

Scottish Government response to the Health and Sport Committee Stage 1 Report

December 2018



Scottish Government
Riaghaltas na h-Alba
gov.scot



T: 0300 244 4000
E: scottish.ministers@gov.scot

Lewis Macdonald MSP
Convener
Health and Sport Committee

By Email.

5 December 2018

I am writing in response to the Health and Sport Committee's Stage 1 Report on the Health and Care (Staffing) (Scotland) Bill.

I would like to thank the Committee for its careful and detailed consideration of the Bill as introduced and welcome the fact that it recommends that the general principles of the Bill should be agreed to by Parliament. I would also be grateful if you could convey to your Members the message that I want to keep the dialogue going with anyone who has an interest in improving this legislation further.

The Committee has raised a number of important points and made a number of significant recommendations. I have considered all of these as set out in the attached Annex.

I note there are areas where the Committee have requested further information in advance of Stage 2. I will commit to providing further information on the following points as soon as is practicable:

- In response to paragraph 143 - An update on the continuous review of the existing workload tools;
- In response to paragraphs 166 and 167 - An update on the outcome of the learning needs analysis and the numbers of staff that may require training as indicated by this;
- In response to paragraph 177 - Confirmation on how clear monitoring will be put in place to allow ease of scrutiny and spread best practice

In the meantime I look forward to hearing Members' further thoughts during the Stage 1 Debate on 6 December.

JEANE FREEMAN

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

Scottish Government response to the Health and Sport Committee Stage 1 Report.

Guiding Principles

Process or Outcomes?

48. When looking at any piece of work our ultimate focus is always on the outcomes to be achieved. We consider the Bill is about enshrining the common staffing method in legislation with the aim of ensuring better outcomes for the individuals who use services.

49. We note the Scottish Government view that outcomes should not be in the Bill however we wish to ensure there is no reduction in focus on the outcomes for those using health and care services. To that end we ask the Scottish Government to make it unambiguous and to consider whether to place on the face of the Bill an additional guiding principle linking the outcome focus to the health and care standard and quality measures.

Scottish Government Response

1. The Scottish Government considers that the general principles in section 1 of the Bill already focus on outcomes for service users, with the most important being the provision of safe and high-quality services. Health Boards and care service providers are already obliged to take account of health and social care standards and quality measures and so an additional principle here would represent unnecessary duplication.
2. There is also a focus on outcomes in other areas of the Bill. In Part 2 of the Bill, the common staffing method requires Health Boards to take into account any measures, as far as relevant, for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) of the National Health Service (Scotland) Act 1978 by the Scottish Ministers.
3. In Part 3 of the Bill, the function that this Bill gives to the Care Inspectorate to develop tools sets out that any methodology developed should take account of:
 - Any assessment of the quality of a care service
 - The needs of the users of a care service
 - Comments by the users of a care service which relate to the duty imposed by section 6 (duty on care service providers to ensure appropriate staffing)
 - Comments by the individuals working in a care service which relate to the duty imposed by section 6
 - The standards and outcomes applicable to care services published by the Scottish Ministers under section 50 of the Public Services Reform (Scotland) Act 2010

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

Accountability

57. We believe there must be more clarity on where accountability for the provision of appropriate staffing in health boards and care services lies. Whilst the Policy Memorandum advises it will lie with organisations we believe unless there is a named accountable officer there is a high likelihood, particularly in health board settings, for those at ward level to be held or feel accountable. We would be grateful if the Scottish Government would advise of their position on this.

58. In the social care services sphere it is even more complicated with the introduction of commissioners into the process. If those providing services do not provide for enough staff to meet the requirements of the legislation then how is it possible to hold the commissioner accountable? It is difficult to understand why commissioners are not referenced in the Bill, especially when they are required to adhere to the guiding principles. We would be grateful if the Scottish Government could advise why commissioners have not been included in the Bill and where they see accountability lying in this sector - including whether a named accountable officer will be appointed.

Scottish Government Response

4. In regards to a named accountable officer in health, this Bill places a duty on the Health Board to ensure appropriate staffing (12IA), as well as duties to follow the common staffing method in specified settings (12IB), train and consult with staff (12ID), consider staffing when commissioning health care (section 2(2)) and report on these duties (12IE). The Health Board is accountable for compliance with all duties placed on it by the National Health Service (Scotland) Act 1978.
5. This Bill requires Health Boards to apply the common staffing method (12IB) in all areas set out in 12IC. In addition to this, the Board must also comply with the duty to ensure appropriate staffing across all staff groups (12IA). In effect, this will require the Board to take into account the outputs from the use of the common staffing method across all areas where a staffing tool currently exists, as well as the needs of staff groups and areas not covered by the common staffing method because a tool does not currently exist. The final decision on staffing levels needs to be taken by the whole Board, informed by the common staffing method (in relation to specified settings) and appropriate clinical advice. The Health Board remains accountable for the final decision and compliance with this legislation.
6. The Board will also be accountable for ensuring their staff are supported to use the common staffing method (12ID) and their views on staffing arrangements are taken into account.
7. Further details will be provided in guidance on which members of staff are expected to run the common staffing method as this will vary across tools. For example, it is expected that a Senior Charge Nurse should run the current adult in-patient tool. As future tools are developed which apply to multiple staff groups the

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



responsibility for running these new tools will be identified as part of the development and implementation of the tool.

