EQUALITY IMPACT ASSESSMENT: RESULTS

Title of Policy	Health and Care (Staffing) (Scotland) Bill
Summary of aims and desired outcomes of Policy	The aim of the Health and Care (Staffing) (Scotland) Bill is to help ensure improved outcomes for service users by putting in place a framework to support appropriate staffing for high quality care. Provision of high quality care requires the right people, in the right place, with the right skills at the right time to ensure the best health and care outcomes for service users and people experiencing care. The Bill will support the profession led development of evidence based approaches to workload planning that has been successful for nursing and midwifery to be shared across health and social care. Staffing tools and methodologies developed in this way will support local decision-making, flexibility and the ability to redesign and innovate in other health and care settings. The Bill creates a coherent overall legislative framework for appropriate staffing across the health and care services landscape by setting out a requirement on Health Boards and organisations providing care services (those care services registered with and inspected by the Care Inspectorate) to consider staffing requirements according to a set of principles. The Bill provides the legislative framework which will support decision making relating to staffing requirements. This framework puts the existing Nursing and Midwifery Workload Workforce Planning tools and methodology on a statutory footing and supports the creation of new tools in health care settings and adult care homes in care settings. The Bill will require NHS Boards and care services to apply a general duty utilising a set of principles to do this. Where staffing tools and methodologies currently exist in Scotland (i.e. in nursing and midwifery) further requirements to ensure evidence-based, transparent decision making about staffing requirements will apply. The Care Inspectorate, in collaboration with organisations they consider to be representative of the providers and users of adult care homes, will be given the ability to

	decide locally with service providers where new tools are required in different service areas or staff groups, and to use that in making recommendations to the Scottish Ministers.
Directors: Division: Team	Chief Nursing Officer's Directorate, Nursing and Midwifery Policy Unit

Executive Summary

1. The public sector equality duty requires the Scottish Government to assess the impact of applying a proposed new or revised policy or practice. It is a legislative requirement. More importantly, however, most policies impact on people. People are not all the same and policies should reflect that different people have different needs. Equality legislation covers the protected characteristics of: age, disability, gender reassignment, sex, pregnancy and maternity, gender including pregnancy and maternity, race, religion and belief, and sexual orientation.

2. This Equality Impact Assessment (EQIA) has considered the potential impacts of the Bill on each of the protected characteristics. The provisions and how they impact across the protected characteristics are set out under Key Findings.

3. The EQIA has not identified any Bill provisions that would adversely impact on such groups. The evidence gathered and data analysed indicate that overall the Bill provisions will have a positive impact as the provision of appropriate staffing will help ensure quality of care across health and care settings, meeting each person's needs. It will also promote a safe working environment for staff and ensure staffing decisions take account of contextual factors. As a result, it is not considered that any changes to the provisions should be made as a result of the assessment.

Background

Policy Aims

4. The link between safe and sustainable staffing levels and the delivery of high quality care in health is well established. There is growing research evidence detailing the clear link between nursing and midwifery staffing and patient outcomes (including mortality and morbidity rates, patient safety, patient experience and other quality of care measures) staff experience and morale; and the efficiency of care delivery.[1] [2] [3] [4]

[1] http://www.journalofnursingstudies.com/article/S0020-7489(06)00244-6/abstract?cc=y
[2] http://www.rwjf.org/en/library/articles-and-news/2014/04/building-the-case-for-more-highly-educated-nurses.html
[3] http://www.safestaffing.org.uk/downloads/hospital-nurse-staffing-and-patient-mortality-nurse-burnout-and-job-dissatisfaction
[4] http://www.safestaffing.org.uk/downloads/nurse-staffing-and-inpatient-hospital-mortality

5. As a result of the 2002 report Planning Ward Nursing Legacy or Design[5], the Scottish Executive Nurse Directors (SEND) group commissioned the Nursing and Midwifery Workload and Workforce Planning Programme (NMWWPP) in 2004. Its aims were to develop a nationally validated, fit for purpose approach to measuring nursing and midwifery workload and providing information on staffing establishments required for workload. There is now a suit of 12 workload tools covering 98% of all clinical service areas.

