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**Safe and Effective Staffing Legislation in Northern Ireland Consultation**

Response from BMA Northern Ireland

**Introduction**

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

BMA Northern Ireland is grateful for the opportunity to provide views on the development of safe and effective staffing legislation, and have been pleased to contribute to some of the pre-consultation engagement in this issue.

We would note at the outset that the consultation document could more clearly outline how protections for health and social care workers will be strengthened, enabling them to report any concerns with staffing levels and patient safety without fear of detriment or sanction. BMA Northern Ireland believes that that safe staffing legislation should provide a clear and accessible route for formally escalating concerns to management and ensuring ministerial, commissioner and employer accountability is transparent. We would want to see employers take clinical advice on the safety of a service when staffing levels are deemed to be too low and patient and staff wellbeing is consequently at risk.

We acknowledge that existing processes such as whistleblowing and regulatory complaints are already available. However, in developing legislation on safe staffing, it will be important to consider what additional support can be provided to ensure staff feel they can raise concerns openly and freely in the interest of supporting HSC organisation to adhere to new duties and to improve patient care.

**Guiding principles**

1) Do you agree with the proposal to introduce legislative guiding principles for staffing in Health and Social Care in Northern Ireland?

2) Do you agree with the proposal that the guiding principles will apply when the provision of services is being sought or secured from outside of directly provided health and social care services, e.g. from the independent sector or community and voluntary sector?

3) Are there any additional considerations that should be included?

BMA Northern Ireland is supportive of the proposal to adopt safe staffing principles for health and social care. This is consistent with similar legislation in place already within the UK and will enable the Department of Health to articulate the key elements underpinning its vision of safe and effective staffing.

We note and agree with the principles set out by the RCN in its *Staffing for Safe and Effective Care in the UK[[1]](#footnote-2)*which include:

* Accountability – we want it to be clear whose job it is to be responsible for making sure there are enough health and care staff to safely meet patients’ needs.
* Numbers – we want the right number of staff, with the right skills, to be in the right place, at the right time – so that patients’ needs are safely met.
* Strategy – we want a vision for each nation to tackle shortages and make sure health and care staffing safely meets the needs of the whole of the UK.
* Plans – we want clear plans for getting the right numbers and skill mix of health and care staff, now and in the future, and we want frequent progress checks to make sure this actually happens.
* Education – we want governments to educate enough health and care students, and develop existing staff, to safely meet patients’ needs.

These principles can be broadly applied across the range of health and care professions, including doctors.

**Workforce Planning**

4) Do you agree with the proposal to introduce a legal requirement on the Department of Health to apply evidence-based strategic workforce planning?

5) Do you agree that Health and Social Care Trusts and health agencies should have a legal requirement to undertake operational workforce planning?

BMA Northern Ireland strongly believes that a more detailed and evidence-based approach to workforce planning is desperately needed. We have repeatedly called for improved medical workforce planning to ensure there are enough doctors to provide high quality and safe patient care. Therefore, legal duties on the Department of Health and HSC Trusts that require them to undertake this work is to be welcomed.

There are a number of key issues we would urge be factored into future workforce planning activity. Firstly, BMA Northern Ireland believes that the workforce data currently captured, such as ‘active recruitment’ in secondary care, is not useful in identifying rota gaps and areas or specialities where recruitment issues exist. To understand where workforce gaps exist, a much more thorough analysis is required, which needs to include more than just roles where there is an active recruitment exercise. This should include:

* any newly-created posts which have not yet been advertised;
* any vacant posts which are awaiting approval for recruitment or are on hold by managers;
* any posts which although currently unfilled are not under active recruitment, e.g. where a previous recruitment exercise has been unsuccessful;
* all posts occupied by a locums or temporary staff, and;
* posts that have been recruited to but applicant not yet in post.

BMA Northern Ireland requested this information, in relation to SAS doctors and consultants from all HSC Trusts in September 2023. The responses found that, whilst the Department of Health recorded a vacancy rate of 7.6%, when the above factors are taken into consideration, over 20% of consultant posts were vacant or only temporarily filled. This clearly represents a flaw in the way that current workforce data is captured and published, and makes effective workforce planning impossible.

