Safe and Effective Staffing in Health and Social Care

Consultation on proposals to enshrine safe staffing in law, starting with the nursing and midwifery workload and workforce planning tools

Independent analysis of responses to the public consultation exercise

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Contents

Executive Summary

This summary presents an overview of the independent analysis of responses to a Scottish Government consultation on safe and effective staffing in health and social care. The consultation paper invited views on proposals to introduce legislation that would require organisations providing health and social care to apply nationally agreed, evidence-based workload and workforce planning methodologies and tools; ensure that key principles - notably consideration of professional judgement, local context and quality measures - underpin workload and workforce planning and inform staffing decisions; and monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

The consultation was published on 11 April and closed on 5 July 2017. A series of consultation events were also held across Scotland. A total of 111 responses were received via the Scottish Government's Citizen Space consultation hub. Of these, 35 were submitted by organisations and 76 by individuals. The types of organisations responding were: Health & Social Care Partnerships (five respondents); Independent sector health or social care organisations (two respondents); NHS based professional groups or committees (five respondents); NHS Bodies or Boards (six respondents); Others (three respondents); Other public bodies (two respondents); and Professional colleges, bodies, groups or unions (12 respondents).

A total of 177 people attended the consultation events, with 25 discussion groups held.

Proposed purpose and scope

A majority of Citizen Space respondents answering the question, 90%, agreed that the requirement should apply to organisations providing health and social care services. The majority of both individual and organisational respondents agreed (70 out of 74 respondents and 22 out of 28 respondents respectively). Health and Social Care Partnerships and Other public bodies were the only respondent types in which the majority of those answering the question did not agree. At the consultation events, 21 of the discussion groups agreed, one disagreed, one held a mixed view and two did not answer the question.

The three most frequently-raised themes were:

- Any future development requires to be cognisant of the health and social care integration agenda.
- The specific context and requirements of social care need to be understood.
- The focus should be firmly placed on achieving better patient outcomes.

A clear majority of Citizen Space respondents answering the question, 88%, agreed that that the requirements should be applicable in settings, and for staff groups, where a nationally agreed framework, methodology and tools exist. The majority of both individual and organisational respondents agreed (69 out of 76 respondents and 21 out of 26 respondents respectively). All of the Independent sector health or

social care organisations, NHS based professional group or committees, NHS Bodies or Boards, Other and Other public body respondents who answered the question agreed. Health and Social Care Partnerships were the only respondent type in which the majority did not agree. At the consultation events, 17 of the discussion groups agreed, five disagreed, one held a mixed view and two did not answer the question.

The three most frequently-raised themes were:

- The need to ensure any approach is effective, robust and evidence based.
- That relevance and applicability are considered in relation to the social care sector.
- That future proposals should be cross-referenced with other existing developments in relation to workforce planning within the health and social are fields.

In terms of how the proposed requirements should apply or operate within the context of the integration of health and social care, the three most frequently-raised issues were:

- The majority of current tools do not take into account multi-disciplinary or multi-agency working.
- The need for a whole-systems approach to workforce planning capturing the collective contribution of partners.
- That consideration is needed regarding the role, responsibilities and functions of the Integrated Joint Boards (IJBs).

A majority of Citizen Space respondents answering the question, 82%, agreed that introducing a statutory requirement to apply evidence based workload and workforce planning methodology and tools across Scotland will help support consistent application. The majority of both individual and organisational respondents agreed (65 out of 76 respondents and 19 out of 27 respondents respectively). Health and Social Care Partnerships were the only respondent group in which the majority of those answering the question did not agree. At the consultation events, 20 of the discussion groups agreed, two disagreed, two had mixed views and one did not answer the question.

The three most frequently-identified issues were that:

- The application of a workload and workforce planning tool would support consistent and equitable practice.
- This should extend beyond nursing and midwifery to the wider multi-agency team.
- The relationship with the health and social care integration agenda and the role of IJBs requires consideration.

In terms of other ways in which consistent and appropriate application could be strengthened, the three most frequently-raised themes were the need to:

- Fully understand the challenges experienced with the current tools.
- Work closely and consult with staff.
- Ensure sufficient governance and scrutiny of the workforce planning process.

Approach to workforce planning

The consultation paper moved on to ask a number of questions about the approach to workforce planning. A substantial majority of Citizen Space respondents answering the question, 92%, agreed with the proposal to use a triangulated approach. The majority of both individual and organisational respondents agreed (67 out of 74 respondents and 21 out of 22 respondents respectively). There was only one organisational respondent, from the Professional college, body, group or union group, who disagreed. At the consultation events, 24 of the 25 discussion groups agreed and one discussion group did not answer the question.