6. In December 2012 the application of available nursing and midwifery workload and workforce planning tools was mandated in NHS Boards as part of the Local Delivery Planning.

7. The Government's Programme for Scotland 2017-18, a Nation with Ambition, published on 7 September 2017, committed to introduce a Safe Staffing Bill to enshrine NHS staffing in law, starting with nursing and midwifery. The key driver for the legislation is the increasing evidence of the link between appropriate staffing and high quality care.

8. The policy intention of the Scottish Ministers is to enable a rigorous, evidence based approach to decision making relating to staffing requirements that ensures safe and effective staffing, takes account of service users' health and care needs and professional judgement, and promotes a safe environment for service users and staff.

9. The Bill will enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice across Scotland; and will support consideration of service delivery models and service redesign.

10. It will support an open and honest culture with the aim that all staff are engaged in relevant processes and informed about decisions relating to staffing requirements and feel safe to raise any concerns about staffing levels.

11. As integration of health and social care progresses it is more important to facilitate multi-disciplinary and multi-agency working across a range of professionals and staff groups. It is also important to ensure that robust evidence is available to support decisions about staffing requirements if and when services are redesigned across multi-disciplinary or multi-agency teams.

12. To support and enable the Scottish Government's ambition to deliver integrated workforce planning and appropriate staffing across health and care services, the Bill will span the health and care service landscape in an appropriate and proportionate way.

13. This Bill builds on existing measures to ensure safe and high quality care and to support and sustain the health and care workforce and takes a further important step by creating a coherent legislative framework regarding appropriate staffing across health and care services.

[5] http://www.audit-scotland.gov.uk/docs/health/2002/nr_021212_ward_nursing.pdf

14. The legislation does not intend to set out or prescribe minimum staffing levels or fixed ratios; this would be at odds with our established policy approach and would and could potentially undermine innovation in service provision. Rather, the legislation will support local decision-making, flexibility and the ability to redesign and innovate across multi-disciplinary and multi-agency settings.

15. It is also not the intention to prescribe approaches to workload and workforce planning, in terms of development of the tools for the care sector on the face of the Bill. The ambition is to enable the further development of suitable approaches by and for the sector where this is considered appropriate and in collaboration with the sector. If and when a tool is developed, the methodology agreed during the tool development process will be prescribed by the Scottish Ministers to ensure consistent application across the sector.

16. Meeting the objectives of this Bill will provide assurance, including for staff and service users, that appropriate staffing is in place to enable the provision of high quality care, irrespective of health or care service setting. The case for the Bill is set out fully in the Policy Memorandum published alongside the Bill on its introduction to the Scottish Parliament on 23 May 2018.

17. The Bill will contribute significantly to the delivery of the Quality Ambitions: safe, person-centred and effective care and to the triple aim by ensuring that there are enough staff with the right skills in the right place to ensure reliable delivery of care to the people we serve every time reducing harm and variation and prevent costs associated with harm. The underpinning principles and key deliverables required when using the tools will support service redesign and transformation based around the needs of the service user.

18. In order to achieve this purpose, Scottish Ministers are committed to the outcomes based approach as set out in the National Performance Framework's 10 year vision. This is a single framework to which all public services in Scotland are aligned, encouraging more effective partnership working. It is a framework based on delivering outcomes that improve the quality of life for people in Scotland, rather than on inputs and outputs.

19. The Bill’s provisions closely align with the Healthier and Wealthier & Fairer Strategic Objectives.

20. The Bill contributes to the following National Outcomes:

- We live longer, healthier lives;
- We have tackled the significant inequalities in Scottish society;
- We live in well-designed, sustainable places where we are able to access the amenities and services we need;
- Our public services are high quality, continually improving, efficient and responsive to local people’s needs.

Who was involved in this EQIA?

21. The Bill has been developed involving colleagues from within the Scottish Government and with external stakeholders.

22. We have consulted twice on proposals around Bill proposals. A public consultation was held between April and July last year, with a further, month long engagement exercise on refreshed legislative proposals during January/February this year.

23. The proposals in the initial consultation asked a question on whether any of the proposed options outlined would have a direct or indirect positive or negative impact on any protected equality characteristic. It also included a Partial Business and Regulatory Impact Assessment.