We note other gaps across the workforce, with the Department of Health’s evidence to the Review Body on Doctors’ and Dentists’ Remuneration (DDRB) for 24-25[[2]](#footnote-3) citing a reduction of 33 GP practices since 2014, and a reduction in WTE GPs, active GPs and GP Principles at the same time as increasing patient numbers and growing average list sizes.

The Department’s DDRB evidence also notes the increasing impact of Sláintecare on the secondary care workforce, particularly in the Western and Southern Trusts, as well as the concerning loss of Northern Ireland medical students to training programmes in the Republic of Ireland and the rest of the UK.

As well as medical capacity, patient demand is also a vital consideration. It’s important to plan services that account for the needs of the population now and into the future, ensuring demand is matched by required NHS capacity. However, it’s unclear what work is being routinely undertaken to understand what the needs of the population will be over the short- and long-term, or what the workforce profile will need to be to meet those needs.

Understanding and addressing these issues is crucial to realising the ambition of a health and care service that can deliver the right healthcare, in the right place at the right time, and do so on a sustainable footing. We would suggest that there is independent analysis of the demand and capacity modelling used to inform any workforce plans developed to ensure data and assumptions are tested and reliable. It must also look at medical specialties as opposed to the number of doctors in the round, to ensure that there is sufficient capacity within all areas of medicine. All of this work should heavily influence the workforce planning requirements on the Department and HSC organisations.

6) Do you agree that there should be a legislative requirement on the Department of Health to carry out workforce reviews every 10 years and conduct interim evaluations every 3 years?

7) Do you agree with the proposal to place a legislative duty on the Department of Health to take all reasonable steps to ensure implementation of workforce reviews?

8) Do you agree with the proposal that an annual duty is placed upon the Minister to review the commissioning of healthcare preregistration training places by the Department?

BMA Northern Ireland agrees with the need for workforce reviews and ongoing monitoring and evaluation. However, 10 years between reviews is too long both in terms of inevitable changes in population health, staffing demand and supply of staffing over a decade. The Department must be responsive to the needs of the population and the changing profile of the workforce and could therefore consider more regular reviews, for example, every two years.

In any case, it’s vital that workforce planning and reviews must be fully integrated with existing processes, for example, workforce planning requirements under this proposed legislation must align with any other workforce plans, including the Health and Social Care Workforce Strategy 2026[[3]](#footnote-4) as well as any other specialty specific strategies. That said, we are not convinced that the existing strategy is fit for purpose and it is in need of a significant update to meet and address the current challenges facing the HSC workforce – and this must include clear and measurable objectives, timescales and accountability mechanisms.

We note that the consultation document refers to the introduction of ‘new supporting roles’ as means of workforce development*.* BMA Northern Ireland would urge caution in the use of such roles, including the range of Medical Associate Professions (MAPs), given significant concerns raised by the medical profession[[4]](#footnote-5).

The NHS Long-term Workforce Plan[[5]](#footnote-6) in England provides for a rapid increase of MAPs, despite these roles not currently being regulated or working to a defined scope of practice. We note that whilst expansion of MAPs in Northern Ireland has been slower, our concerns about these roles, including on patient safety, public confusion and the impact on the training of doctors, are equally applicable. In the context of safe staffing levels, there are many instances where care should only be provided by a medically qualified doctor. BMA Northern Ireland is clear that any workforce planning requirements must recognise the clear distinction between these professions and be explicit about their individual scopes of practice.

Workforce planning, if done effectively can help to reduce administrative bureaucracy and ensure that doctors do what only doctors can do, by identifying work currently undertaken by doctors that can be done by other staff, for example, note chasing, investigation chasing and ensuring IT glitches are quickly rectified. This involves clearly defining the scope of practice of other HSC professions, so that boundaries are not blurred, and medical-clinical supervision arrangements are clear.

BMA Northern Ireland agrees that a duty to ensure implementation of reviews would be a necessary safeguard, as is the proposed Ministerial duty to review commissioning of healthcare preregistration training places. However, it’s crucial that exercise of these duties is adequately informed by accurate data and forward planning. For example, simply increasing medical school places may be seen as the first step to growing the medical school workforce in the longer term, but if any growth isn’t accompanied by the requisite number of foundation training places and an increase in training and supervision capacity for senior doctors, then graduates will be forced out of Northern Ireland in search of work opportunities.