8. In care services it should be noted that each care service provider is already required to ensure appropriate staffing. The Bill levels up requirements on Health Boards to broadly mirror the existing requirements on care services, set out in existing regulations, which the Bill moves from secondary to primary legislation. As part of inspection and registration, the Care Inspectorate currently assesses care service providers on their compliance with regulation 15 of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, which stipulates that providers must ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health, welfare and safety of service users.
9. Commissioners are already included in the Bill. Section 3(2) of the Bill requires commissioners of care services – that is, local authorities and integration authorities – to take account of the guiding principles, and to have regard to the duties placed on care service providers by this Bill, when planning or securing (i.e. commissioning) care services.
10. This recognises that a staffing methodology and tool would be used by a service provider, not a commissioner. It ensures that service providers retain flexibility in deciding how they choose to staff their service to meet the workload associated with the care of their service users. When a service is commissioned, both commissioner and provider will agree a contract based on an informed decision on what staff are required.

Assurance

69. Given the extensive training required of users to operate the tools we are doubtful there is appropriate or adequate accessibility for the public and are pleased to hear the resource is being reviewed. We would welcome an update on the review together with details of how it is anticipated this can provide improved accessibility for the public.

70. We are also unclear how members of the public will be assured sufficient staff are in place to provide safe staffing in a hospital at any specific time and be assured their family member or friend, is or will be cared for properly. We welcome the work HIS is undertaking as part of their excellence-in-care approach and would like to see every ward in Scotland display information on staffing levels as they suggest.

71. We welcome the commitment from the Scottish Government to work with staff to ensure reporting routes are better understood and more meaningful. We would be grateful if the Scottish Government can provide an update on how this commitment will be taken forward for both staff and patients and how this can be clarified within the legislation for all care settings.

Scottish Government Response

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



11. As outlined at paragraphs 46 and 47 in this response, further details of the review of the existing staffing tools will be provided separately.
12. Healthcare Improvement Scotland (HIS) and the Care Inspectorate inspect health and care services in order to provide quality assurance that give the public confidence in the services they use. The Care Inspectorate will continue to assess whether care service providers have appropriate staffing in place and, once a tool and methodology is developed for care homes, take this into account as part of their inspection which results in a publically available grade for each service. HIS will now take into account the guiding principles, duty to ensure appropriate staffing, the common staffing methodology and use of staffing tools as part of their inspection regime, the results of which are made public.
13. As part of the Excellence in Care approach, NHS Scotland is developing a dashboard which will include information on the common staffing method and quality outcome measures. It is planned that a public facing version will be developed.
14. In relation to concerns raised by patients in both health and care, there are already existing mechanisms in place to allow them to do this. The Scottish Government wants everyone to receive the best possible care and treatment from our health and care services. We have set out the wider policy within which NHS Scotland is expected to deliver services, and expect all Health Boards to provide high quality care that is safe, effective and person-centred.
15. The Patient Rights (Scotland) Act 2011 and supporting legislation, provides a specific right for patients to make complaints, raise concerns, make comments and give feedback. The Health Board, Special Health Board or Common Services Agency (as the case may be) must consider any complaint, concern, comment or feedback received, with a view to improving the performance of its functions. The relevant NHS body must have adequate arrangements in place for handling and responding to any complaint, concern, comment or feedback received. They must also monitor any complaints, concerns, comments or feedback received with a view to identifying any areas of concern, and improving the performance of its functions.
16. When a patient has concerns about their treatment or care, this should be addressed at a local level through the NHS complaints procedure. When that is not possible, the complaint can be referred to the Scottish Public Services Ombudsman (SPSO).
17. Health Boards also have a duty to provide information on the advice and support services available for patients who wish to make a complaint including providing contact details of the Patient Advice and Support Service (PASS). The PASS service is free, confidential and independent and is delivered the Citizens Advice Bureau.
18. In 2013 the Scottish Government publically endorsed Care Opinion as an independent, open and transparent way for patients and the public to share their stories and experiences of health services across Scotland. All Health Boards in Scotland are using Care Opinion, listening to what people and their families have to

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

say, and are responding and showing where they are making improvements as a result.

19. We are working closely with representatives of staff groups in health to develop a dynamic assessment of risk and associated escalation processes, as appropriate, to ensure reporting routes are more meaningful and understood.
20. My officials are continuing to work with clinical representatives, including medical, nursing and midwifery and Allied Health Professionals (AHP) colleagues, to consider how best to make clear that Health Boards have in place appropriate processes for the real-time assessment of staffing needs and risk mitigation, alongside an appropriate escalation process that ensures staffing concerns can be raised when they arise, and to further ensure that appropriate clinical advice will be obtained when making decisions in these situations and also ensuring effective feedback mechanisms to staff are in place.
21. For care services there are already robust regulatory and escalation regimes in place which include having procedures in place through the powers of the workforce regulator (Scottish Social Services Council (SSSC)), an inspection regime (the Care Inspectorate) and a national whistleblowing regime (complaints).
22. For care services there are a diverse range of providers in the voluntary, public and private sector delivering care home services for older people. The SSSC Code of Conduct for Employers of Social Services, requires them to:
 - Have systems in place for social service workers to report inadequate resources or difficulties which might have a negative effect on the delivery of care. Work with social service workers and relevant authorities to tackle such problems.
 - Have systems in place to support workers to whistle-blow when they feel that working practices are inappropriate or unsafe for any reason.
23. The escalation route for concerns is the Care Inspectorate and set out under section 79 of the Public Services Reform (Scotland) Act 2010 which provides that :
 - The Care Inspectorate must establish a procedure by which a person, or someone acting on a person's behalf, may make complaints (or other representations) in relation to the provision to the person of a care service or about the provision of a care service generally.
 - The procedure must provide for it to be available whether or not procedures established by the provider of the service for making complaints (or other representations) about that service have been or are being pursued.
 - Before establishing a procedure the Care Inspectorate must consult the Scottish Public Services Ombudsman, all local authorities and such other persons, or groups of persons, as it considers appropriate on its proposals for such a procedure.
 - The Care Inspectorate must keep the procedure under review and must vary it whenever, after such consultation, it considers it appropriate to do so.
 - The Care Inspectorate must give such publicity to the procedure as it considers appropriate and must give a copy of the procedure to any person who requests it.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



