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Stage 1 report on the Health and Care (Staffing) (Scotland) Bill



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Contents

Introduction	1
Background and Overview of scrutiny	1
Purpose of the Bill	2
Part 1 - Guiding Principles	3
Part 2 - NHS Staffing	3
Common staffing methodology	4
Part 3 - Care Services Staffing	7
Part 4 - General provisions	7
Part 1 - Guiding principles for staffing	9
Process or outcomes?	9
Accountability	10
Assurance	12
Wellbeing of staff	13
The professional voice	14
Integration of health and social care	16
Equity and parity across services	17
Part 2 - Staffing in the NHS	21
National workforce planning	21
Current tools and development of new tools	22
SSTS platform	24
Training	25
Compliance and sanctions	27
Part 3 - Staffing in care services	29
Background	29
Existing Governance and regulation of social care services	30
Is the Bill required for social care services?	30
The role of the Care Inspectorate	31
Wider recruitment and retention issues	34
Finance Committee and Delegated Powers and Law Reform Committee consideration	36
Overall conclusion	37
Annexe A - Minutes of meetings	38
Annexe B - Evidence	41
Written Evidence	41
Additional Written Evidence	43

Survey	43
Official Reports	44

Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.



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healthandsport@parliament.scot



0131 348 5524

Committee Membership



Convener
Lewis Macdonald
Scottish Labour



Deputy Convener
Emma Harper
Scottish National Party



Miles Briggs
Scottish Conservative
and Unionist Party



Keith Brown
Scottish National Party



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Scottish National Party



Sandra White
Scottish National Party



Brian Whittle
Scottish Conservative
and Unionist Party

Introduction

Background and Overview of scrutiny

1. The First Minister announced the Scottish Government's intention to enshrine safe staffing in law at the Royal College of Nursing Congress in Glasgow in 2016. In its [Programme for Government 2017/18](#) the Scottish Government committed to "deliver" on the commitment to enshrine in law the principles of safe staffing in the NHS, starting with the nursing and midwifery workforce planning tools'.
2. [These commitments resulted in the Health and Care \(Staffing\) \(Scotland\) Bill](#) ("the Bill") being produced to enable safe and high quality care by making the provision of appropriate staffing in health and care statutory, resulting in better outcomes for services users. The Bill was introduced into the Scottish Parliament on 23 May 2018 by Shona Robison, then Cabinet Secretary for Health and Sport. The Bill was referred to us on 28 May 2018.
3. Safe staffing is an issue that has been considered across the UK. The [Francis Report](#) (looking at care quality at Mid Staffordshire NHS Foundation Trust) explicitly stated inadequate staffing levels led to poor quality care. Staffing levels in England are not set in law and whilst this Bill aims to ensure safe and high quality care through the provision of appropriate staffing, it does not set staffing levels in law.
4. Following introduction of the Bill, we issued a [call for evidence](#), which ran from 6 June 2018 to 1 August 2018. We received [70 submissions](#).
5. In an effort to engage with as many front line staff as possible we attended the NHS Scotland Event at the SEC, Glasgow on 18 and 19 June. At the event we ran a parallel session which used the Bill as a test case, inviting attendees to think like a Committee member and consider how they would scrutinise the Bill. In doing so we gathered the views of the NHS staff in attendance on the Bill and identified areas where they thought scrutiny was required.
6. We also issued a survey which sought views on the current nursing and midwifery workforce tools and as such was specifically aimed at those who use the tools. The survey ran from 29 June 2018 until 1 August 2018 and 195 responses were received. SPICe produced a [summary of the responses](#) received and a [report](#) covering the full survey responses.
7. We held an informal evidence session on 11 September with nursing and midwifery staff to discuss with them their experience of how workforce planning is managed in their work settings.
8. We took formal evidence on the Bill at our meetings on 11 September, 18 September, 25 September and 2 October 2018. These sessions looked at the Bill in relation to integration and multi-disciplinary teams, staff groups already covered by workforce and workload tools, the impact of the Bill on the care home sector and the development of new workload tools.

9. We thank everyone who provided written and oral evidence, or engaged with us as part of our consideration of the general principles of the Bill. Their input has greatly assisted our deliberations.
10. A full list of witnesses and written submissions can be found at Annexe A

Purpose of the Bill

11. The Bill covers both health and social care services, with the aim of ensuring more integrated workload and staff planning. This broader approach is noted as seeking to ensure there will be appropriate staffing to deliver high quality care whatever the setting.
12. The [Policy Memorandum](#) notes "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".
13. It is important to be clear the Bill does not focus on national workforce planning. The Bill includes a focus on the development and application of workload planning tools aiming to ensure health and social care providers (those registered and inspected by the Care Inspectorate) are providing adequate numbers of suitably qualified staff to provide safe and high quality services.
14. The Bill sets out principles which must be taken into account when considering staffing requirements across health boards and by those providing care services. The Policy Memorandum states the Bill "creates a coherent overall legislative framework for appropriate staffing across the health and care services landscape".
15. The Policy Memorandum also notes the policy intention of the Scottish Ministers is to "enable a rigorous, evidence based approach to decision making relating to staffing requirements". The overall aim of the Bill is to ensure safe and appropriate care staffing levels based on clear, evidence-based methodologies, regardless of setting.
16. The Policy Memorandum states:
 - ” The legislation is not intended to set out or prescribe minimum staffing levels or fixed ratios; this would be at odds with the Scottish Government’s established policy approach 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.
17. The Bill is structured in four parts:
 - Part 1 sets out the guiding principles for health and care staffing and sets out duties in relation to these principles in health care and care services, including in the planning and securing of such services;
 - Part 2 relates to staffing in the NHS;
 - Part 3 relates to staffing in care services;

- Part 4 contain what are described as standard provisions, an ancillary power to make regulations, commencement powers and the Bills' short title.

Part 1 - Guiding Principles

18. Part 1 of the Bill sets out the guiding principles for both health and care staffing with duties including the planning and securing of health and care services. The principles in the Bill combine:
 - outcome focus;
 - transparency in decision making for service users and staff and;
 - the value of the importance of staff wellbeing.¹
19. The guiding principles will apply to health boards, NHS National Services Scotland and those special health boards with a clinical facing role, as well as all care service providers. Health boards will have to consider the guiding principles when commissioning care services from other providers and commissioning authorities will have to consider them and the duties placed on care providers when commissioning care services.
20. The principles intend to ensure equity and parity in decision making for staffing requirements across all staff groups and they note that the primary purpose of staffing health and care services is to provide safe and high-quality services.

Part 2 - NHS Staffing

21. Part 2 of the Bill sets out staffing duties on the NHS. Every health board in Scotland has a duty to workforce plan and to ensure the provision of high quality care. The Bill would place further duties and guiding principles on health boards to ensure staffing requirements are appropriate for the patients in their care, in all locations and specialities.
22. A set of 12 workforce planning tools were developed for nursing and midwifery following the work of the [Nursing and Midwifery Workload and Workforce Planning Programme \(the Programme\)](#) and these have been mandated by the Scottish Government for use in health boards since 2013. They form part of a methodology for health boards to determine on an annual basis what the establishment should be for each nursing setting.ⁱ
23. For areas where one of the 12 staffing tools currently exist, the Bill will make it explicit that health boards are expected to:

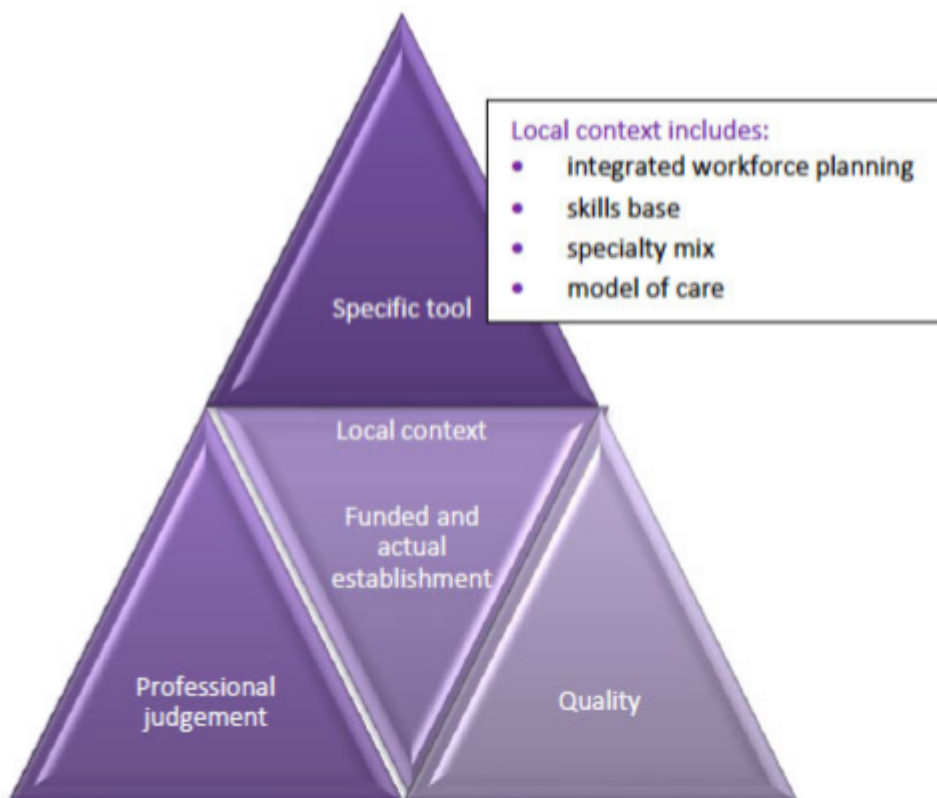
ⁱ There are currently tools for the following [nursing settings](#): Adult inpatient, neonatal, SCAMPS (paediatrics), clinical nurse specialist/community children's and specialist community nurse, mental health, small wards, maternity, emergency medicine/medicine, peri-operative and professional judgement

- apply the common staffing method (further details of this can be found in the next section);
- use the output from the tools along with professional judgement, local context and quality measures to underpin and inform decisions about staffing requirements;
- make sure a consistent approach is taken to identification and lessening of risk, take account of appropriate clinical advice and consider whether services can be redesigned;
- ensure staff are properly trained to apply the common staffing method and tools, engage with the process and understand the decisions made in relation to staffing decisions;
- monitor and report on how they have achieved all the above and provide assurance regarding safe and effective staffing.