The three most frequently-raised themes were:

- It will be important to value professional judgement.
- Developing a 'one size fits all' approach is unlikely to be successful.
- Sufficient consideration needs to be given to the local context in which the tools would be applied.

A majority of Citizen Space respondents answering the question, 71%, thought there are other measures to be considered as part of the triangulation approach to workload and workforce planning. The majority of both individual and organisational respondents agreed (43 out of 69 respondents and 24 out of 25 respondents respectively). There was only one organisational respondent, a Health and Social Care Partnership, who disagreed. At the consultation events, 21 of the 25 discussion groups agreed and four did not answer the question.

The three most frequently-raised themes were:

- That staffing cannot be considered in isolation from other factors ensuring good quality care
- Education, recruitment and retention, and other work supply issues, need to be examined.
- Any approach should be deliverable and supported by sufficient training.

Staff governance

Views were mixed as to whether, given existing staff governance requirements and standards, there are sufficient processes and systems in place to allow concerns regarding safe and effective staffing to be raised. A small majority of Citizen Space respondents who answered the question, 52%, agreed. However, a majority of individual respondents and Professional college, body, group or union respondents disagreed (41 out of 73 respondents and six out of seven respectively). In contrast, all of the other organisational respondents who answered the question were in agreement.

Amongst the discussion groups, 13 groups agreed, two held a mixed view, and seven disagreed. The remaining three discussion groups did not answer the question.

The three most frequently-raised themes were:

- Systems are in place to support safe practice and raise concerns, but these are not resulting in a change in practice.
- Poor organisational cultures can make staff feel that they are not listened to.
- It would be beneficial to place a greater emphasis on current care and clinical governance structures.

In terms of additional mechanisms required, the three most frequently-raised themes were:

- There need to be clear pathways and processes for escalation of issues.
- Ongoing consultation and discussion with staff regarding their experiences is important.
- There is potential value in independent review or external scrutiny of service standards.

A substantial majority of Citizen Space respondents answering the question, 96%, agreed with the proposal to require organisations to ensure that professional and operational managers and leaders have appropriate training in workforce planning in accordance with current guidance. All organisational respondents who answered the question agreed and only four individual respondents disagreed. All of the discussion groups also agreed.

The three most frequently-raised themes were:

- Training would support consistent and transparent practice and help embed workforce principles.
- The impact of training on clinical duties should be considered.
- There are already tools, with associated training packages, in existence.

A substantial majority of those answering the question, 95%, agreed with the proposal to require organisations to ensure effective, transparent monitoring and reporting arrangements in place. The majority of both individual and organisational respondents agreed (71 out of 73 respondents and 25 out of 28 respondents respectively). Health and Social Care Partnerships, Professional college, body, group or union and individual respondents were the only respondent types in which anyone disagreed. Twenty-two of the discussion groups agreed, one disagreed and two did not answer the question.

The three most frequently-raised themes were:

- Transparency is crucial in terms of both staff and public confidence.

- Any reporting information produced should be both easy to understand and contextualised.
- A number of external scrutiny bodies are in existence that may currently, or could, play a monitoring role.

Future approach and priorities

A majority of Citizen Space respondents answering the question, 86%, agreed with the proposal to consider extending the requirement to apply nursing and midwifery workload and workforce planning approach to other settings and/or staff groups in the future. The majority of both individual and organisational respondents agreed (66 out of 75 respondents and 20 out of 25 respondents respectively). However, a majority of Health and Social Care Partnership respondents disagreed. Twenty-two of the discussion groups agreed, one disagreed and two did not answer the question.

The three most frequently-raised themes were:

- A whole-systems, multi-disciplinary approach is required, rather than having a focus on particular professions or specialties.
- In terms of particular staff groups, all AHPs and medical staff were the most-frequently suggested.
- In terms of the clinical areas or settings respondents felt should be considered, the suggestions were again many and varied but the most frequently-identified was nursing and care homes.

Risks and unintended consequences

A majority of Citizen Space respondents answering the question, 90%, thought there are risks or could be unintended consequences arising as a result of the proposed legislation and the potential requirements to extend the requirement to other settings and/or staff groups in the future. A majority of individual respondents agreed (58 out of 68 respondents), and all organisational respondents who answered the question agreed. Twenty-one of the discussion groups agreed there were risks or could be unintended consequences and four did not answer the question.