24. The Care Inspectorate's statutory complaints function is well publicised, well used and extends to whistle-blowing. This year the Care Inspectorate issued a publication titled 'Complaints about care services in Scotland 2014/15 to 2016/17' which showed complaints were made by staff and complaints were made about staffing levels.

Wellbeing of Staff

75. We welcome the requirement to ensure staff wellbeing is encompassed within the general principles but are unsure how this will be achieved given the ever increasing demands on the health and social care sector. There is no detail in the Policy Memorandum around how this will be achieved or how the Bill will ensure it happens.

76. We agree with Marie Curie that staff safety and wellbeing contribute to safe and high quality care. We would be grateful if the Scottish Government could advise how they plan to include staff wellbeing as part of the provision of safe and high quality services.

Scottish Government Response

25. The welfare of NHS staff is critically important with every Health Board required to have policies in place and to comply with national policies on managing health at work, which includes wellbeing. We are improving our approach to staff experience to better understand and respond to the health and wellbeing issues that matter to staff, through the iMatter Staff Experience Continuous Improvement Model. Evidence from the first national report suggests that the model is having a positive impact on both staff wellbeing and patient outcomes.
26. NHS Scotland's staffing levels have increased by over 12,000 under this Government; the consultant workforce has grown by over 48% and the nursing and midwifery workforce has grown by 5.7% NHS Scotland Boards are required to have the correct staff in place to meet the needs of the service and ensure high quality patient care; they have fully delegated powers in relation to employment issues.
27. The Scottish Government works closely with Boards to support their efforts in staff recruitment. We are investing £4 million over the next three years in domestic and international recruitment for GPs, nursing, midwifery and consultant specialties with the highest existing vacancy rates.
28. Our staff are our most important asset and to maintain their physical and psychological wellbeing, we need to ensure that there are sufficient levels of staff at all times with the right skills to deliver the workload required to carry out safe, effective, person-centred care.
29. By setting out a workload system in legislation we can ensure that everyone knows what is expected, how to apply the process and how to make decisions based on the evidence generated by it. It also ensures transparency in this process. Staff, patients, the Scottish Government and the Scottish Parliament will

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



be assured that there is a consistent assessment of workload, based on an assessment of acuity, patient need and the delivery of patient outcomes.

The Professional Voice

88. Professional judgment must be an essential part of this Bill. All recognise the staff on the ground on any given day are best placed to take decisions on what staffing requirements are and whether they are being met and this must include the involvement of other professions, beyond nursing and midwifery. Section 1 refers to "taking account of the views of staff" but we see the merit in it being prominent and exercisable in both Part 2 and Part 3 of the Bill.

89. We think there must be clearer direction in this legislation of who will be included in professional judgement. From Nurse Directors to Senior Charge Nurses and Team Leaders, AHPs to social care workers, they all must have a role to play in deciding on what is a "safe" staffing level. This is the only way to ensure the voice of those on the ground is not drowned out by competing priorities such as finance, medicines, a need for more doctors/clinical care. We would welcome confirmation from the Scottish Government on how this will be achieved.

Scottish Government Response

30. The common staffing method is built around ensuring that the staff on the ground take a systematic approach to the assessment of workload and can use their professional judgement to make an evidence based decision on the appropriate staffing to deliver this. The voice of the professional is referred to at multiple points throughout the common staffing methodology and sought in a number of ways.
31. The voice of the professional is central to the guiding principles, which apply across health and social care. The principles set out that services are to be arranged while taking account of the views of staff.
32. The common staffing methodology requires that the professional judgement tool be used alongside the speciality specific staffing tools (12IB(2)(a)). Boards are also required to take into account the comments of its employees in relation to the duty to ensure appropriate staffing (12IB(2)(c)(v)) as part of the common staffing methodology.
33. Boards must also take appropriate clinical advice before deciding on staffing levels (12IB(2)(d)(iii)). The Bill sets out that *"appropriate clinical advice" means advice obtained from the appropriate level and area of clinical professional structures depending on the particular circumstances of each case (for example from a person holding a senior executive role in the provision of nursing services)."*
34. As there is not yet a common staffing method for use in care services the Bill allows the Care Inspectorate to develop a method and sets out factors that may be taken account of, including comments by the individuals working in a care service, ensuring that the professional voice is prominent here too.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



35. We expect future staffing level tools will be more multi-disciplinary in nature. The tools are used as part of the common staffing method - each staffing level tool will be used alongside a professional judgement tool and must be used by the relevant professionals. As the output from the range of health care settings covered by the common staffing method is fed up to the Board they will be required to take clinical advice before setting staffing levels. It is our intention to set out in guidance further detail on who should be given responsibility for running the common staffing method in the areas in which it is applied and which professionals clinical advice should be sought from for each of these areas. This will ensure the level of clinical advice is specific and appropriate for each health care setting while allowing flexibility to define differing staff groups in different health care settings.