Common staffing methodology

24. The tools noted above are based on an average workload for each speciality across Scotland, and are supplemented by considering the specifics of local context - for example, the age profile of staff, local recruitment challenges; quality indicators and professional judgement. The Scottish Government describe this as a triangulated approach. Figure 1 is produced by NHS Scotland to show the 'triangulated' process used as part of the staffing methodology.

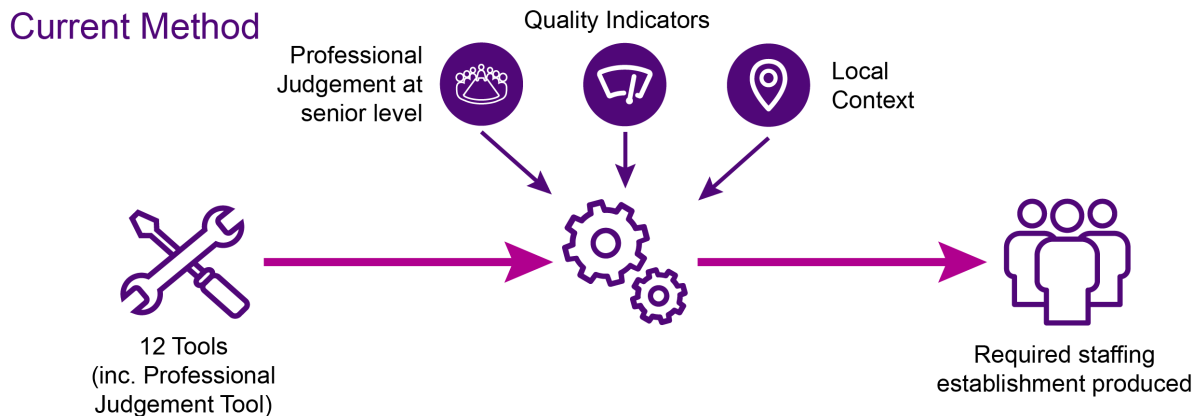
Figure 1: NHS Scotland Triangulation Diagram for workforce planning



Source: NHS Scotland

25. In the SPICe Bill briefing they have taken figure 1 and shown it in linear format. Figure 2 below shows our linear description of the approach.

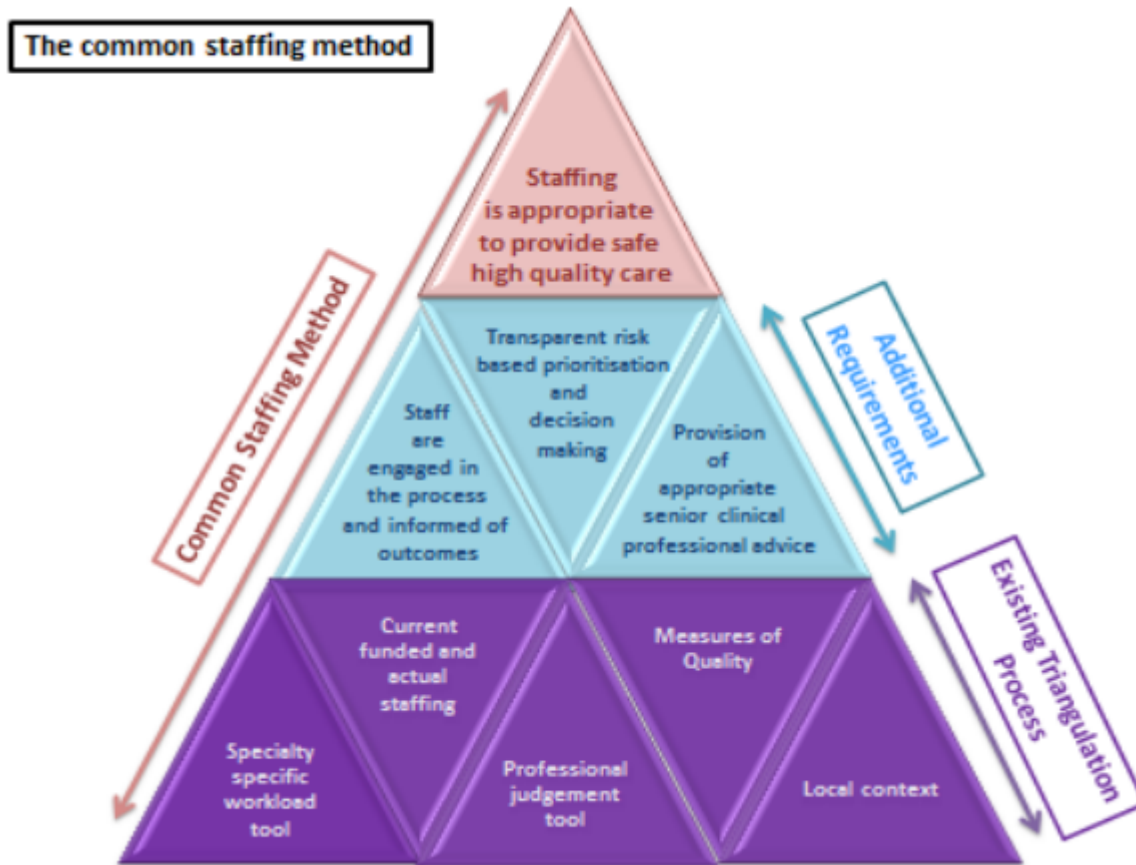
Figure 2: Diagram of the current method



Source: Scottish Parliament Information Centre (SPICe)

26. Although it has been mandatory for health boards to use the tools and methodology since 2013 the Policy Memorandum notes there have been "inconsistencies in the way in which tools are applied and the extent to which the existing methodology is utilised to make informed decisions about staffing requirements".
27. An updated common staffing method is proposed in the Bill and detailed below. The diagram illustrates the common staffing method and identifies which aspects relate to the existing triangulation process (the base of the pyramid) and which are additional duties under this Bill (shown in the middle section). All leading to the proposed new common staffing method as show in figure 3.

Figure 3: Proposed new common staffing method



Source: Health and Care (Staffing) (Scotland) Bill, Policy Memorandum

28. An equivalent linear description of the approach shown in figure 3 has been prepared by SPICe and is shown below in figure 4.

Figure 4: SPICe interpretation of ‘common staffing method’



Source: Scottish Parliament Information Centre (SPICe)

Part 3 - Care Services Staffing

29. Part 3 of the Bill sets out staffing duties in care services. It is currently the responsibility of every provider of care services to engage properly qualified and competent people working in appropriate numbers to ensure the health, welfare and safety of service users. Providers are also required to ensure their employees receive appropriate training to carry out their duties and are given time for further training.
30. The Policy Memorandum notes the purpose of including care services in the legislation is to allow the sector to build on and strengthen existing mechanisms. This is achieved by placing Regulation 15 of the Social Care and Social Work Improvement (Scotland) Regulations 2011 in the Bill to create a single legislative framework in this area across health and care settings. By having parity in the legislation the expectation is that it will allow, and support, innovative approaches to workload and workforce planning which take into account the role of the range of staff groups employed across multiple organisations delivering care.
31. The Bill builds on existing legislative functions by providing:
 - A power for the Care Inspectorate (CI) to work in consultation with the care sector to develop staffing methods (workforce planning tools) for application in specific settings, where a need has been identified. Initially this will only be for care homes for adults. Other powers include:
 - A regulation-making power for the Scottish Ministers to enable the CI to develop tools for other care settings in the future, if required;
 - A regulation-making power for the Scottish Ministers to require the use of staffing methods developed by the CI;
 - The ability for Scottish Ministers to issue guidance to care service providers setting out further detail around the duties contained within the Bill.
32. The CI's statutory function requires them to work with the relevant sector to examine if a tool is appropriate. If there is agreement it would be up to the CI to facilitate the development and validation of a tool, in collaboration with the sector.
33. Care homes for older people will be the first setting for which a tool is developed. This will build on existing work by the sector to produce a dependency tool for use in care homes. By initially focussing on only care homes for adults the Scottish Government believe this will provide an opportunity to test and evaluate an approach and its impact on quality of care as well as service users' experiences.

Part 4 - General provisions

34. Part 4 of the Bill includes general provisions falling into three sections:
 - Section 12 sets out the scope of the regulation power available to Scottish Ministers under the Bill, including power to amend other Acts (only by affirmative instrument).

- Section 13 provides that Scottish Ministers may by regulations commence the provisions of the Bill on such dates as they determine.
 - Section 14 gives the Bill its short title as the Health and Care (Staffing) (Scotland) Bill.
35. Each of these provisions are of a standard nature found in most legislation. The Delegated Powers and Law Reform Committee have scrutinised the regulation-making powers and we report their conclusion later in this report. Beyond that we have nothing to add in relation to section 4.
36. This report considers the evidence we have received and uses it to examine the general principles of the Bill.

Part 1 - Guiding principles for staffing

37. We examined the general principles of Part 1 of the Bill as set out in paragraphs 18-20 as they apply in territorial health boards, service providers and others. Our primary purpose was to understand the breadth of the provisions in this part and the extent, if at all, to which they would achieve their primary purposes.
38. Most submissions to the Committee's call for views were supportive of the guiding principles of the Bill. Scottish Borders Council/Integration Joint Board stated:
- The guiding principles for staffing are laudable. No-one is likely to take issue with a main purpose aimed at providing "safe and high quality services"
39. However the Law Society summarised initial thoughts of a number of witnesses when they stated:
- ” the guiding principles are unobjectionable, but so general and multi-factorial as to leave plenty of scope for subjective judgement and the inevitable juggling of competing priorities....It is difficult to assess from the face of the Bill whether the main policy objective of appropriate staffing will be met, as the Bill is largely a vehicle for more legislation to come.
40. We therefore determined to look at the individual components making up the general principles in turn.