The three most frequently-raised risks were:

- Insufficient funding to address additional staffing requirements.
- Difficulties in recruiting and retaining staff.
- Resources being drawn from one service to another if a whole-systems approach is not taken.

In terms of what steps could be taken to deal with these risks, the three most frequently-identified themes were that:

- Ensuring adequate funding is in place for health and social care services will be important.

- Any future workforce planning legislation needs to take into account the integrated practices of the Health and Social Care Partnerships
- Collaboration with educational establishments should be improved.

Monitoring requirements

A majority of Citizen Space respondents, 70% of those who answered the question, agreed with the proposals to use existing performance and monitoring processes to ensure compliance with the legislative duty and associated requirements. The majority of both individual and organisational respondents agreed (47 out of 71 respondents and 19 out of 23 respondents respectively). However, a majority of Health and Social Care Partnership respondents disagreed. Fifteen discussion groups agreed, five disagreed and five did not answer the question.

The three most frequently-identified themes were:

- The implications of legislation on social care and Health and Social Care Partnerships needs to be better understood.
- The role of existing scrutiny bodies, for example the Care Inspectorate, needs to be considered.
- Clear lines of accountability will be required across both professions and organisations.

In terms of what other ways organisations' progress in meeting requirements could be monitored, the three most frequently-identified themes were:

- There are existing scrutiny or governance processes which could be drawn on.
- Staff feedback, including anonymous feedback and any data on staff morale, should be used.
- There would be value in external reporting to a central body or the Scottish Government.

In terms of the consequences if organisations do not comply with requirements, the three most frequently-identified themes were:

- The focus should be on improvement and on being supportive rather than punitive.
- There should be corporate or political liability when improvements are not made.
- Actions must be set within the context of reducing public sector resources.

Equality considerations

The nine protected equality characteristics are age, sex, gender reassignment, sexual orientation, race, religion or belief, pregnancy and maternity, disability, and marriage and civil partnership.

A majority of Citizen Space respondents answering the question, 79%, did not anticipate any of the proposed options outlined in this consultation will have a direct or indirect positive or negative impact on any protected equality characteristics. The majority of individual and organisational respondents (59 out of 70 and 18 out of 28 respectively) did not expect the proposals to impact on any protected equality characteristics. However, the majority of Professional college, body, group or union respondents did expect the proposals to have an impact. Fifteen discussion groups did not anticipate any impact, six did and four did not answer the question.

The three most frequently-identified themes were:

- The potential impact on individuals using services in the event of service closure.
- The disproportionate impact on women because of the number of women working in the care sector.
- The need to engage with affected staff as well as specialist equality advisors.

Chapter 1 - Introduction

Background

This report presents analysis of responses to a Scottish Government consultation on safe and effective staffing in health and social care and proposals to enshrine safe staffing in law, starting with the nursing and midwifery workload and workforce tools.

The consultation paper invited views on proposals to introduce legislation that would require organisations providing health and social care to: apply nationally agreed, evidence based workload and workforce planning methodologies and nursing and midwifery workload workforce planning tools; ensure that key principles - notably consideration of professional judgement, local context and quality measures - underpin workload and workforce planning and inform staffing decisions; and monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

The introduction of these requirements is intended to further ensure, and assure, safe and effective staffing and strengthen and enhance the arrangements already in place to support continuous improvements in workforce planning and employment practice across Scotland. The proposals build on the progress made through the Nursing and Midwifery Workload and Workforce Planning Programme. Ongoing experience and learning from this programme, nationally and locally, will inform detailed development of the proposed legislation.

The proposals are intended to:

- Strengthen and enhance arrangements already in place to support continuous improvement and transparency in workforce planning and employment practice across Scotland.
- Enable consideration of service delivery models and service redesign to ensure Scotland's health and social care services meet the needs of the people they serve.
- Provide assurance - including for patients and staff - that safe and effective staffing is in place to enable the provision of high quality care.
- Actively foster an open and honest culture where all staff feel safe to raise concerns regarding safe and effective staffing.

The consultation, which can be viewed at https://consult.scotland.gov.uk/nursing-and-midwifery/safe-and-effective-staffing-in-health-care-setting/, was published on 11 April and closed on 5 July 2017.

A series of consultation events were also held, primarily targeted at nurses but with members of the general public also welcome to attend. Data gathered from these events has also been included in the analysis presented.