Equity and Parity Across Services

116. The integration of health and social care is an essential step for the future of services in Scotland. We believe this is the right way forward and, like witnesses, are concerned to ensure this Bill does not have negative effects on the process of integration. The Scottish Government believes the Bill will support the increased integration of health and social care services by providing a consistent framework for staff planning across the sectors. We are concerned to ensure this is the case.

117. Legislation should not create a rigid compliance framework that undermines the new outcomes focused integrated environment for health and social care. We share the aspiration this Bill will support increased integration of health and social care while observing the extended timescales over which any tools will be developed in social care. We would welcome details on how the Bill supports integration and how it will continue to allow Health and Social Care Partnerships to work at locality level to identify local needs and then meet those outcome needs.

118. There is a significant overlap of governance responsibilities between health boards, integration joint boards and local authorities. Shared responsibility is clearly helpful to integration and we are keen to ensure this supports integration and it is clear where the Bill adds further responsibilities under Part 2. We would welcome detail from the Scottish Government on what guidance will be provided, should the Bill be passed, to ensure this joint working can continue and where governance responsibility and accountability lie in situations of joint working.

119. The work of AHPs is essential to the running of a safe, effective and efficient health care system. We are concerned about their omission from the Bill and the Government's admission to the DPLR Committee about the absence of any evidence or experience as to how multi-disciplinary tools might be developed and operated. The Cabinet Secretary was clear the Scottish Government expect AHPs' expertise to be involved in work to develop the tools appropriate for a care home setting. We would be grateful if the Scottish Government could confirm what they see as the role of AHPs in the health service and how the Bill will be changed to reflect their input and essential role in both health and social care.

120. We agree with the AHPFS concerns that Directors of Finance may be in a difficult position when it comes to deciding priorities as the legislation may tie them

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

to providing funds for nurses and midwives to the detriment of AHPs and multidisciplinary working. Can the Scottish Government advise how they can ensure this does not happen?

121. The potential for resources to be skewed is a concern. In a tight staffing environment with many recruitment difficulties it is essential the Bill does not exacerbate the position and lead to the closure of other services should resources be skewed towards the acute sector. We would welcome details from the Scottish Government on how any such issue can be mitigated and both the care sector and community health sector be reassured.

Scottish Government Response

Working at locality level

36. The Bill will provide for all Health Boards and care service providers to have regard to the same shared guiding principles and to comply with the duty to ensure appropriate staffing for high quality care and the health, wellbeing and safety of service users. The current tools, to be used as part of the common staffing method within specified health care settings, identify the workload required to deliver service users' needs within the local population and context and allow Health Boards, integration authorities and local authorities to identify and agree staffing requirements on a shared understanding of the workload. Future tools are likely to be multi-disciplinary in nature and therefore the broader needs of a local population and associated workload needs will be established.

Joint accountability

37. Requirements on Health Boards will be linked to the planning and provision of health care services, so where those services are delegated to an Integration Authority as per the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 – whether an Integrated Joint Board, Health Board or local authority – then that body must also comply with them when planning and delivering those services. This will require open communication between the Integration Authority and those responsible for delivering the services to provide assurance that the duties in the Bill are being met. Statutory guidance will cover this.

Role of AHPs

38. The guiding principles (in Part 1) and the duty to ensure appropriate staffing (in section 4 inserted section 12IA) cover all health care settings and all staff groups, including AHPs. We recognise the valuable role AHPs play, and anticipate that future staffing level tools will be of a multi-disciplinary nature, which may include medics and AHPs as well as nurses and midwives.

39. The Committee note that AHPs work in all the types of health care listed in 12IC however they are not included in the staff groups covered by this section. 12IC sets out the types of health care in which the duty to follow the common

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

staffing method applies – this list mirrors the health care settings for which staffing level tools already exist, since the use of a tool is a key part of the common staffing method. The existing staffing level tools have been developed by measuring the workload specifically for nurses associated with care in that setting. It would be inappropriate for other professions to use the current tools and this is why they are not currently covered by this section. As new staffing level tools are developed which include other staff groups, and once they have been tested for those staff groups, this section will be updated by the use of the Bill's regulation-making powers to reference those health care settings and staff groups.

Appropriate staffing duty and competing interests

40. It is not the Director of Finance's or IJB senior financial officer's role to decide staffing priorities, this is the role for the Health Board or care service provider. The duty to ensure appropriate staffing is intended to mitigate against skewing of resources to one staff group by requiring the Health Board to ensure appropriate staffing for all staff groups, including AHPs. Importantly, as part of the common staffing method, Health Boards are required to take into account appropriate clinical advice before setting staffing levels. Health Boards and local authorities are required to put in place a workforce development/organisational development plan for the workforce providing services and ensure arrangements are in place to develop and support staff in the delivery of those integration functions. The Bill places a duty on Integration Authorities and local authorities, when planning or securing care services, to consider the guiding principles and the safe staffing duties placed on care service providers by this Bill.