**Common Staffing Method**

9) Do you agree with the proposal that a statutory duty be placed on the Department of Health and Health and Social Care Trusts to utilise a common staffing calculation tool for nursing and midwifery?

10) Do you agree with the proposal that a statutory duty is placed on the Department of Health and Health and Social Care Trusts to utilise a common staffing method for nursing, midwifery and social work?

11) Do you agree with the proposal that a statutory requirement is placed on the Department of Health to consider the use of a common staffing method and staffing calculation tool for Allied Health Professionals, Dentistry, Pharmacy and Social Care within 1 year of the legislation coming into operation, and if determined applicable, should develop and utilise these within 3 years of the legislation coming into operation?

12) Do you feel that the Department should have a statutory duty placed on it to utilise common staffing methods across the full range of social care settings including, but not limited to, nursing and care homes, residential homes, respite care, day centres and day opportunities, and domiciliary care services provided both by statutory services and by the independent sector?

13) Are there any areas where you consider it not to be appropriate to develop common calculation methods or tools?

14) Do you agree with the proposal to place a statutory duty on the Department to consult with relevant trade unions and professional bodies when developing common staffing methods across the full range of professional disciplines?

BMA Northern Ireland notes the proposals for developing and implementing common staffing methods for the professions outlined. We are broadly supportive of an ambition to ensure safe and effective staffing levels across the range of health and care environments, while recognising that specific consideration will need to be given to each profession.

We would however wish to see swifter process in the development of staffing tools to ensure safe medical staffing levels are maintained in Northern Ireland. The proposals to engage with trade unions is welcome, however, there is no specific commitment to medical staffing levels in the proposals presented which is a concern. We would urge the Department to set a clear timetable for the application of safe staffing requirements to the medical profession.

Whilst we recognise that there are comparatively fewer established medical staffing methodologies, as compared with other professions such as nursing, there are existing frameworks which act as a foundation for further development. For example, the Royal College of Emergency Medicine (RCEM) published its workforce recommendations for Consultant Staffing in Emergency Departments in the UK[[6]](#footnote-7). This paper outlined the model of senior care delivery and supervision required in emergency departments in order to meet the standards of safety, consistent quality in emergency care and sustainable working practices for Consultants.

We are aware of further work on safe medical staffing undertaken by the Royal College of Physicians[[7]](#footnote-8), as well as ongoing developments to the Scottish common staffing method to include doctors in some environments. These will inevitably help to inform developments in Northern Ireland, and we would wish to see rapid progress in ensuring safe medical staffing requirements are introduced.

Similarly, in general practice, the BMA has recommended a safe level of patient contacts per day (in England) in order for a GP to deliver safe care at not more than 25 contacts per day. The BMA has further recommended that consultations are typically 15 minutes in length and that no more than 3 hours out of 4 hours 10 min session should be spent consulting[[8]](#footnote-9). Equivalent recommendations for safe staffing levels could be developed in Northern Ireland.

Of course, it must be noted that the Department of Health already provides HSC Trusts with funding to directly manage GP Practices where an alternative contractor can’t be found. It would seem, therefore, that in commissioning Trusts to directly manage GP practices, the Department must have a clear outline of how much funding and support a practice requires to deliver safe and effective care. Such information would be useful in developing safe staffing models for general practice. Indeed, BMA Northern Ireland has requested such information from the Department of Health but it has not been provided.

15) Do you agree with the proposal to place a statutory duty on all providers of public health and social care services in Northern Ireland to take all reasonable steps to always ensure that suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for –

* the health, wellbeing, and safety of patients,
* the provision of safe and high-quality health care, and
* in so far as it affects either of those matters, the wellbeing of staff?

16) Do you agree with the proposal to place a statutory duty on the Department of Health and Health and Social Care Trusts to take all reasonable steps to ensure there are sufficient numbers of –

* registered nurses,
* registered midwives,
* allied health professionals,
* social workers,
* registered care workers,
* dentists,
* pharmacists,
* medical practitioners, and
* any professional disciplines set out in Appendix 2?