Profile of respondents

A total of 111 responses were received via Citizen Space, of which 35 were from groups or organisations and 76 from individual members of the public.

Organisational respondents were allocated to one of seven categories by the analysis team. A breakdown of the number of responses received by respondent type is set out in Table 1 below and a full list of organisational respondents can be found in Annex 1.

Table 1: Respondents by type

Type of respondent	Number
Individuals	**76**
Organisations:	
Health & Social Care Partnership	5
Independent sector health or social care organisation	2
NHS based professional group or committee	5
NHS Body or Board	6
Other	3
Other public body	2
Professional college, body, group or union	12
Total Organisations	**35**
Total	**111**

In addition to the standard consultation process, a series of discussions groups were held across Scotland, with a total of 177 people attending. The location and number of events held are set out in the table below.

Table 2: Discussion Groups

Location	Number
Aberdeen	5
Edinburgh	4
Glasgow	7
Inverness	4
Orkney	2
Shetland	1
Stornoway	2
TOTAL	**25**

Analysis and reporting

A small number of respondents did not make their submission on the consultation questionnaire but submitted their comments in a statement-style format. This content was analysed qualitatively under the most directly relevant consultation question.

The remainder of this report presents a question-by-question analysis. Where a closed question was asked, the results from the Citizen Space responses are presented first. The overall results from the discussion group feedback is also presented. This gives sets out how the 25 discussion groups answered the question. Please note, however, that no information is available as to the number of people in each group, or the basis on which a question was answered; for example, it is not known whether the option selected represents a unanimous or majority view. For this reason, these results should be seen as indicative rather than as representing a known balance of views amongst the 177 individuals who attended the discussion groups. The answers at closed questions by location of the group are presented in Annex 2 to this report.

The qualitative analysis of further comments sets out the range of views expressed by both Citizen Space respondents and those taking part in a discussion group. The most frequently-raised themes are set out at the beginning of the analysis of comments made at each question.

Chapter 2 - Proposed purpose and scope

The consultation paper set out the proposal that an organisation providing health and social care services would be required to: apply nationally agreed, evidence-based workload and workforce planning framework, methodologies and tools; ensure that key principles – notably consideration of professional judgement, local context and quality measures – underpin workload and workforce planning and inform staffing decisions; and monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

Question 1 - Do you agree that introducing a statutory requirement to apply evidence based workload and workforce planning methodology and tools across Scotland will help support consistent application?

Table 3: Question 1 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	65	11		76
Organisations:				
Health & Social Care Partnership	*2*	*3*		*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*3*	*2*		*5*
NHS Body or Board	*4*	*1*	*1*	*6*
Other			*3*	*3*
Other public body	*2*			*2*
Professional college, body, group or union	*6*	*2*	*4*	*12*
Total organisations	19	8	8	35
All respondents	**84**	**19**	**8**	**111**
% of all respondents	**76%**	**17%**	**7%**	**100%**
% of those answering the question	**82%**	**18%**		**100%**

A majority of those answering the question, 82%, agreed that introducing a statutory requirement to apply evidence based workload and workforce planning methodology and tools across Scotland will help support consistent application. The majority of both individual and organisational respondents agreed (65 out of 76 respondents and 19 out of 27 respondents respectively). Health and Social Care Partnerships were the only respondent group in which the majority of those answering the question did not agree.

Table 4: Question 1 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
20	2	2	1	25

At the consultation events, 20 of the discussion groups agreed, two disagreed, two had mixed views and one did not answer the question.

There were 71 further comments made through Citizen Space and all of the discussion groups made a comment.

The three most frequently-identified issues in relation to Question 1 were that:

- The application of a workload and workforce planning tool would support consistent and equitable practice.
- This should extend beyond nursing and midwifery to the wider multi-agency team.
- The relationship with the health and social care integration agenda and the role of IJBs requires consideration.

In their further comments, some respondents identified specific advantages to introducing a statutory requirement, including that it should help embed the approach at an organisational level. A robust legislative framework for safe and effective staffing was seen to support the very best practice and drive improvement where needed by using high quality, validated tools that could support equitable practice across services. Those in agreement felt that legislation would provide a means of quality assurance against poor standards or organisational cultures and that the public's right to safe, quality care and appropriate staffing for all those using services would be supported. The most frequently-identified advantage raised by both individuals and organisational respondents was that agreed staffing levels based on patient need and skill mix, would ensure agile teams responsive to changing needs and in turn prepare the workforce to move towards integrated practice.