Part 2 Staffing in the NHS

Current Tools and Development of New tools

141. We understand the tools are only one part of the common staffing method. However, as they are providing a baseline figure which the other parts of the triangulation process then use to establish 'safe' working it is essential these are as accurate and relevant as possible.

142. We welcome the working group which has been set up to review the tools but are surprised this did not happen until after the Bill was introduced. It would have been helpful for this work to have been completed before legislation was introduced allowing us and the Scottish Government to be confident about the Health and Sport Committee Stage 1 report on the Health and Care (Staffing) (Scotland) Bill, efficacy of the tools. We are disappointed the review will not now be completed by the end of Stage 1 consideration of the Bill.

143. We ask the Scottish Government for the information from the review to be available prior to Stage 2 and welcome details on when the working group is expected to report on their review of the current tools. We would also welcome details of how it is proposed the results of the review will be implemented and impacts on the Bill promulgated.

Scottish Government Response

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

41. When the tools were initially being developed a tools and maintenance sub group was established within the Nursing and Midwifery Workload and Workforce Planning Programme (NMWWPP). This was disbanded when the programme went on a business as usual footing as tools were developed for 98% of nursing and midwifery service areas. The tools were then reviewed with oversight from the Directorate of the Chief Nursing Officer.
42. There has been a cycle of review of all the workload tools since they were created. This is done by:
- 6 monthly cycle of builds/revision to the software as required. This is undertaken by keeping an issues log for all of the tools and ensuring that issues are addressed in the 6 monthly build cycle as required.
 - Bringing together of the clinical reference group for each tool to review current practice / policy changes in the specialty which may have impacted on workload to establish if further work on the tools are required, consideration of any common themes or issues with the tool from a service perspective and any technical issues that have arisen that have not been resolved in the 6 monthly review cycle identified above.
43. These reviews have been ongoing since development of the first workload tool. As previously advised the governance structure of the programme has recently been revised and a workload tools and maintenance group was established last year. The function of this group was to oversee and monitor the work described above, not to establish a mechanism for doing so as this was already in place.
44. There has been a mandate for use of all tools and existing triangulated methodology since 2013 and the expectation therefore is that Health Boards achieve this. The legislation will make the use of these tools and the common staffing method (which is an updated version of the current triangulated methodology) a requirement. In addition to training resources available in the form of video clips and an education toolkit the NMWWPP programme advisors are a resource that can be used by Health Boards to provide additional advice and training in application of tools and triangulation process, analysis of reports to make informed decisions about staffing requirements using available evidence from tools, professional judgment, local context and quality measures.
45. Once the decision was made to put the workload tools on a statutory footing as part of the Scottish Government's Programme for Government 2016-17, additional governance structures were re-established. This included re-establishment of the NMWWPP steering group which oversees the work of the programme and reports to the Health and Care Staffing Strategic Programme Board. The steering group then established two sub groups, the tools and maintenance group and the education and training sub group. The cycle of reviews will continue and will be enhanced by consideration being given at each review about the ability to extend each tool to a multi-professional/disciplinary approach.
46. The reviews have been ongoing, however extension to the multi-disciplinary approach will require detailed analysis of workload in the wider team and will require extension of the clinical reference group to other staff groups. This will allow for consideration of a methodology for extending the tools to other staff groups,

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

development work to ensure activity analysis includes activities for all staff groups, extensive data collection by way of observation studies, testing, and refining before the tools can be validated for use in the multi-disciplinary team. The tools are kept under continuous review, the programme of which is planned but needs to be dynamic to respond to changing policy, models of care, research and best practice. There is therefore no end date to this work as it is crucial to constantly assess and continuously improve the tools.

47. However, should this review, or any future review of the tools and method, require the common staffing method or staffing tools to be updated there is an ability to do so. Section 12IB(4) contains a power enabling the Scottish Ministers to change the description of the common staffing method set out in new section 12IB(2). Section 12IC(3) contains a power enabling Scottish Ministers to add remove or change the table setting out the types of health care in 12IC to which the application of the common staffing method, and the use of the tools, applies. Both powers are affirmative and so Parliament will have an adequate opportunity to scrutinize any changes which may be proposed. The specific tools to be used as part of the common staffing method will be set out in regulations made under the power contained in 12IB(3).

SSTS Platform

151. We are pleased NSS is undertaking work to procure a new platform. Issues have been raised with SSTS and we would welcome details on how these will be rectified if the tools are not moved to a new system.

152. As with the review of the current tools we are surprised the required replacement platform was not addressed prior to the introduction of the Bill. We ask the Scottish Government to confirm the expected time frame for having a new system up and running and how that links with commencement of the relevant Bill provisions.

Scottish Government Response

48. The current suite of staffing tools sit on the SSTS platform as this is accessible to all Health Boards. Regardless of which system is used to host the staffing tools, the process of using the tools remains unchanged. As set out elsewhere in this response, significant resources are being put in place to ensure staff using the common staffing method are appropriately trained in the use of the tools, this includes accessing the system on which the tools sit.
49. NHS Education for Scotland (NES) as part of their broader piece of work on workforce systems in NHS Scotland led by NES and supported by National Services Scotland (NSS), are working to procure and implement an e-Rostering system for NHS Scotland to cover all staff groups. This will then inform the next steps in the programme of work. However no part of the current system will be

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



decommissioned until there is a replacement in place and consideration will be given to where hosting of the workforce tools is best placed in the new environment.