24. The responses to the consultation indicated that almost all stakeholders were broadly supportive of all, some or a few of the Bill proposals.

25. The majority of those answering the question did not anticipate any of the proposed options outlined in this consultation will have a direct or indirect positive or negative impact of any protected equality characteristics. The majority of the individuals and organisational respondents did not expect the proposals to impact on any protected equality characteristic. However, the majority of Professional college, body, group or union responded did expect the proposals to have an impact.

26. For those who thought there would be an impact, comments included:

- Women, because they make up such a significant proportion of the affected workforces. It was suggested that the impact could be positive or negative depending on whether staffing is increased or decreased and grades increased or decreased.

- Pregnant women, if midwifery services are affected or if there is downward pressure on requests for flexible working from women who are pregnant or have caring responsibilities.

- Older people and people with a disability could be affected positively if staffing levels increase.

- Children and adults with Down's Syndrome and their families. It was felt that, provided implementation is monitored and action taken when agencies fail to comply, the proposals will improve quality of life. However, it was also suggested that greater attention should be given to training to ensure that the proposed options have a positive impact on expectant or new parents and people with Down's Syndrome. The particular issues raised were around the terminology used by some healthcare professionals and experiences of ante/post-natal care.

27. In addition to the formal consultation process, the Bill Team ran and participated in a programme of Scottish Government and stakeholder arranged engagement events, during which stakeholders had the opportunity to express views about possible Bill provisions and identify areas of particular challenge in relation to protected characteristic groups. Almost all those who participated did not expect that any of the proposals would impact on any protected equality characteristic.

28. The Scottish Government has also published the responses to the two Bill consultations [6] [7]. These set out a summary of consultation views and shows how those views have informed policy development and Bill provisions.

Scope of the EQIA

29. The scope of this EQIA is the impact of the Bill on one or more protected characteristics.

30. Although the general duty to ensure appropriate staffing will apply to Health Boards and care service providers (those care service providers who are registered with the Care Inspectorate) and apply to all staff providing care, the more specific requirements to use a common staffing method will only apply where staffing tools have been developed. At this point in time this will only apply to nurses and midwives, and to nurses and clinicians in the case of emergency care. Should these requirements be later applied to wider workforce groups, i.e Allied Health professionals, Doctors etc, further impact analysis will be required.

Data sources

31. A variety of information sources were used in compiling this EQIA, which includes, but is not exclusive of :

- Scottish Health Survey 2015
- Scotland's Census 2011
- Inpatient Experience Survey 2016
- ISD National Statistics
- Equality Evidence Finder
- Scottish Social Service Sector: Report on 2016 Workforce Data

Key Findings

Data

32. A summary of the data collected, where this is available, to inform the EQIA is set out below:

Note workforce data in respect of NHS consists of staff employed directly by NHSScotland, this excludes many GPs and staff working in GP practices,

[6] http://www.gov.scot/Publications/2017/12/5851
[7] http://www.gov.scot/Publications/2018/05/6645

Pharmacists, Dentists, Bank and Agency staff, and those working for a contractor e.g. some domestic or catering staff

Protected Characteristic	Evidence gathered

AGE	General population:
	
	• Highest rates of outpatient attendance are for people aged 75-84 years
	• The very young and the very elderly are most likely to attend A&E
	
	NHS Workforce:
	
	• As at end December 2017, 14% of the NHSScotland workforce were aged under 30, whilst 47% were aged between 30 and 49, and 39% aged over 50.
	• Looking at the total nursing and midwifery cohort, out of the 68,697 (headcount) staff as at 31 December 2017:
	  ○ 10,280 were under 30
	  ○ 32,381 were between 30 and 49
	  ○ 26,036 were 50 or over
	  ○ of which 3,523 were between 60 and 65, and 551 were aged 65 or over
	
	Social Care Workforce:
	