Process or outcomes?

41. The integration of health and social care is discussed later in the report. However it is noted that the integration agenda is very focused on providing better outcomes for individuals.
42. Some submissions highlighted the Bill was very process focused rather than focussing on outcomes. Some stakeholders were concerned the Bill could undermine individuals by focussing on process and narrowly defined settings, rather than the outcomes for service users.
43. COSLA indicated they "see the Bill as focussing on inputs rather than outcomes" ² . This was supported by Glasgow City IJB who felt it was significant that the Public Bodies (Joint Working) (Scotland) Act 2014 is explicitly about outcomes for individuals and communities whereas they saw the Bill as very process-oriented. They believe "there is real potential that this Bill will mitigate against the delivery of those outcomes" ³ .
44. The Scottish Council for Voluntary Organisations (SCVO) saw "no particular benefit coming from the bill; it has no focus on outcomes, which is how the sector thinks at the moment." ⁴ By contrast, the Scottish Social Services Council (SSSC) believe the Bill "supports continued progress towards outcome focused health and social care scrutiny..." ⁵
45. The Allied Health Professions Federation Scotland (AHPFS) advised they would like the General Principles to have an outcomes focus, noting Part 1 of the Bill


should be "underpinned by an additional principle relating to optimising outcomes for patients and service users".⁶

46. The Policy Memorandum notes that responses to the Scottish Government's consultation highlighted a "focus on achieving better outcomes for service users should be at the heart of the legislation..."⁷
47. The Cabinet Secretary for Health and Sport advised the Bill doesn't explicitly mention outcomes believing it shouldn't. Noting health and care standards and quality measures already define the outcomes the Scottish Government wants to see. The Cabinet Secretary advised the Bill "will put in place a framework to support the systematic identification of the workload needed to improve outcomes and deliver high-quality care".⁸

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.

Accountability

50. The [Policy Memorandum](#) notes the Bill places a general duty to ensure appropriate staffing on health boards and care service providers. It states it will be health boards, commissioners and providers - that is organisations rather than individuals- who will be accountable.
51. Concerns were raised with us that there needs to be greater clarity on where accountability sits. If no-one is named as an accountable officer, there is a risk responsibility is felt at the level of people who are running the tools at ward level (senior charge nurses and team leaders), and it is they who become exposed if there is an adverse event arising as a result of short staffing.
52. The Chartered Society of Physiotherapy noted "what seems to be missing from the bill as it is couched is accountability". Whilst the Royal College of Surgeons of Edinburgh advised:

 Responsibility for implementation and approach to safe staffing should be organisational with non-delegable responsibility for compliance being jointly shared between the commissioning bodies and the institutions and cannot flow into the senior staff on any operational or governing committees. There is a danger that individuals are held accountable for not being able to provide "safe" levels despite circumstances being out of their control.⁹

53. Those in the care sector have similar concerns over lack of clarity around accountability. We heard of confusion about whether accountability will be with the provider or with the commissioner. UNISON Scotland advised if something is put in place and is to be adhered to then people need to know who is responsible for that adherence.¹⁰
54. UNISON Scotland also highlight the potential difficulties inherent in commissioning services where lines of responsibility are not clear cut:
- ” Given the fragmentation of delivery of care services the question of who the designated person with responsibility for ensuring safe staffing levels – and how they are reported is a serious one. This is particularly the case when rather than being provided directly, care provision is commissioned from a third party. Who would be responsible for measurement – the private care provider or the IJB/ Council commissioning the care?¹¹
55. The Scottish Partnership for Palliative care raised a similar issue, "it ends up being very difficult if there is an expectation on the part of the regulator that the provider will meet a certain set of workforce requirements but there is not adequate resource to meet that in the commissioning process. The comeback in that position is often at the level of the provider, who may suffer because of poor ratings from the regulator".¹²
56. The Coalition of Care and Support Providers in Scotland (CCPS) noted it was a huge concern for their members that there is no duty placed on commissioners.¹³ The ALLIANCE advised the procurement of care services should require commissioners to bear some responsibility for ensuring that providers are adequately supported and funded to meet safe staffing obligations.¹⁴
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.

Assurance

59. Whilst this Bill is not about the rights of individuals, but about putting staffing tools and methodologies on a statutory footing, the guiding principles and overall purpose is about providing assurance and reassurance that someone in hospital or social care is receiving both safe and high quality care.
60. Healthcare Improvement Scotland (HIS) noted there were some gaps around dynamic day-to-day management and how someone reacts when they come on shift and a couple of people are off sick or how cover is provided if someone on a night shift goes off. They raised the question of how they can provide assurance that people will have adequately trained staff to look after them 24 hours a day, seven days a week, in health and care services. ¹⁵
61. HIS further advised that although not in the Bill, they have as part of their excellence-in-care approach, been working to make available to the public information on expected staffing levels and actual staffing levels on a ward, and advised some boards are working towards that. ¹⁶
62. The Scottish Government accepted there were issues around staff and members of the public raising concerns with staffing levels. They advised:
- ” staff will tell us that they are not quite sure what to do, or else they put something into the incident reporting system and either nothing happens or something happens three months later. It is something that we would work on with stakeholders, the colleges, HIS and staff. For patients and service users, we would want to work with people to get something that is meaningful and practical and makes a difference
63. A further area we considered where clarity may be required is around assurance. The Policy Memorandum states "The key aims of placing the existing tools and methodology on a statutory basis include providing assurance, for both staff and service users, that appropriate staffing is in place to enable the provision of high quality care." (para 146)
64. We sought more information on how staff on the ground and patients (and their families) can be sure staffing is adequate.
65. The ALLIANCE noted they "are concerned that the principles outlined in section 1(1b) are reliant on a perceived consistency with the purpose of health and care staffing...We believe that a clearer explanation is requiredof 'safe' and 'high quality' services [in section 1(1)(a)] from the perspective of people who use support." ¹⁷
66. The CI noted "the bill's contribution to levelling some of the distinctions that currently exist between health and social care" adding they though "the fact that it is based on a general set of principles that apply to both health and registered care services is important." Before explaining the current statutory condition applying to providers in social care and contrasting that with health services:

” Regulation 15 of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 sets out the condition that providers should have in place adequate numbers of “suitably qualified” staff. We understand that the bill applies that to health services as it currently applies to social care. We see the bill as providing and adding value through that development.¹⁸

67. The Policy Memorandum places "public assurance that the goal of sufficient staff to ensure safe and high quality care across all health care settings is at the heart of the Bill".

68. We asked the Cabinet Secretary to provide detail on how the public can access information on the existing tools. In response she advised information could be found on the Information Services Division Scotland (ISD) website which directs users to the Scottish Standard Time System (SSTS) website which includes video clips on how to use the tools. She added the information resource and associated learning packages are currently being reviewed.

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.

Wellbeing of staff

72. The guiding principles of health and care staffing are to provide safe and high quality services, helpfully, the Policy Memorandum notes whilst doing this staff wellbeing also has to be assured.

73. The Royal College of Nursing Scotland (RCN) notes the duty to ensure appropriate staffing is set out in the Bill however they would like to see the health, safety and wellbeing of staff included in the duty.¹⁹

74. Marie Curie believe ensuring staff safety and wellbeing is paramount to ensuring safe and high quality care can be delivered. They welcome the provisions in the Bill which focus on an open and honest culture but believe further work needs to be undertaken across health and social care to ensure staff are valued, recognised and have the time needed to provide care and support. ²⁰

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.

The professional voice

77. The need for the role and input of professional judgment to be more prominent in the Bill was noted by numerous witnesses. It was felt professionals had to be involved in the process, with views taken at a local level i.e. below executive and senior management level.

78. At present, while professional judgment is part of the new common staffing method it is not included in the Bill. The Policy Memorandum notes the Programme for Government states "The Bill will ensure nationally agreed, evidence based workload and workforce planning tools are applied, and ensure key principles relating to professional judgment, local context and quality measures underpin workload and workforce planning."

79. Currently professional judgment is mentioned only in relation to the consideration of the results from the common staffing method. We wanted to understand the adequacy of this in light of the commitment given.

80. The concern seems to stem from the fact the tools within the common staffing method are often only run once a year. This means on a day-to-day basis staff have to use their professional judgment when factoring in skills mix, absence levels and acuity of patients. NHS Orkney advised sensitivity is not built into the tools for them to make day-to-day changes and the tools do not facilitate the piece of work that needs to be done on the skills mix and risk. ²¹

81. We heard the Bill does not adequately cover the day to day, dynamic staffing of health settings. The existing tools assist only in setting staffing establishments in nursing and midwifery settings, not how staff are deployed. It is the deployment of staff that determines whether or not staffing is safe and this is carried out through professional judgment, on the ward, on a daily basis.