Training

163. Training is a crucial aspect of any process and will impact on the success of the process. We were disappointed to hear from front-line staff how little (if any) training had been provided on the tools. Many felt completely confused by the process and the outputs and as a result felt completion of the tools was more time consuming than anticipated.

164. Whilst we welcome the detail in the Financial Memorandum around training costs we are concerned these may not be a true reflection of likely amounts required given their reliance on "existing knowledge and experience." 53 Given the evidence we have received coupled with our survey responses we are concerned the number of staff required to be trained is much higher than anticipated. We are also concerned the potentially extensive training required as a result of the procurement of a new platform has not been included.

165. We have a further concern around the assumption that time for training will be available within continuous professional development. We have heard during numerous inquiries staff just do not have the time to access such training, work priorities always take over. As the success of the common staffing method relies on the understanding of the tools by staff we ask the Scottish Government to reconsider how time is provided for training.

166. We ask the Scottish Government to provide information on the numbers of staff they consider will require training, broken down by health board together with an estimate of the length of the training. We recognise the latter will depend upon the trainee, and in particular, whether they are familiar with the existing models or not.

167. The Scottish Government advised details on access to training and the continuous roll-out of training to new staff would be covered in guidance should the Bill be passed. We would welcome further detail on what might be proposed here prior to Stage 2.

Scottish Government Response

50. Health Boards have access to on line learning resources on applying the tools and to the education tool kit. In addition professional advisors provide advice and face to face training on request. It is for Health Boards to establish their training requirement and to access the resources available as required. Each of the programme advisors are aligned to Health Boards. As set out in the Financial Memorandum, the Scottish Government committed to increasing the number of advisors (para 44). These assistant programme advisors have recently been appointed and will focus on training requirements in Boards.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

51. The education and training sub group of NMWWPP are currently developing a learning needs analysis to inform the review of the on line education and training resources, education tool kit and face to face training sessions. The training needs analysis will inform content and methods for training in the future. Once complete, this analysis will be shared with the Committee, it is anticipated this will be complete by Summer 2019.
52. Procurement of a new platform will not necessarily impact on training requirements. The tools themselves will not change and therefore training on application of the tools will not change as a result of any new platform.
53. There are areas of good practice where tools are running well and staff are fully engaged in the process. There is therefore some level of understanding and knowledge available within the system. Scottish Government will continue to engage with Health Boards and NHS Education for Scotland to assess the need for training.
54. The implementation of the new e-rostering system will come with a separate training programme on the use of the system, which will be costed separately but aligned to the predictable absence allowance element of the current tools.
55. The on-line training videos which guide clinicians through each of the tools vary in length depending on the complexity of the tool. The time taken to watch the videos varies from 7 to 15 minutes. Each video is accompanied by a written user manual which can be referred to when inputting information. This information is sufficient for staff to input information to the tool.
56. The education tool kit goes into more detail about using the output from the tools and using the triangulation method to make decisions about staffing. This level of understanding will not be required by all staff. The revised training programme will include training on the common staffing method. This training will commence from Summer 2019.
57. As set out in the Financial Memorandum and referenced elsewhere in this response, the Scottish Government has already provided funding for additional staff to support Health Boards to consistently apply the methodology, and to collate, analyse and report information across the organisation. These staff have been apportioned across all Health Boards and will play a key role in ensuring Health Boards are adequately training their staff to carry out the common staffing methodology. It is important to note that Health Boards will have a new statutory duty to ensure that staff have adequate time to apply the methodology, under section 4 inserted section 12ID.
58. The NMWWPP team also provide advice and training to Health Boards where required. The team has recently been expanded to ensure there is capacity within the team to develop tools in other areas and to ensure appropriate advice is available to Health Boards in preparation for the proposed legislation.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

59. The Scottish Government will review the number of staff who will need trained based on the outcome of the learning need analysis and share this with the Committee.
60. Guidance will lay out that all staff using the tools should access on-line training and what other training modalities may be pertinent. It will then further detail the training required at each level of decision making following application of the common staffing method. Further details will be provided prior to Stage 2.

Compliance and Sanctions

177. We welcome confirmation from the Cabinet Secretary that health boards will be expected to report on how they have ensured appropriate staffing and the outcomes from running the tools as well as the application of the tools. We note Audit Scotland have on a number of occasions stressed the importance of new policies including clear monitoring provisions at the outset. Clear monitoring should allow both ease of scrutiny and the means to spread and incorporate learning and best practice. We would welcome confirmation from the Scottish Government prior to stage 2 how these aspects are met by this Bill.

178. We have noted the powers of sanction in the 1978 Act and believe it would be helpful for us and health boards to understand the process in the context of noncompliance. While we hope use of the powers never becomes necessary we would welcome a breakdown of the steps that could follow.

