own.

The subsidiary policy objective of ensuring appropriate staffing ("the right people, in the right place, with the right skills at the right time") also can't be achieved by the Bill on its own.

The objective "to enable a rigorous, evidence-based approach to decision-making relating to staffing requirements that ensures appropriate staffing for the delivery of safe and effective care, which takes account of service user health and care needs and promotes a safe environment for both service users and staff" can be promoted through the Bill.

Other factors (affordability, national workforce planning, labour market impacts on recruitment and retention) will be very important in determining whether NHS Boards and care providers are able to implement required staffing levels. These factors are largely outwith the control of service providers.

What are the key strengths of:

- **Part 2 of the Bill? (Staffing in the NHS)**

SPPC welcomes the multi-faceted approach of general duty, guiding principles and the development/application of specific evidence-based tools. SPPC welcomes the requirement to consider staff and patient views, and to inform staff of decisions.

- **Part 3 of the Bill? (Staffing in Care Services)**

SPPC welcomes the intention to develop approaches to workforce planning in care homes in an inclusive way, working closely with stakeholders. The approach needs to be flexible and the outputs useable by a range of providers.

- **What are the key weaknesses of:**

- **Part 2 of the Bill? (Staffing in the NHS)**

It is not entirely clear from the Bill or Policy Memorandum how the duties created by the Bill apply to hospices and the services they provide. Amongst their broad range of provision hospices provide several healthcare services of the types listed in the schedule at 121c of the Bill (the schedule of types of healthcare where the Bill proposes the application of a common method). However, the

locations listed in the same table do not clearly equate to hospices. In addition, there should not be a blanket assumption that tools developed for use in NHS contexts can necessarily be applied without adaption to other types of setting.

- **Part 3 of the Bill? (Staffing in Care Services)**
- **Is there anything that you would change in the Bill?**
- **What differences, not covered above, might the Bill make? (for example: will the Bill have any unintended consequences, will it ensure that staffing levels are safe, does the Bill take account of health and social care integration, how are 'safe and high-quality services' assured/guaranteed by the Bill?)**

There is a risk of unanticipated and unintended consequences. Although the Bill covers all settings through its general duty and guiding principles, it appears that there will be a different approach to areas where there are specific tools available, and a differing approach to health services and care services. It is difficult to predict how this may play out, and a risk of scarce workforce resources becoming skewed to particular settings or specialities in response to the requirements of the Bill rather than in response to service priorities.

It is not clear how the duty placed on commissioning authorities when commissioning to have regard to the duties and principles placed on care service providers will impact in practice when commissioners are trying to achieve a balance of quality, safety and affordability.

Part of the rationale for the Bill is to provide assurance to staff and public. As noted, key factors relating to adequate workforce are largely outwith the control of NHS Boards and care providers. In the event of service reduction (where workforce requirements can't be met) there is a risk that this is perceived as a failure of local workforce planning (with associated harm to trust and confidence in provider organisations) rather than as a consequence of complex interplay between labour market and/or affordability issues.

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