82. The RCN believe it is essential this legislation enables and empowers nurses, from Nursing Directors to ward level, to use their knowledge, skills and experience in order to exercise their professional judgment. The RCN also noted:
- ” Without nurses of appropriate seniority (i.e. those ranging from directors of nursing and integration authority nurse board members to senior charge nurses and community team leaders) exercising their professional judgment through each and every step of the process, safe staffing establishments cannot be set; care assurance cannot be monitored; risk assessment cannot be undertaken; local resolution cannot be sought; and effective exception reporting cannot be completed. ²²
83. NHS Forth Valley noted the Bill encourages all levels of staff to be involved in reviewing safer staffing levels and be given adequate time to do this. ²³
84. COSLA observed professional responsibility was not reflected in the Bill, suggesting this should be an area for attention when looking at improvements to the Bill. ²⁴ Glasgow City Health and Social Care Partnership felt professional judgment had to be at the heart of the Bill rather than a mechanistic tick box exercise. ²⁵
85. The BDA Scotland Board advised determination of staffing must consider the mix of professions needed as well as the skill mix within each profession. They were concerned the Bill could well result in uneasiness and affect staff morale, noting staff will need to be properly supported and their wellbeing taken into account. ²⁶
86. The Chief Nursing Officer (CNO) when supporting the Cabinet Secretary advised:
- ” I absolutely expect there to be a professional judgment element. The grass-roots staff know best how to deliver most effectively, and professional judgement should support that. ²⁷
87. The Cabinet Secretary was clear in evidence to us "The approach in the bill is more transparent and allows for better decision making because it is evidence-based, with application of professional judgment." ²⁸ The Cabinet Secretary agreed the bill provides a tool that will help providers and commissioners of health and care services to recognise when there is a need for increased staffing "when we have a consistent methodology that produces evidence on the workload, to which professional judgment is applied, and that process takes place on a statutory basis". ²⁹
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.

Integration of health and social care

90. We received considerable evidence on the impact the Bill could have on the integration agenda. The Scottish Government advised the Bill will support the increased integration of health and social care services by providing a consistent framework for staff planning across the sectors, and more specifically across the organisations entailed in integration: health boards, local authorities and integration authorities.
91. Integration Joint Boards (IJBs) are not currently employers themselves and the Bill, in effect, requires health boards and local authorities to put in place a workforce development/organisational development plan for those parts of the workforce providing services. They also require to ensure arrangements are in place to develop and support staff in the delivery of those integration services.
92. Participants at the NHS Scotland Event Session and a large number of submissions to the Committee's Call for Viewsⁱⁱ as well as witnesses we heard from all suggested the Bill could undermine or stall integration. It was suggested that rather than integrate services the Bill separates out health from social care and misses the important role of allied health professionals (AHPs) and other staff groups.
93. Scottish Borders Council and Scottish Borders Integration Joint Board noted restricting the application of the proposed duty to care homes reinforces a perception that different expectations continue to apply to different parts of a system, which should be seen as a whole.³⁰
94. The Chief Officers Group Health and Social Care Scotland believe the development of tools considering one professional group (or a limited number of groups) in isolation may be detrimental to the development of integrated services across health and social care.³¹
95. The Law Society of Scotland believe the Bill does not particularly take account of integration of health and social care other than the imposition on them of a similar list of principles and duties in regard to staffing.
96. Concerns were expressed the Bill focusses on inputs rather than outcomes. Glasgow City Health and Social Care Partnership told us:

ii Aberdeenshire IJB, NHS Ayrshire and Arran, Borders IJB, Royal Blind, SPDS, East Ayrshire IJB

” ‘The Public Bodies (Joint Working) Scotland Act 2014 clearly sets out nine national health and wellbeing outcomes that integration authorities are expected to work towards achieving. It is significant that that legislation is explicitly about outcomes for individuals and communities. There is real potential that this Bill will militate against the delivery of those outcomes because....it is very process-oriented.’³²

97. However the SSSC welcome the Bill's policy intention on collaborative working across the health and social care system and feel the Bill takes account of the needs of service users and ultimately creates a safer environment for service users and staff.³³

Equity and parity across services

98. Multi-disciplinary working is essential for positive service user outcomes (in both health and social care environments). The integration of health and social care relies on multi-disciplinary working and as indicated above the lack of reference to AHPs in the Bill is a major concern for many witnesses.

99. AHPs work across health and social care, as independent professionals covered by their own professional bodies and regulation. AHPs are involved throughout a persons lifetime from birth to end of life palliative care, they work in public health preventive services and in primary, secondary and community care. AHPs account for more than 11,500 staff, 8.3 per cent of the NHS workforce. They are increasingly central to bridging the gap between health and social care. They are key to keeping people out of hospital.

100. The AHPFS suggested the Bill does not reflect the reality of multi-disciplinary working, and some parts of the Bill seem specifically to exclude AHPs.³⁴

101. Concerns were also raised the Bill could create an unbalanced approach to staffing, with a focus only on nursing and midwifery staff. Integrated services utilise skills across a multi-disciplinary team and it was unclear to witnesses how an integrated environment could be viewed as being safely staffed when only one part of this team is represented in that assessment.

102. Similar concerns that this approach risked skewing resources from multi-disciplinary teams to ensure the resource requirements on nursing and midwifery would be met were raised with the Scottish Government as part of their earlier consultation.

103. Paragraph 93 of the [Policy Memorandum](#) suggests that a general duty to ensure appropriate staff covers all appropriate staff:

” For health boards, this general duty to ensure appropriate staffing would be required in addition to a health board's existing duty in the 1978 Act, to put and keep in place arrangements for the purposes of workforce planning...This general appropriate staffing duty will apply to health boards in relation to all their employees who deliver care, including but not limited to nurses, midwives, doctors, allied health professionals.

104. The Policy Memorandum at paragraph 18 acknowledges the emergence of multi-disciplinary teams:
- ” the emergence of local multi-disciplinary teams comprising staff from both health and social care backgrounds is becoming more widespread. The Scottish Government considers that it is therefore important that approaches to staffing, including the development of workload tools, enable seamless, joined up services, support - rather than constrain - service innovation and redesign and ensure an evidence-based approach can be taken when considering staffing requirements.
105. AHPs work in all 11 types of health care listed in proposed new section 12IC of the NHS (Scotland) Act 1978, which would be inserted by section 4 of the Bill. The list of employees in section 12IC, however, identifies only registered nurses, midwives and medical practitioners, along with other people providing care for patients who work under the supervision of those staff groups. As AHPs do not work under the supervision of any of those staff groups they do not appear to fall within the ambit of the Bill.
106. The Chartered Society of Physiotherapists noted the Bill will result in risks to the quality of patient care, in terms of experience and outcomes, unless a multi-disciplinary team approach is taken.
107. AHPFS advised the Bill will create unintended consequences and will skew resources from the current financial distribution. With the likelihood Directors are likely to say: “Sorry, we can see what you mean about needing more AHPs or multi-disciplinary teams, but my hands are tied by the legislation.”³⁵ And the Society and College of Radiographers stated there would be a problem if the Bill only applied to nurses and midwives, noting if there was too much emphasis on them only their numbers could be funded because the tools applied only to them.³⁶
108. The Policy Memorandum responds to the criticisms that resources could be skewed by noting the Bill applies a general duty to all staff groups. Adding this will require health boards to take account of the impact of staffing decisions across all staff and prevent diversion of resources to one staff group. The Memorandum also notes the general duty which applies to all staff groups provides a framework for the use of multi-disciplinary tools, should they be developed, in the future.³⁷ The Financial Memorandum seems to indicate that it will be 10 years plus before any multi-disciplinary tools are available for use.
109. In their [response](#) to the Delegated Powers and Law Reform Committee (DPLR), the Scottish Government acknowledge that the creation of multi-disciplinary tools is new territory, let alone tools that can function across health and social care settings and services:
- ” In particular, since multi-disciplinary tools, with the exception of the emergency care tool, have not yet been developed, there is currently no body of evidence or experience to call upon to determine what type of changes, if any, might be necessary to improve the common staffing method in the future in light of the experience of developing and operating further multi-disciplinary staffing level tools.

110. The British Dietetic Association (BDA) Scotland Board recognises the Bill permits the creation of new tools where necessary and sets a mechanism to develop new tools. However, they are concerned there is no commitment to develop such tools for AHPs and also a complete lack of timescales for development and implementation. ³⁸
111. The Scottish Government advised during evidence:
- ” ...as consideration is given to what the right skills mix is for the workload, allied health professionals will turn out to be the very people who have the skills that are required to meet that need...the Care Inspectorate will enable work to be done to review the current tools and to look at how they need to be modified and applied to a care home setting. We expect a degree of AHPs’ expertise to be involved in that work to develop the tools that would be appropriate for a care home setting. ³⁹
112. There is also a concern in the social care sector that resources could be skewed towards the nursing sector. The [Policy Memorandum](#) advised "some social care bodies were also worried that a focus on NHS settings could skew resourcing decisions and lead to an under-resourcing of social care with a concern that integration authorities will have to prioritise resources to nursing and midwifery over the rest of the health and social care workforce."
113. This was an issue reiterated by some of our witnesses. Scottish Care noted:
- ” If the health aspect of the bill is implemented first, resource will go first into getting people employed in that sector. That means that we are likely to lose staff. ⁴⁰
114. Those working in the care sector also raised a concern other care services outwith care homes would then become third in line for services, making them very difficult to resource. The SCVO were concerned they would have to divert staff from one service to focus on care homes. ⁴¹ CCPS noted a similar concern, highlighting a very small proportion of their members have care homes and if resources initially go to health and then to care homes, services that deliver community support will become under resourced.
115. The Cabinet Secretary addressed these issues on 2 October indicating:
- ” I am keen not only that we should break down some of the current barriers, but that we should not create additional barriers. I understand the concerns that he [Alex Cole-Hamilton] raises.
- When the developed tool is worked through in social care settings, it will include the skill sets that come from AHPs in many cases, so it is not entirely accurate to say that they are excluded. As one applies the assessment of workload and then considers the skill sets that are required to deliver against the detail of that workload, AHPs in particular will have a critical role to play. They are covered in that way.

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 to providing funds for nurses and midwives to the detriment of AHPs and multi-disciplinary 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.