Scottish Government Response

61. A number of measures are already in place to monitor Health Boards' compliance with their legal duties and it is therefore expected that non-compliance with the duties in the Bill would be managed in line with the existing performance and monitoring process and escalation levels. Healthcare Improvement Scotland provide public assurance about the quality and safety of health care, including monitoring and inspecting services provided by Health Boards. They also provide improvement support where required and ultimately have the power to close wards where necessary improvements are not made.
62. The Care Inspectorate regulate a range of care services. It undertakes strategic inspection of local authority social work services and scrutiny of care services, and can take action where problems are found.
63. The Scottish Government and HIS are currently revising the escalation process to deal with issues, concerns and service failures and how these are more effectively escalated and resolved between Scottish Government, HIS and Health Boards for the protection of the public.
64. If successful resolution is not achieved the steps that could follow if there is an issue with Health Boards' compliance with their duties are set out clearly in the 1978 Act. Ministers have powers to hold inquiries into NHS services under section 76; may declare a Health Board to be in default of their obligations under section 77; and have defined powers of direction and intervention under section 78A where there has been some sort of failure in provision of service. There is also the power

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

of direction in section 2(5) of the 1978 Act which can be used generally or for specific matters – this could involve directing a particular Board to undertake specific actions before the use of the other powers mentioned above is contemplated. These powers will all apply to the duties placed on Health Boards by this Bill, as will the existing powers of Health Improvement Scotland to monitor, inspect, and in extremis to shut down services.

Part 3 – Staffing in Care Services

194. We can see the attractions and advantages from treating all parts of the delivery of health and care in the same manner. We can see no rationale to ultimately treat this sector any differently from the NHS, both are providing services to the public and the public should be assured they and their relatives are being looked after adequately with care, professionalism and dignity.

195. We recognise the different environments that exist across the delivery of health and social care, and in particular that definitions of safety and how quality is measured inevitably differ between hospitals and care homes reflecting the type of care being provided from intensive to respite care. We also recognise the very different contexts within which acute hospitals and care homes operate in terms of commissioning, procurement, funding, governance and ownership. We are also mindful of the necessity that this Bill does not impinge on the requirements of the social care sector in particular, to be responsive and to be able to devise innovative solutions (as a disparate sector) to particular pressures. This innovation is required for the integration agenda to succeed. We ask the Scottish Government for detail of how it will be ensured such differences will be factored into the development of new tools and methodologies.

196. When tools are introduced we would expect the same criteria to apply as set out across Part 2. Including provision for training, monitoring and evaluation, compliance and sanctions as well as covering the role of AHPs and the visibility of information on every site for the public.

Scottish Government Response

65. It is our intention that the development of any new tool and methodology would be carried out in a similar manner to the way in which the existing tools were developed in health. A clinical reference group is established prior to the development of any new tool. All Health Boards are invited to contribute to the clinical reference group. The group has representation from clinical staff at different levels in the specialty, managers, finance, workforce and partnership organisations from service and programme advisor and analyst representation from the programme with external expert opinion being sought from our academic partner as required. The group works to a standard operating procedure for the development of a workload tool and is chaired by a senior clinician from the specialty. Once the tool is developed and being utilised in service the clinical reference group is reconvened as necessary to review the tool or to provide expert opinion where issues have arisen.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot



66. It is crucial that any tool is developed by the sector, for the sector. This is why section 82A(2) of the Bill requires the Care Inspectorate to collaborate when developing a staffing methodology. As a minimum, the Care Inspectorate must collaborate with Scottish Ministers, Healthcare Improvement Scotland, local authorities, integration authorities, representatives of the providers of care services, representatives of the users of care services, trade unions and professional bodies.
67. The Financial Memorandum makes an estimate of the costs associated with this collaborative approach to the development of a staffing method, taking account of input from both the Care Inspectorate and collaborators. The Financial Memorandum notes that as this work is to be coordinated by the Care Inspectorate but led by the sector, and the way in which a tool is developed will be informed by previous research, some of these costs may be spread across organisations other than the Care Inspectorate. However, an estimate of likely staff requirements is given assuming they would be employed by the Care Inspectorate.
68. We welcome the Committee's support for the same criteria to apply as set out across Part 2. Part 3 applies to all those working in a care service and therefore AHPs are already included.

The Role of the Care Inspectorate

203. We welcome the confirmation from COSLA they have received assurances from the Scottish Government any tools for the social care sector will be co-produced with the sector and service users. We think it is essential this is the case. We suggest the Scottish Government make this explicit on the face of the Bill allowing guidance to further develop how this is to be achieved.

204. We note references within the Policy Memorandum relating to the CI agreeing with the sector the need for a tool. To avoid any confusion we recommend section 10 of the Bill is amended to confirm that the sector will require to agree the need for a tool which will then allow the detail to be covered in guidance.

Scottish Government Response

69. Section 82A(2) of the Bill already requires the Care Inspectorate to produce staffing methods in collaboration with the sector.
70. A collaborative approach is key to the success of this legislation and the Care Inspectorate have confirmed their commitment to this approach. They are to lead and facilitate the development of tools in line with their statutory improvement function. The Bill does not place an explicit legal duty on the sector to agree because such a duty would be unenforceable and impractical: it would be difficult to find or to measure universal agreement across all providers in what is a diverse sector, and it would be inappropriate for the Scottish Government to attempt to compel such agreement. We are satisfied that the Bill will provide for the coproduction of tools in a manner which is enforceable in law and in practice.
71. There may also be certain circumstances where a staffing method should be developed for safety reasons. In these instances it is crucial that Scottish Ministers

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

retain a power to instruct the Care Inspectorate to facilitate the development of a method. It would still be expected that this would, in so far as is possible, be done in the collaborative manner set out previously.