	• As at December 2016, 30.1% of the Social Care workforce in Scotland were under the age of 35, 45.8% were aged 35 to 54 and 21.3% were aged 55 and over.
	• Looking at the total social care workforce, out of the 200,650 (headcount) staff as at December 2016:
	  ○ 60,490 were under 35
	  ○ 91,970 were between 35 and 54
	  ○ 42,660 were over 55
	  ○ 5530 were classified as 'Age Not Known'
	• The median age of workers was as follows:
	  ○ 48 in the public sector
	  ○ 40 in the private sector
	  ○ 44 in the voluntary sector
	  ○ 44 across all sectors

Protected Characteristic	Evidence gathered
DISABILITY	According to SG core survey results, 23% of adults in Scotland had a long-term limiting health condition or disability in 2015. The 2011 census reported that 20% of adults in Scotland had a long-term activity-limiting health problem or disability. Within this there was wide variation according to age: 12% of people aged under 25, 72% of people 75-83 and 87% of people aged 85 or over. In 2014, people with long-term physical or mental health conditions that limit their daily activities have lower levels of mental wellbeing. **NHS Workforce** As at end March 2018, 0.8% of NHSScotland staff declared a disability, although completion is not mandatory. **Social Care Workforce** As of December 2016, 2% of the social care workforce declared a disability with 13% classified as Unknown. Declared disabilities ranged from 0% to 4% across the sub-sectors.
SEX	There have consistently been higher numbers of elderly women than men aged 70+ years, but the number of men in these age groups is increasing more steeply over time than for women. Boys are more often admitted as an emergency than girls. Alcohol-related hospital admissions are around three times more common in males compared to females, and drug-related hospital admissions are around two times more common in males. Admissions for heart disease are around two times more common for males, and admissions for stroke are slightly higher for males compared to females. Statistics on GP consultations show a higher rate and number of females visit their GP, except in the very youngest and oldest age groups where the rate for makes is slightly higher. **NHS Workforce** – Of the 68,697 nursing and midwifery staff (as at 31 December 2017) • 6,940 were male, and 61,757 were female • 37,537 staff worked full time • A total of 31,274 worked part time, 1,114 were male, whilst 30,160 were female **Social Care Workforce:** • Of the 200,650 staff working in the social care sector (as at

Protected Characteristic	Evidence gathered
	December 2016): o 85% were female o 15% were male
SEXUAL ORIENTATION	Stonewall estimates that around 5-7% of the population is lesbian, gay or bisexual. Scottish Government patient experience surveys collect data on the sexual orientation of service users. Several analyses of inpatient experience surveys have suggested that sexual orientation is less likely to influence rating of experience than factors such as health status, age or gender. In 2014, after age standardisation, the proportion of "LGB & Other" group reporting good or very good general health is significantly lower than the rest of the population (65.6% compared with 74.5%). **NHS Workforce** As at end March 2018 53.3% of staff employed by NHSScotland declared their sexual orientation as Heterosexual, and 1.7% as Lesbian, Gay, Bisexual, or Other. Note that 16.3% declined to declare their sexual orientation, and the sexual orientation of 28.7% of staff is not known. **Social Care Workforce** There is no publicly available data at present.
RACE	The 2011 census reports 84% of Scotland's population as "White Scottish", a further 8% as "White British", and 4% reporting as being from minority ethnic groups (an increase from 2% in 2001). The largest minority ethnic group in Scotland was "Asian" at 3% (a third of whom are Pakistani, including British/Scottish Pakistani). "African", "Caribbean" or "Black" groups made up 1% of the population. Glasgow City Council area had the highest proportion of minority ethnic groups at 12% of the population, followed by the City of Edinburgh and Aberdeen City both at 8%. Males and females in most of the larger ethnic minority groups in Scotland have longer life expectancy than the majority White Scottish (WS) population. Compared to WS, Indian, Pakistani, Other South Asian, African and Chinese groups all had lower rates of hospitalisation or death from