Part 2 - Staffing in the NHS

122. Part 2 relates to staffing in the NHS and we examined the general principles set out in paragraphs 21-27 as they apply in territorial health boards.
123. Every health board and the Common Services Agency for the Scottish Health Service has a duty to workforce plan and to ensure the provision of high quality care. The Bill would place further duties and guiding principles to ensure staffing requirements are appropriate for the patients in their care.
124. As part of wider measures to ensure a sustainable health workforce a set of 12 workforce planning tools were developed for nursing and midwifery. Over a period of years from 2004, the tools were developed following the work of [the Programme](#) and have been mandated by the Scottish Government since 2013. These form part of a methodology for health boards to decide on an annual basis what the establishment should be for each nursing setting.
125. For areas where one of the 12 staffing tools currently exist, section 106 of the Policy Memorandum explains that the Bill will make it explicit that health boards are expected to:
- apply the common staffing method (further details of this can be found later in this report);
 - use the output from the tools along with, professional judgement, local context and quality measures to underpin and inform decisions about staffing requirements;
 - make sure a consistent approach is taken to identification and lessening of risk, take account of appropriate clinical advice and consider whether services can be redesigned;
 - ensure staff are properly trained to apply the common staffing method and tools, engage with the process and understand the decisions made in relation to staffing decisions;
 - monitor and report on how they have done all the above and provide assurance regarding safe and effective staffing.

National workforce planning

126. Although this Bill is not linked to national workforce planning, the National Health and Social Care Workforce Plan (the Plan) is mentioned throughout the Policy Memorandum and relates to duties on health boards, and providers of care services and service providers to ensure appropriate staffing. **We discuss wider recruitment and retention issues and their links to the Bill later in this report.**
127. The Plan was published by the Scottish Government in three parts and lays the foundations for improved national workforce planning across integrated health and social care services. [Part 1](#) of the Plan covers NHS Scotland, [Part 2](#) covers social care and [Part 3](#) covers primary care.

128. The Scottish Government believe 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; and
 - supporting consideration of service delivery models and service redesign. ⁴²

Current tools and development of new tools

129. As mentioned above, there is a set of 12 workforce planning tools for nursing and midwifery which were developed following the work of the Programme. We have been advised the tools have not been evaluated or modified since they were created.
130. Given the absence of any evaluation carried out on the tools we issued a survey to nursing and midwifery staff at various levels across all health boards who are responsible for using or completing workforce planning tools. We sought to determine the extent of current usage and whether the tools remained fit for purpose. We received 195 responses from staff across eight of the 14 territorial health boards.
131. The full summary of responses can be read [here](#). However, some of the main observations from the survey were:
- Some respondents were explicit about problems with specific tools. For example, the Community Nursing Tool, the Midwifery Tool in community settings, the Mental Health and Learning Disability Tool were stated to be not helpful in community settings. The perioperative tool duplicated other methods and some tools were very time-consuming to carry out.
 - A range of other methods (eg. SafeCare, Shelford, Risk assessment and staff 'huddles') were used by staff to try to ensure their ward or area had adequate staff of the right skill mix, on a day to day basis
 - Many respondents were unsure how the tools contributed to ensuring staffing was safe for patients.
132. The issues noted above were also discussed and confirmed during our informal session with frontline staff.
133. In a [letter](#) dated 10 September 2018 the CNO provided us with a breakdown of the number of wards/teams/departments in each NHS board area who have applied each of the workload tools during the financial years 2016/17 and 2017/18 .
134. The letter also notes "We do not currently hold validated data on how many wards/ teams in each Board should apply each of the tools. In the absence of this information we are unable to ascertain the number of wards who should be applying each tool and, therefore, what 100% compliance looks like." The CNO went on to advise work was underway that will enable them to report on the percentage of wards who are applying the tools as required.

135. The letter from the CNO allowed us to identify discrepancies in the running of the tools. We wrote to the relevant boards' seeking clarification on these discrepancies. The letters and the responses can all be viewed [here](#).
136. The reasons for not using the tools provided by NHS boards vary and provide a basic understanding of some of the issues with the tools as they currently stand. Some boards had good reasons for not running certain tools such as service reconfiguration and ward changes. Other reasons are listed below:
- the repeated use of the children's community nursing and specialist nurse tool is extremely time consuming to apply and does not currently provide a useful output to enable a decision about staffing levels.
 - In the professional opinion of the Nurse Director, using the clinical nurse specialist tool during 2017-18 was not a priority when compared with the need to use limited resources to run other more complex tools.
 - use of Trakcare used as a source of gathering patient and acuity and dependency information, in preference to the manual collation required to run the tools.
 - lack of capacity within the workforce - significant additional support required to run tool.
 - attempted to run the tools but were unable to interpret the data and were therefore unable to run reports.
137. It is clear services provided by nurses and midwives are very different from those 10-12 years ago. As such we were pleased to learn from witnesses that the Scottish Government set up a working group to review the tools.⁴³
138. In a [letter](#) dated 20 September 2018 the Cabinet Secretary for Health and Sport advised the newly established Nursing and Midwifery Tool and Maintenance sub-group of the Programme steering group met for the first time on 4 September 2018.
139. The role and remit of the group includes providing assurance that existing workload tools remain contemporary by overseeing regular review and updating of existing tools as necessary and to oversee the development of new tools.
140. The creation of the working group was welcomed by witnesses. The RCN noted it is encouraging the Scottish Government has put in place a process to review the 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

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.

SSTS platform

144. The Scottish Standard Time System (SSTS) is the software platform on which the tools are located. This platform is used by all health boards to run the tools as well as its prime purpose of holding their payroll and time recording information.
145. Several responses from NHS boards noted issues with SSTS. NHS Shetland advised there was no requirement to upload results onto the SSTS platform so they used the 'offline' version. This has been largely due to technical difficulties in accessing the SSTS platform. NHS Tayside advised there is currently no facility to capture school nursing workforce activity on SSTS.
146. The National Waiting Times Centre advised they are co-hosted by another board which has resulted in challenges with accessing the tools via the SSTS platform over a sustained period.⁴⁴
147. The Scottish Executive Nurse Directors Group noted SSTS is not necessarily fit for purpose, because it involves the entry of lots of old data/information requiring duplication of effort by staff to triangulate information.⁴⁵
148. Witnesses, including the Cabinet Secretary for Health and Sport advised NHS National Services Scotland (NSS) are undertaking a procurement exercise for a new platform to replace SSTS.
149. The Scottish Government advised:
- ” We are looking at the e-rostering platform, after which we will take a decision about whether to stay on the present site or to transfer over to that. As part of the procurement exercise, we will be asking about the ability of the platform to feed into our workload tools platform.⁴⁶
150. The Financial Memorandum does not note any costs in relation to procuring a new platform to replace SSTS. The CNO, in her letter dated 10 September 2018 advised these costs were not included "because the need for, and procurement of, the new platform is not due to the requirements of the Bill, but rather the need to significantly enhance the functionality available to manage and monitor the deployment of staff on a real-time basis."

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.

Training

153. One of the issues highlighted by our survey was that around a third of respondents had not received training on how to use the tools, or had only received ad hoc training from a colleague. There was no consistency in how training was delivered. This issue was also noted in the responses we received from NHS boards.
154. [NHS Western Isles](#) advised they had not received training on certain tools so were unable to run them. [NHS Orkney](#) advised the on-line training packages are not user friendly and are difficult to understand, lacking depth of explanation. They also noted they had lost a number of personnel who were skilled in operating the tools with little training available to replace those who were lost.
155. The Scottish Executive Nurse Directors Group advised "when the tools were first established, there was a huge training effort to support them. That cohort of trained people has changed and moved out. We have not kept as up to date as we should have on the tools".⁴⁷ They further noted more education and training needs to be undertaken.
156. It was advised assessment was required to understand where staff need more training and education to use the tools properly. UNISON believe the more prepared senior charge nurses and their equivalents in the community are to understand the importance of safe staffing, the better the service will be.⁴⁸
157. We heard many just didn't have the time to undertake training; and Audit Scotland advised there was a risk the time needed to train affected staff would put additional workload pressures on staff and services.⁴⁹
158. NHS Education for Scotland stated people being given the time and space to undertake training was important. They advised training was available, and the legislative process could bring a greater prioritisation to it.⁵⁰
159. The Bill's Financial Memorandum (FM) details the training costs of implementing the Bill. The cost per year for 2019-2021 is given as £332,215. Section 4 (at proposed new 12ID) of the Bill states that NHS Boards must ensure that those employees affected receive adequate time to use the common staffing method, and understand the results and processes.

160. NHS Lothian, NHS Greater Glasgow and Clyde and the Scottish Executive Nurse Directors Group all felt training costs had not been worked through and may bring an additional cost to bear.⁵¹
161. The RCN expressed training requirements and costs set out in the Memorandum were insufficient. They also noted serious concerns about the training need as identified in the Financial Memorandum, believing it was much higher than stated. They also questioned the Financial Memorandum's statement that training could be completed as part of the continuous professional development which is included in current nursing and midwifery establishments, noting, at present, nursing staff getting time to complete even mandatory training such as moving and handling and infection control can be a challenge.⁵²
162. The Cabinet Secretary addressed training with us stating
- ” The role of Healthcare Improvement Scotland is critical in that regard, as is the role of NHS Education for Scotland, the education body, to ensure that we have a consistent planned programme of roll-out and training and that training is continuous so that as new staff come on board we are able to meet their training needs, too. Should the bill be passed, that will be covered in the guidance on the bill and in the programme of work that is carried out by the chief nursing officer and colleagues”.

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.