Wider Recruitment and Retention Issues

213. We recognise the concerns of witnesses about how the outcomes of the Bill can be achieved without a link to wider national workforce planning. If there is insufficient labour available nationally to fill vacancies then clearly resolution should lie initially at the national level. We are unclear what the implications for a health board, or social care service, will be if they are unable to meet the requirements of the Bill due to circumstances such as above and would welcome information from the Scottish Government on how the Bill recognises and addresses such a situation.

214. The concerns noted above bolster the issues highlighted in the section on integration of health and social care. If there is a shortage of nurses, midwives and social care workers the requirement for AHPs is going to be even greater along with other changes in the way services are delivered.

Scottish Government Response

72. This Bill is about workload planning not workforce planning. However, the common staffing methodology and tools set out in this Bill create an important evidence base upon which Health Boards will make decisions about their staffing. This evidence base will also inform wider local and national decisions about workforce planning and how best to respond to staffing challenges.

73. We understand the pressure staff are facing and we are clear that workforce planning needs to be improved, which is why we published the National Health and Social Care Workforce Plan, which will enhance workforce planning and help ensure appropriate staffing for safe, high quality care. The Plan recommends actions to improve collation of health and social care workforce data to support national and local workforce planning. Work is being led by NHS Education for Scotland and will draw initially on the work of the Care Inspectorate and the SSSC to develop a whole system approach across health and social care. The first phase of development of an integrated supply side platform will be delivered in late 2018 and will seek to enable future modelling of workforce requirements.

74. Under sections 12H and 12I of the National Health Service (Scotland) Act 1978¹ (“the 1978 Act”) Health Boards in Scotland have an existing duty to put and keep in place arrangements for the purposes of monitoring and improving the quality of health care which they provide to individuals, and to put and keep in place arrangements for the purposes of workforce planning. The National Workforce Planning Framework² and the National Workforce Planning Framework 2005

¹ <http://www.legislation.gov.uk/ukpga/1978/29/part/I/crossheading/quality>

² <http://www.gov.scot/Publications/2005/08/30112522/25230>

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

Guidance³ established how the requirement for NHS Scotland to workforce plan should be met. We expect Health Boards to comply fully with their duties under the Bill, as with these existing statutory duties.

75. The Scottish Government, with partners, analyse available supply and demand information and undertake modelling to inform decisions regarding the numbers of student nurse and midwife training places required for a sustainable workforce.
76. National support for workforce planning in social care includes the publication by the Scottish Social Services Council (SSSC) of annual official statistics on workforce numbers and composition, biennial workforce skills reports, and quarterly reports on the provision of Scottish Vocational Qualifications. Skills Development Scotland produce regular reports on Modern Apprenticeships, including those in health and social care and the Care Inspectorate have published information on vacancies in the sector. These reports seek to assist effective workforce planning and service providers are engaged in developing the approaches for data collection and reporting.
77. The Bill does not require Health Boards to meet minimum staffing levels, it is about putting in place an evidence based method to assess and monitor the workload associated with the delivery of care in a systematic way. As part of the common staffing method the Bill requires Health Boards to identify and take all reasonable steps to mitigate any risks and consider if changes are needed to staffing levels or the way in which it provides health care.
78. As set out in the Policy Memorandum, professional risk assessment of short term staffing requirements may require a variety of mitigating factors to be put in place to ensure safety is maintained, for example through the redeployment of staff from one area to another or the use of supplementary staffing to support short term gaps.
79. Using the common staffing methodology and tools will require Health Boards to consider all aspects of the methodology, including the use of supplementary staffing and redesign of services, to ensure they are using their resources in the best possible way to achieve high quality care. The methodology will support Health Boards to plan and use staff and, where required, redesign services to ensure existing safety and quality measures continue to be met.
80. We recognise that there are currently significant challenges in recruitment in both health and care service settings. This legislation will not, in itself, address these challenges and should be viewed in conjunction with other measures that we are taking to support and sustain the health and care workforce. However, by taking an evidence-based approach to workload and workforce planning that takes account of identified risks this legislation will not penalise organisations for factors beyond their control. It will, however, provide Health Boards with robust evidence on which to forecast workforce requirements which will in turn ensure that national level workforce planning is based on sound evidence.

³ http://www.sehd.scot.nhs.uk/mels/HDL2005_52.pdf

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

Overall Conclusion

217. Although it is already the duty of health boards and care service providers to ensure appropriate numbers of staff the guiding principles of this Bill are unobjectionable. Having the right people with the right skills in the right place at the right time to ensure the highest quality of care and outcomes are delivered across health and social care is a principle we share. Although we have heard many concerns about the Bill, including possible unintended consequences the Committee supports the general principles as set out above.

218. We have however endeavoured to raise constructive concerns and suggestions throughout this report and to seek further detail and information in order to strengthen the Bill. We look forward to the Scottish Government response on these issues which we hope will provide reassurance not just for us but also for staff, stakeholders and service users.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot





Scottish Government
Riaghaltas na h-Alba
gov.scot

© Crown copyright 2018

OGL

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.scot

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78781-429-5 (web only)

Published by The Scottish Government, December 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS505046 (12/18)

W W W . G O V . S C O T