BMA Northern Ireland agrees with the premise of these duties, however we are clear that there should be no such duties on GP partners in relation to their surgeries. It would be unreasonable for these duties to extent to GPs in this context given they have no ability to influence the wider factors, such as education and training places, financial restrictions and policy decisions, that inform the availability of health and care professionals in their area.

We note that the proposals refer to ‘actual funding’ as a consideration in developing and implementing safe staffing models. BMA Northern Ireland would strongly push back on inclusion of this as a consideration in this way. Available funding is of course a limiting factor on what an organisation is able to do, however, it shouldn’t be a consideration in determining the safety of running a service. Cost should be taken out of any decisions about what constitutes safe staffing levels. If an organisation can’t provide a safe level of staffing because of funding constraints, then it would be reckless to run the service at all.

The proposed duty on the Department of Health and Health and Social Care Trusts to ensure ‘sufficient numbers’ of different health and care professions is important, however, we would welcome further detail on how such sufficiency will be assessed. As referenced earlier, this must be at an appropriate level of detail, including individual medical specialties, rather than just doctors in the round.

 **Reporting and Monitoring**

17) Do you agree with the proposal that a statutory duty be placed on reporting arrangements for the Department of Health, Health and Social Care Trusts and relevant employers?

18) Do you agree with annual reporting on compliance with the responsibilities outlined within the legislation? If not annually, what would be your preferred reporting cycle?

19) Do you agree with the proposal to place a statutory duty on Health & Social Care Trusts and health care providers to –

* Have real-time staffing assessment of compliance with the proposed duty to have appropriate numbers of staff in place;
* Have a risk escalation process in place; and
* Ensure appropriate staff training is in place?

20) Do you agree with the proposal that a statutory duty is placed on social care service providers that have been procured by the Health & Social Care Trusts to have real-time staffing assessment and risk escalation processes in place?

21) Do you agree with the proposal that the primary legislation will provide powers to make further regulations?

BMA Northern Ireland agrees that the monitoring and reporting arrangement proposed are broadly proportionate, although more detail would be welcome on what this would look like in practice. For example, a regional approach would ensure consistency across different HSC organisations, and so template monitoring reports using comparable data sets would be important.

Similarly, despite the consultation document acknowledging that prior stakeholder engagement recognised the desire to have a clear reporting structure from front line staff up to Ministers and the NI Assembly, the proposals don’t make clear how this would operate. For example, consistent with legislation in other UK jurisdictions, we would expect the Department of Health to lay safe staffing reports before the Assembly annually for scrutiny.

Again, BMA Northern Ireland would stress that and additional reporting arrangements on GP practices would be a matter for negotiation with NIGPC through the regular mechanisms. GPs do not have the resources of HSC trusts to fulfil stringent monitoring requirements over and above those they are already obliged to undertake. Any increase in such duties has a consequential impact on direct patient care.

1. RCN (2020) *Staffing for Safe and Effective Care in the UK*: <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2020/january/008-067.pdf> [↑](#footnote-ref-2)
2. Department of Health (2024) *Department of Health Northern Ireland Evidence the Review Body on Doctors’ and Dentists’ Remuneration*: <https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-ni-evidence-ddrb-24-25.pdf> [↑](#footnote-ref-3)
3. Department of Health (2018) *Health and Social Care Workforce Strategy 2026*: <https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026> [↑](#footnote-ref-4)
4. BMA (2024) *Medical associate professions (MAPs):* <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/medical-associate-professions-maps> [↑](#footnote-ref-5)
5. NHS England (2023) *NHS Long Term Workforce Plan* <https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/> [↑](#footnote-ref-6)
6. RCEM (2018) *RCEM Workforce Recommendations 2018 - Consultant Staffing*

*in Emergency Departments in the UK:* <https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Consultant_Workforce_Document_Feb_2019.pdf> [↑](#footnote-ref-7)
7. RCP (2018) *Guidance on safe medical staffing:* [*https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/guidance-on-safe-medical-staffing*](https://www.rcp.ac.uk/policy-and-campaigns/policy-documents/guidance-on-safe-medical-staffing) [↑](#footnote-ref-8)
8. BMA (2024) *Safe working guidance in general practice in England – a summary:* <https://www.bma.org.uk/media/xn5onwjy/bma-safe-working-in-general-practice-a-summary-england.pdf> [↑](#footnote-ref-9)