Compliance and sanctions

168. The Bill at section 4 (proposed new 121E) requires annual reports by health boards and the Common Services Agency to be made to the Scottish Government. The reports are required to cover how duties have been carried out ensuring appropriate staffing, use of the common staffing method and the training of staff. No specific sanction for failure to comply with the provisions of the Bill are stated although it is understood existing powers contained in the 1978 Act allow Scottish Ministers to take action.
169. The Policy Memorandum advises that in practice reporting will be done through existing annual reporting mechanisms (para 124) and through existing local and national reporting and regulatory mechanisms and HIS and the CI scrutiny processes. (para 89)
170. HIS advised us they were to be given new powers, similar to those of the CIⁱⁱⁱ, and their roles should mirror each other. Social Care providers are assessed by the CI to ensure appropriate staffing of services.
171. The Cabinet Secretary for Health and Sport advised us the Scottish Government will expect boards to report not only on the application of the tools but on the outcomes, and HIS will look at that in its inspections.⁵⁴
172. NHS Forth Valley noted there is no mention of what the national monitoring processes will be to ensure consistency across all boards.⁵⁵ As mentioned above there is a lack of detail in the Bill around sanctions should the statutory requirements not be fulfilled by health boards. It is not clear what will happen to health boards if they do not adhere to the results of the common staffing method.
173. This issue was raised by many witnesses. NHS Orkney advised clarity must also be established regarding the scrutiny methodology and consequences of failure to comply.⁵⁶ The Royal College of Physicians of Edinburgh raised various questions around escalation and would welcome strengthening in this area of the Bill to allow for greater scrutiny and transparency, to ensure the confidence of healthcare professionals and the public is maintained.⁵⁷ The Scottish Executive Nurse Directors Group noted a need for clarity in the process of escalation.⁵⁸
174. When asked if HIS will have powers and the ultimate sanctions in parallel with those available to the CI, the Cabinet Secretary for Health and Sport advised:

ⁱⁱⁱ The Care Inspectorate discussed these powers and sanctions with us on 25 September. See the [Official Report](#) for that date.

” In its inspection role, HIS has a number of powers, which it will continue to have. It also has an important improvement function so, when standards are not being met and duties are not being complied with, it has a responsibility to offer support to allow people to improve and meet standards or fulfil duties. If improvement does not happen, other steps can be taken.

175. The enforcement issue was raised by the Delegated Powers and Law Reform Committee in their [Stage 1 report](#). In response to that report the Scottish Government stated the Bill inserts the provisions relating to health boards into the National Health Service (Scotland) Act 1978, noting:

” the existing powers contained in the 1978 Act for Scottish Ministers to take action where there are issues about discharge of health board duties will apply to the duties placed on health boards by this Bill. For example, there is a power of direction in section 2(5) of the 1978 Act which can be used generally or for specific matters (which could involve directing a particular board). There are also powers in section 78A where there has been failure in provision of a service.

176. The Scottish Government further advised if following improvement support and intervention there are still areas of non-compliance this can ultimately lead to the powers of intervention in the 1978 Act detailed above being applied. This was reiterated by the Cabinet Secretary for Health and Sport.⁵⁹

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 non-compliance. While we hope use of the powers never becomes necessary we would welcome a breakdown of the steps that could follow.

Part 3 - Staffing in care services

Background

179. Part 3 relates to staffing duties in care services and we examined the general principles set out in paragraphs 28-33 as they may be developed and applied to care services in the future.
180. Regulation 15 of the Social care and Social Work Improvement (Scotland) Regulations 2011 makes clear the responsibility of every provider of care services to ensure suitably qualified and competent people are working in appropriate numbers to ensure the health, welfare and safety of service users. Providers are also required under that regulation to ensure their employees receive appropriate training to carry out their work and time off work for further training. Section 6 of the Bill repeats the above regulation.
181. The Policy Memorandum at paragraph 128 notes the purpose of including care services in the legislation is to allow the sector to build on and strengthen existing mechanisms, thereby creating a cohesive legislative framework across health and care settings. By having parity in the legislation the expectation is stated that it will allow, and support, innovative approaches to workload and workforce planning which take into account the roles of the range of staff groups employed across multiple organisations in the delivery of care.
182. In addition the Bill provides a power at section 10 for Social Care and Social Work Improvement Scotland (SCSWIS) better known as the Care Inspectorate to work in consultation with the care sector to develop staffing methods (workforce planning tools) for application in care settings, where a need has been identified. Initially this will only be for care homes for older adults.
183. The Policy Memorandum at paragraph 133 states the CI is required to work with the relevant sector to examine if a tool is appropriate (although this requirement is not included in the Bill). The Bill does however require the CI in section 10 to collaborate with a range of interested parties in the development and validation of a tool.
184. The Policy Memorandum makes clear care homes for older people will be the only setting for which a tool is developed within the first five years. It is indicated this will build on existing work by the sector to produce a dependency tool for use in care homes. By focussing on only care homes for adults the Scottish Government believe this will provide an opportunity to test out and evaluate an approach and its impact on quality of care and service user's experiences.

Existing Governance and regulation of social care services

185. Registered care services across Scotland are regulated by the CI who are also the scrutiny and improvement body for social work. The CI inspects care services and social work services. The CI website states:

” The Care Inspectorate is a scrutiny body which supports improvement. That means we look at the quality of care in Scotland to ensure it meets high standards. Where we find that improvement is needed, we support services to make positive changes.⁶⁰

186. The Health and Social Care Standards have been in place since 2018 and are used by the CI (and HIS) in their scrutiny and improvement work. The Standards note individuals should have the following outcomes:

- experience high quality care and support that is right for them;
- fully involved in all decisions about their care and support;
- have confidence in the people who support and care for them;
- have confidence in the organisation providing their care and support; and
- experience a high quality environment if the organisations provides the premises.

Is the Bill required for social care services?

187. The [Policy Memorandum](#) notes the purpose of including care services in the legislation is to enable the sector to build on and strengthen existing mechanisms by placing Regulation 15 into primary legislation and creating a cohesive legislative framework across health and care settings.

188. The Scottish Government undertook two consultations on proposals for this Bill. The first consultation sought views on the proposals to enshrine safe staffing in law, starting with the nursing and midwifery workload and workforce planning tools. The second consultation included refreshed legislative proposals, in particular detailed proposals for care services.

189. A majority of respondents to the Scottish Government second consultation agreed the requirements of the Bill should extend across health and social care settings - thus reflecting the importance of an integrated approach to planning and delivery of services. However, some respondents (mostly Health and Social Care Partnerships and public bodies) felt it was unnecessary to expand to care settings. They believe the current statutory frameworks were sufficient to ensure safe staffing in the sector.

190. Our witnesses were generally unsure whether Part 3 of the Bill was required. The majority of witnesses we heard from felt there was already a clear statutory

requirement for ensuring appropriate staffing in the care sector and the Bill was not needed for this purpose.

191. COSLA advised through discussions with all of its partners they:
- ” found a common thread, that neither COSLA nor its partners can see where the Bill adds value to the social care workforce, as safe and high-quality services are already assured through existing legislation, the inspection regime, current policy and the Health and Social Care Standards.⁶¹
192. The Scottish Partnership for Palliative Care noted the main issues of having the right people, in the right place at the right time was not primarily caused by problems with local workforce planning or by inadequacies in legislative or regulatory frameworks. They believe major workforce issues are caused by factors including national workforce planning, affordability for commissioners and wider issues that affect recruitment and retention.⁶²
193. However, not all witnesses were against Part 3 of the Bill. The SSSC felt the Bill was positive, advising "The tools can help to start to align them to the national health and social care standards...From our perspective, the tools fit nicely with our codes of practice on the values, behaviours, skills and competencies that workers are required to have in delivering care."⁶³

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.

The role of the Care Inspectorate

197. The Bill provides a new statutory function for the CI: to work in consultation with the care sector to develop staffing methods. Initially this function is only for care homes

for adults, however, a regulation-making power enable the powers of the CI to be extended to other care settings in the future. The Public Services Reform (Scotland) Act 2010 at section 47(1) defines "care service" as covering:

- (a) a support service,
- (b) a care home service,
- (c) a school care accommodation service,
- (d) a nurse agency,
- (e) a child care agency,
- (f) a secure accommodation service,
- (g) an offender accommodation service,
- (h) an adoption service,
- (i) a fostering service,
- (j) an adult placement service,
- (k) child minding,
- (l) day care of children,
- (m) a housing support service.⁶⁴

198. The [Policy Memorandum](#) notes throughout the process of agreeing on a need for a tool and its development the CI would be required to work collaboratively with commissioning authorities, providers, recipients of services, partnership organisations, trade unions and professional bodies. Although we observe again the Bill only covers development of a tool and does not cover, as presently drafted, agreement of the need for a tool within section 10.
199. We heard some concerns about the CI having lead responsibility for producing such tools and many of the witnesses worried the Bill only noted a need for the CI to collaborate, not for co-production. Witnesses believe for any future tools for care services to be developed correctly they must be co-produced, specifically with providers and recipients of services.
200. Scottish Care highlighted collaboration is not the same as co-production and if tools are to be produced, the CI can lead, but they must be co-produced. They also advised any tool would need to be developed for the sector and co-produced by those who work in the sector.⁶⁵
201. The ALLIANCE advised:

” The national care standards were developed in co-production with providers, people who use the services and other bodies. The Care Inspectorate should see the value of doing that...We would be supportive of that, but with the caveat...that it is done in co-production, particularly with people who receive support and use services and with providers. ⁶⁶

202. COSLA noted they had received assurances from the Scottish Government the tools will be co-produced with the CI. ⁶⁷

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.