Protected Characteristic	Evidence gathered
	cancer as a whole. Pakistani men and women had the highest rates of hospitalisation and death due to heart attack. • There is increasing evidence that Gypsy/Travellers experience significant health inequalities, high infant mortality rates, premature deaths and higher than average rates of major long-term conditions such as diabetes and cardiovascular disease.[8] • In the case of ethnicity, due to small numbers, responses in the inpatient survey were grouped into white and non-white. There were generally no differences in the experiences of white and non-white patients. However there may have been variations within these groups. **NHS Workforce** As at end March 2018, 66.3% of staff employed by NHSScotland declared their ethnicity as White, 0.4% as Mixed, 2.1% as Asian, 0.5% as Black, and 0.2% as Other. Ethnicity is unknown or not declared for 30.4% of staff. **Social Care Workforce** As of December 2016, 80% of staff employed in the social care sector were classified as White, 0% mixed, 1% Asian, 1% Black, 1% Other and 17% Unknown or not declared.
RELIGION OR BELIEF	The 2011 census reports that 54% of Scotland's population were one of the Christian denominations, a drop from 65% in 2001. Of these 32% said they were Church of Scotland and 16% Roman Catholic. The proportion stating they had no religion increased from 28% in 2001 to 37% in 2011. There was an increase of 0.6% from 2001 to 2011 to those stating they were Muslim, 1.4% of the population. The number of Jewish people declined slightly between 2001 and 2011, with around 6,000 in 2011, about .01% of the population. **NHS Workforce** As at end March 2018, 33.5% of NHSScotland staff declared their religion as Church of Scotland, Roman Catholic, or Christian –

[8] Hidden Carers – Unheard Voices – Informal caring within the Gypsy/Traveller Community in Scotland http://www.scottish.parliament.uk/S4_EqualOpportunitiesCommittee/Inquiries/MECOPP.pdf

Protected Characteristic	Evidence gathered
	Other. Just under 6% declared their religion as belonging to another faith group (Buddhist, Hindu, Jewish, Muslim, Sikh or other). 27% declared they followed no religion, and religion was unknown or not declared for 33.6% of staff. **Social Care Workforce** There is no publicly available data at present.
GENDER RE-ASSIGNMENT	The Registrar General for Scotland maintains a Gender Recognition Register, which records the birth of any person whose affirmed gender has been legally recognised and their birth certificate updated accordingly. In 2015, this contained 25 entries, up from 16 the previous year. However, this figure only reflects a very small proportion of people who identify as trans, as many do not have a Gender Recognition Certificate, or consider themselves non-binary.
MARRIAGE AND CIVIL PARTNERSHIP	The average age of women giving birth is increasing: the number of babies born to women aged over 35 years has increased threefold over the past 40 years. Teenage pregnancies are decreasing over time.
PREGNANCY AND MATERNITY	No data was available. This is addressed in the recommendations section of this EQIA (paragraph 23).

Impact of Bill provisions on those in protected groups

33. Consideration of equality and giving due regard to the needs of the public sector equality duty has been embedded throughout the development of this legislation. As the legislation will touch the lives of almost every person in Scotland, as all people will at some point will require health and care, it was vital that any potential impacts on people with protected characteristics were identified as early as possible to ensure any issues were addressed from the outset.

34. Ensuring appropriate staffing will enable provision of safe and high quality care across health and care settings, meeting each person's needs. It will also promote a safe working environment for staff and ensure staffing decisions take account of contextual factors.

35. The decision in the first instance to limit the Bill's application to care homes for adults is not aimed at excluding children or other vulnerable groups. Instead it is to implement a phased approach ensuring the testing of the concept and application in care in line with evidence and practice, which if applicable will be extended elsewhere through powers within the Bill.

Recommendations and Conclusion

36. The Scottish Government has concluded that no changes to the Bill provisions are necessary as a result of the EQIA, as the Bill is intended to apply equally to those affected by its provisions and appear to have no detrimental effect on the basis of the protected characteristics.

37. Gaps have been identified in the current evidence base around specific protected groups and this has led to difficulties in establishing effects of the Bill on some of the protected characteristics. This issue will be considered in further development of data.

Monitoring and Review

38. It will be necessary to revisit this EQIA to take account of any changes to Bill provisions resulting from the parliamentary scrutiny process. As a consequence the EQIA will become a living document requiring regular review and updating as and when new tools and methodology are revised.

Conclusion

39. The EQIA has confirmed that the provisions of the Bill will not directly or indirectly discriminate on the basis of age, disability, gender, gender re-assignment, sexual orientation, or race and belief. The Bill is intended to apply equally to those affected by its provisions.

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