Wider recruitment and retention issues

205. As mentioned previously, this Bill is about staffing and workload planning, and does not cover wider workforce planning designed to ensure an adequate supply of staff to meet future requirements in health and social care.
206. The majority of witnesses raised concerns that the Bill was being introduced into a workforce context under pressure from general recruitment and retention problems nationally. Lack of availability of staff, high levels of predicted retirements is leading to short supply in many health professions, as well as the social care sector. These factors together with Brexit uncertainties mean that it is challenging to meet the existing requirements and staffing establishments currently set by health boards and social care providers.
207. Audit Scotland noted concerns associated with the risk of increasing vacancies, and over what measures health boards and social care providers should take if the rise continues. The National Health Workforce Plan acknowledges that for the next few years the numbers of student nurses and midwives entering the workforce will not be enough to meet demand.
208. Concerns were indicated about how providers could meet the requirements under the Bill and ensure sufficient staff given there are national shortages. The RCN stated:
- ” We also need to ensure that supply is dealt with, but the bill does not do that. We cannot tie the hands of boards and put a duty on them to provide appropriate staffing if the supply, which is held by the Scottish Government, does not come through. We would like that to be added. ⁶⁸
209. Cancer Research UK noted the workforce issues are not primarily caused by deficiencies in workforce planning at local level or by inadequacies in legislative or regulatory frameworks. They saw the problem as being primarily driven by factors including national workforce planning. ⁶⁹
210. Scottish Borders Council and Scottish Borders Integration Joint Board advised placing workforce planning tools on a statutory footing does nothing to address recruitment and resourcing issues in the health and social care service and among providers. ⁷⁰
211. The Scottish Government have not included national workforce planning in the Bill. They believe the application of a methodology and tools will provide evidence on workload demand and that the Bill provides a tool to help providers and commissioners of health and care services recognise when there is a need for increased staffing. ⁷¹
212. In evidence to us the Cabinet Secretary was confident that the Bill "will contribute significantly to robust workforce planning across health and social care." Later noting the link between local planning requirements and the national position:

- ” It is important that the approach will also contribute to increased robustness in workforce planning at local level. If local plans are more robust and evidence based, we will be able to collate more robust evidence-based data at national level to help us to work on national workforce planning with increasing acuity.

72

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.

Finance Committee and Delegated Powers and Law Reform Committee consideration

215. The Finance Committee issued a call for views on the Financial Memorandum of the Bill and received [11 responses](#). The issues raised included lack of training costs, costs associated with reviewing the staffing tool and costs to other social care providers. Following this they advised us they did not need to undertake any further work on the Bill. We have throughout this report addressed financial issues as appropriate.
216. The Delegated Powers and Law Reform Committee considered the Bill at its meetings on 19 June and 18 and 25 September. The Committee published its [report](#) on the Bill on the 25 September and we have nothing further to add to their report.

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.

Annexe A - Minutes of meetings

18th Meeting, 2018 (Session 5) Tuesday 5 June 2018

11. Health and Care (Staffing) (Scotland) Bill (in private): The Committee considered and agreed its approach to the scrutiny of the Bill at Stage 1.

22nd Meeting, 2018 (Session 5) Tuesday 11 September 2018

4. Health and Care (Staffing) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

- Dr Sally Gosling, Assistant Director, Practice and Development, Chartered Society of Physiotherapy;
- Kim Hartley Kean, Head of the Royal College of Speech and Language Therapists Scotland, representing the Allied Health Professions Federation Scotland; and
- Patricia Cassidy, Chief Officer, Falkirk Health and Social Care Partnership, representing the Chief Officers Group Health and Social Care Scotland

and then from—

- Rachel Cackett, Policy Adviser, Royal College of Nursing Scotland;
- Dr Mary Ross-Davie, Director, Scotland, The Royal College of Midwives;
- Dr David Chung, Vice President, The Royal College of Emergency Medicine (Scotland);
- Professor Alex McMahon, Executive Nurse Director, NHS Lothian, representing the Scottish Executive Nurse Directors Group; and
- David McArthur, Director of Nursing, Midwifery and Allied Health Professionals, NHS Orkney.

Brian Whittle declared a relevant interest. Full details of which can be found in the Official Report of the meeting.

5. Health and Care (Staffing) (Scotland) Bill (in private): The Committee considered the evidence heard earlier in the meeting.

23rd Meeting, 2018 (Session 5) Tuesday 18 September 2018

2. Health and Care (Staffing) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

- Karen Hedge, National Director, Scottish Care;
- Alison Christie, Policy and Development Officer (Workforce), Coalition of Care and Support Providers in Scotland;
- Andrew Strong, Assistant Director (Policy and Communications), Health and Social Care Alliance Scotland;

- Mark Hazelwood, Chief Executive, Scottish Partnership for Palliative Care; and
- Katherine Wainwright, Head of Human Resources, Turning Point Scotland, representing the Scottish Council for Voluntary Organisations;

and then from—

- John Wood, Chief Officer, Health and Social Care, COSLA;
- Stuart Bain, HR Business Partner (Health and Social Care Partnership), Fife Council, representing the Society of Personnel and Development Scotland;
- Dr Jane Kellock, Head of Social Work Strategy and Development, Social Work Scotland;
- David Williams, Chief Officer, Glasgow City Health and Social Care Partnership; and
- Eddie Fraser, Director, East Ayrshire Health and Social Care Partnership.

5. Health and Care (Staffing) (Scotland) Bill (in private): The Committee considered the evidence heard earlier in the meeting.

[24th Meeting, 2018 \(Session 5\) Tuesday 25 September 2018](#)

1. Health and Care (Staffing) (Scotland) Bill : The Committee took evidence on the Bill at Stage 1 from—

- Gordon Paterson, Chief Inspector Adult Services, Care Inspectorate;
- Phillip Gillespie, Director of Development and Innovation, Scottish Social Services Council;
- Ann Gow, Director of Nursing, Midwifery and Allied Health Professionals, Healthcare Improvement Scotland; and
- Joy Atterbury, Member of the Health and Medical Law Sub-Committee, Law Society of Scotland;

and then from—

- Karen Wilson, Director of Nursing, Midwifery and Allied Health Professions, NHS Education for Scotland;
- Joyce Thompson, Chair of the British Dietetic Association Scotland Board, and Dietetic Consultant in Public Health Nutrition, NHS Tayside;
- Dr Tony Axon, National Officer Scotland, The Society and College of Radiographers; and
- Tracey Dalling, Regional Organiser - Local Government Scotland, UNISON Scotland.

3. Health and Care (Staffing) (Scotland) Bill (in private): The Committee considered the evidence heard earlier in the meeting.

[25th Meeting, 2018 \(Session 5\) Tuesday 2 October 2018](#)

1. Health and Care (Staffing) (Scotland) Bill: The Committee took evidence on the Bill at Stage 1 from—

- Jeane Freeman, Cabinet Secretary for Health and Sport,
- Fiona McQueen, Chief Nursing Officer, Diane Murray, Associate Chief Nursing Officer,
- Louise Kay, Safe Staffing Bill Team Leader, Programme and Stakeholder Engagement, and
- Ailsa Garland, Principal Legal Officer, Scottish Government.

Brian Whittle declared a relevant interest. Full details of which can be found in the Official Report of the meeting.

3. Health and Care (Staffing) (Scotland) Bill (in private): The Committee considered the evidence heard earlier in the meeting.

[29th Meeting, 2018 \(Session 5\) Tuesday 13 November 2018](#)

5. Health and Care (Staffing) (Scotland) Bill (in private): The Committee considered a draft Stage 1 report and agreed to continue consideration at its next meeting.

[30th Meeting, 2018 \(Session 5\) Tuesday 20 November 2018](#)

5. Health and Care (Staffing) (Scotland) Bill (in private): The Committee continued its consideration and agreed a draft Stage 1 report.

Annexe B - Evidence

Written Evidence

- [HS/S5/18/HCSS/1 - Scottish Borders Council and Scottish Borders Integrated Joint Board for Health and Social Care](#)
- [HS/S5/18/HCSS/2 - Scotland Excel](#)
- [HS/S5/18/HCSS/3 - Scottish Partnership for Palliative Care](#)
- [HS/S5/18/HCSS/4 - MND Scotland](#)
- [HS/S5/18/HCSS/5 - Society of Personnel and Development Scotland \(SPDS\)](#)
- [HS/S5/18/HCSS/6 - Law Society of Scotland](#)
- [HS/S5/18/HCSS/7 - NHS Orkney](#)
- [HS/S5/18/HCSS/8 - Royal College of Nursing](#)
- [HS/S5/18/HCSS/9 - Royal Blind](#)
- [HS/S5/18/HCSS/10 - MS Society Scotland](#)
- [HS/S5/18/HCSS/11 - Social Work Scotland](#)
- [HS/S5/18/HCSS/12 - Chief Officers Group Health and Social Care Scotland](#)
- [HS/S5/18/HCSS/13 - Royal College of Psychiatrists in Scotland](#)
- [HS/S5/18/HCSS/14 - South Lanarkshire Health and Social Care Partnership](#)
- [HS/S5/18/HCSS/15 - Coalition of Care and Support Providers in Scotland \(CCPS\)](#)
- [HS/S5/18/HCSS/16 - Chest Heart and Stroke Scotland](#)
- [HS/S5/18/HCSS/17 - Marie Curie](#)
- [HS/S5/18/HCSS/18 - Care Inspectorate and Scottish Social Services Council](#)
- [HS/S5/18/HCSS/19 - Audit Scotland on behalf of the Auditor General for Scotland](#)
- [HS/S5/18/HCSS/20 - NHS Forth Valley](#)
- [HS/S5/18/HCSS/21 - Royal College of Emergency Medicine](#)
- [HS/S5/18/HCSS/22 - East Ayrshire Health and Social Care Partnership](#)
- [HS/S5/18/HCSS/23 - NHS Lothian](#)
- [HS/S5/18/HCSS/24 - Scottish Executive Nurse Directors Group](#)
- [HS/S5/18/HCSS/25 - Cancer Research UK](#)

- [HS/S5/18/HCSS/26 - Scottish Independent Advocacy Alliance \(SIAA\)](#)
- [HS/S5/18/HCSS/27 - NHS Tayside](#)
- [HS/S5/18/HCSS/28 - The Association of Anaesthetists](#)
- [HS/S5/18/HCSS/29 - Clackmannanshire and Stirling Health and Social Care Partnership](#)
- [HS/S5/18/HCSS/30 - Royal College of Physicians of Edinburgh](#)
- [HS/S5/18/HCSS/31 - NHS Health Scotland](#)
- [HS/S5/18/HCSS/32 - Bliss Scotland](#)
- [HS/S5/18/HCSS/33 - NHS Ayrshire and Arran](#)
- [HS/S5/18/HCSS/34 - Aberdeen City Health & Social Care Partnership and Aberdeen City Council](#)
- [HS/S5/18/HCSS/35 - The Brain Tumour Charity](#)
- [HS/S5/18/HCSS/36 - Aberdeenshire Integration Joint Board](#)
- [HS/S5/18/HCSS/37 - NHS National Services Scotland](#)
- [HS/S5/18/HCSS/38 - Health and Social Care Alliance Scotland \(the ALLIANCE\)](#)
- [HS/S5/18/HCSS/39 - BDA The Association of UK Dietitians, Scotland Board](#)
- [HS/S5/18/HCSS/40 - NHS Western Isles](#)
- [HS/S5/18/HCSS/41 - Royal College of Anaesthetists](#)
- [HS/S5/18/HCSS/42 - Royal College of Nursing Scottish Inflammatory Bowel Disease Nurses Network](#)
- [HS/S5/18/HCSS/43 - Healthcare Improvement Scotland](#)
- [HS/S5/18/HCSS/44 - The Royal College of Speech and Language Therapists](#)
- [HS/S5/18/HCSS/45 - COSLA](#)
- [HS/S5/18/HCSS/46 - Allied Health Professions Federation Scotland](#)
- [HS/S5/18/HCSS/47 - The College of Podiatry](#)
- [HS/S5/18/HCSS/48 - The Royal College of Surgeons of Edinburgh](#)
- [HS/S5/18/HCSS/49 - Scottish Council for Voluntary Organisations \(SCVO\)](#)
- [HS/S5/18/HCSS/50 - The State Hospitals Board for Scotland](#)
- [HS/S5/18/HCSS/51 - Scottish Care](#)
- [HS/S5/18/HCSS/52 - NHS Greater Glasgow and Clyde](#)

- [HS/S5/18/HCSS/53 - Chartered Society of Physiotherapy](#)
- [HS/S5/18/HCSS/54 - General Medical Council](#)
- [HS/S5/18/HCSS/55 - North Ayrshire Health and Social Care Partnership](#)
- [HS/S5/18/HCSS/56 - Falkirk Health and Social Care Partnership](#)
- [HS/S5/18/HCSS/57 - AHP Directors Scotland Group \(ADSG\)](#)
- [HS/S5/18/HCSS/58 - Royal College of Occupational Therapist's \(RCOT\)](#)
- [HS/S5/18/HCSS/59 - NHS Education for Scotland](#)
- [HS/S5/18/HCSS/60 - British Healthcare Trades Association \(Scotland\)](#)
- [HS/S5/18/HCSS/61 - The Society and College of Radiographers](#)
- [HS/S5/18/HCSS/62 - Catherine Hughes](#)
- [HS/S5/18/HCSS/63 - Irene Barkby, Executive Director of Nursing, NHS Lanarkshire](#)
- [HS/S5/18/HCSS/64 - NHS Grampian](#)
- [HS/S5/18/HCSS/65 - BMA Scotland](#)
- [HS/S5/18/HCSS/66 - Inclusion Scotland](#)
- [HS/S5/18/HCSS/67 - Glasgow City Health and Social Care Partnership](#)
- [HS/S5/18/HCSS/68 - NHS Borders](#)
- [HS/S5/18/HCSS/69 - UNISON Scotland](#)
- [HS/S5/18/HCSS/70 - Royal College of General Practitioners Scotland](#)
- [HS/S5/18/HCSS/71 - The Royal College of Midwives](#)

Additional Written Evidence

Following our formal evidence session on 18 September, we received further written evidence from the Scottish Partnership for Palliative Care and Scottish Care:

- [Scottish Partnership for Palliative Care](#)
- [Scottish Care](#)

Survey

The Committee issued a survey which sought views on the current nursing and midwifery workforce tools and as such was specifically aimed at those who use the tools.

- [Full survey responses](#)

- [Summary of survey responses](#)

Official Reports

- [Tuesday 11 September 2018](#) - evidence from stakeholders
- [Tuesday 18 September 2018](#) - evidence from stakeholders
- [Tuesday 25 September 2018](#) - evidence from stakeholders
- [Tuesday 2 October 2018](#) - evidence from the Scottish Government

- 1 [Policy Memorandum paragraph 98](#)
- 2 [Health and Sport Committee Official Report 25 Sept 2018, COL 2](#)
- 3 [Health and Sport Committee Official Report 18 Sept 2018, COL 20](#)
- 4 [Health and Sport Committee Official Report 18 Sept, COL 4](#)
- 5 [Health and Sport Committee Official Report 25 Sept 2018, COL 2](#)
- 6 [Health and Sport Committee Official Report 11 Sept 2018, COL 06](#)
- 7 [Health and Care \(Staffing\) \(Scotland\) Bill Policy memorandum - page 13](#)
- 8 [Health and Sport Committee Official Report 2 Oct 2018](#)
- 9 [Royal College of Surgeons of Edinburgh written submission](#)
- 10 [Health and Sport Committee Official Report 25 Sept 2018, COL 35](#)
- 11 [UNISON Scotland written submission](#)
- 12 [Health and Sport Committee Official Report 18 Sept 2018, COL 13](#)
- 13 [Health and Sport Committee Official Report 18 Sept 2018, COL 13](#)
- 14 [The ALLIANCE written submission](#)
- 15 [Health and Sport Committee Official Report 25 Sept 2018, COL 6](#)
- 16 [Health and Sport Committee Official Report 25 Sept 2018, COL 10](#)
- 17 [The ALLIANCE written submission](#)
- 18 [Health and Sport Official Report 25 Sept 2018, COL 2](#)
- 19 [RCN Scotland written submission](#)
- 20 [Marie Curie written submission](#)
- 21 [Health and Sport Committee Official Report 11 Sept 2018, COL 45](#)
- 22 [Royal College of Nursing written submission](#)
- 23 [NHS Forth Valley written submission](#)
- 24 [Health and Sport Committee Official Report 18 Sept 2018, COL 24](#)
- 25 [Health and Sport Committee Official Report 18 Sept 2018, COL 24](#)
- 26 [BDA Scotland Board written submission](#)
- 27 [Health and Sport Committee Official Report 2 Oct 2018, COL 8](#)
- 28 [Health and Sport Committee Official Report 2 Oct 2018, Col 11](#)
- 29 [Health and Sport Committee Official Report 2 Oct 2018, Col 21](#)

Health and Sport Committee

Stage 1 report on the Health and Care (Staffing) (Scotland) Bill, 11th report, 2018 (Session 5)

- 30 [Scottish Borders Council and Scottish Borders IJB written submission](#)
- 31 [Chief Officers Group Health and Social Care Scotland written submission](#)
- 32 [Health and Sport Committee Official Report 18 Sept 2018, COL 20](#)
- 33 [Health and Sport Committee Official Report 25 Sept 2018 COL 2](#)
- 34 [Health and Sport Committee Official Report 11 Sept 2018, COL 5](#)
- 35 [Health and Sport Committee Official Report 11 Sept 2018, COL 5](#)
- 36 [Health and Sport Committee Official Report 25 Sept 2018, COL 29](#)
- 37 [Health and Care \(Staffing\) \(Scotland\) Bill, Policy Memorandum - Para 157](#)
- 38 [BDA written submission](#)
- 39 [Health and Sport Committee Official Report 2 Oct 2018, COL 20-21](#)
- 40 [Health and Sport Committee Official Report 18 Sept 2018, COL 13](#)
- 41 [Health and Sport Committee Official Report 18 Sept 2018, COL 14](#)
- 42 [Health and Care \(Staffing\) \(Scotland\) Bill - Policy Memorandum](#)
- 43 [Health and Sport Committee Official Report 11 Sept 2018](#)
- 44 [Responses from NHS Boards](#)
- 45 [Health and Sport Committee Official Report 11 Sept 2018, COL 35](#)
- 46 [Health and Sport Committee Official Report 2 Oct 2018 COL 20](#)
- 47 [Health and Sport Committee Official Report 11 Sept 2018 COL 35](#)
- 48 [Health and Sport Committee Official Report 25 Sept 2018 COL 25](#)
- 49 [Audit Scotland on behalf of the Auditor General for Scotland written submission](#)
- 50 [Health and Sport Committee Official Report 25 Sept 2018 COL 24](#)
- 51 [Written submissions to the Finance and Constitution Committee](#)
- 52 [Royal College of Nursing written submission to the Finance and Constitution Committee](#)
- 53 [Financial Memorandum paragraph 39](#)
- 54 [Health and Sport Committee Official Report 2 Oct 2018, COL 23](#)
- 55 [NHS Forth Valley written submission](#)
- 56 [NHS Orkney written submission](#)
- 57 [Royal College of Physicians of Edinburgh written submission](#)

- 58 [Health and Sport Committee Official Report 11 Sept 2018, COL 47](#)
- 59 [Health and Sport Committee Official Report 2 Oct 2018, COL 14](#)
- 60 [Care Inspectorate website - about us](#)
- 61 [COSLA written submission](#)
- 62 [Health and Sport Committee Official Report 18 Sept 2018, COL 3](#)
- 63 [Health and Sport Committee Official Report 25 Sept 2018, COL 6](#)
- 64 <http://www.legislation.gov.uk/asp/2010/8/section/15>
- 65 [Health and Sport Committee Official Report 18 Sept 2018, COL 15 and 18](#)
- 66 [Health and Sport Committee Official Report 18 Sept 2018, COL 16](#)
- 67 [Health and Sport Committee Official Report 18 Sept 2018, COL 25](#)
- 68 [Health and Sport Committee Official Report 11 Sept 2018, COL 27](#)
- 69 [Cancer Research UK written submission](#)
- 70 [Scottish Borders Council and Scottish Borders Integration Joint Board written submission](#)
- 71 [Health and Sport Committee Official Report 2 Oct 2018](#)
- 72 [Health and Sport Committee Official Report 2 Oct 2018, COL 3 and 9](#)