The legislation was felt to mitigate some of the risks of increasing pressure on the nursing and midwifery workforce through recruitment issues, an increasing ageing population and changing models of care. Staff would therefore feel supported and less likely to experience burn out or stress.

However, there was also a question as to how precisely the 'additional lever of legislation' would increase the current leverage and effective usage of the mandated nursing and midwifery workforce and workload planning tools. This issue was raised at the discussion groups and by individual and organisational respondents. It was suggested that the workforce planning tools are only one of the components required to achieve high quality care and improved outcomes and that setting out further guiding principles on safe and effective staffing in primary legislation would be welcome.

Although in agreement with the principle of introducing a legislative requirement, there were concerns about this requirement extending only to certain staff groups or organisation settings; this was most likely to be raised by Professional College, Body, Group or Union respondents. Their main concern was that if statutory regulation applies to nursing and midwifery services in isolation, and not to multi-disciplinary or multi-agency teams, workforce deployment will be flawed, and this could result in less safe and effective practice. An approach which focused on the nursing and midwifery profession alone was also seen as at odds with how health and social care services are currently delivered.

A number of the respondents who disagreed with the introduction of a statutory requirement raised very similar concerns. The most frequently-raised concern tended to be highlighted by the Health and Social Care Partnerships or NHS Body or Board respondents and was that the proposals were at odds with the integration of health and social care agenda and the delivery of localised health and social care services. Further comments included that the Integrated Joint Boards (IJBs) should have the flexibility to make workforce planning decisions based on strategic need and should not be restricted or directed by statute. There was equally a common view from the social care sector that despite using the term 'health and social care' throughout, the consultation focuses on the implications for the health sector and NHS Scotland. It was felt that to genuinely consider a health and social care approach the size and diversity of the social care workforce needs to be understood. It was also suggested that there has to be an acknowledgement that the social care sector has existing statutory requirements around both workload and workforce and that there is no demonstrable evidence that the current tools utilised within the NHS are applicable, usable or beneficial to the social care sector.

A small number of respondents, chiefly NHS bodies or Boards and Other public bodies, felt that the introduction of legislation could potentially restrict employers in the delivery of innovative and responsive person-centred services. They raised concerns that the focus of the consultation was on outputs and not on the achievement of improved outcomes for individuals.

As noted above, concerns were raised about areas of potential overlap or duplication in terms of workforce development and planning, particularly in relation to integrated and/or social services. Suggestions as to other responsibilities or developments which respondents felt needed to be taken into account included:

- The existing statutory requirement to ensure appropriate workload and workforce planning, as set out in The Social Care and Social Work Improvement Scotland (Requirement for Care Services) Regulations 2011. This statutory requirement informs the scrutiny activity of the Care Inspectorate during initial registration and during subsequent inspection.
- The new Health and Social Care Standards, which will be implemented in April 2018, will apply to the NHS as well as services registered with the Care Inspectorate and will set out the standards people should expect when using health or social care services.

- COSLA is currently co-producing, with the Scottish Government, a National Workforce Plan (NWP) on Health and Social Care. The NWP is intended to lead the social care sector's approach to workload and workforce planning methodologies and tools. Part two of the NWP will consider ways to address the challenges facing the social care workforce as a result of health and social care integration. It will be published in Autumn 2017.

Although the majority supported the introduction of a statutory requirement, they frequently made their support conditional on certain issues being addressed if the proposed legislation is taken forward. Discussions groups and organisational respondents were particularly likely to have made comments along these lines. A number of their concerns were about the existing workforce and workload planning tools. They included that:

- The tools do not necessarily work across the range of differing care environments, and this can undermine consistent application. Respondents sometimes noted that it will be challenging to apply any 'rigid formulae' to potentially complex, integrated services. In particular, it was highlighted that the approach will need to take account of employment, commissioning and resourcing practices.
- They may not be sufficiently responsive to new developments and innovation.
- They do not address adequately the impact of using bank, agency or non-nursing and midwifery staff.

Finally, resources were seen to be essential to the implementation of any new requirement, with some respondents commenting that the constitution of the workforce can be driven by financial imperatives rather than just clinical need.

Question 2 - Are there other ways in which consistent and appropriate application could be strengthened?

There were 92 further comments made through Citizen Space and 24 of the discussion groups made a comment.

The three most frequently-raised themes in relation to Question 2 were the need to:

- Fully understand the challenges experienced with the current tools.
- Work closely with and consult with staff.
- Ensure sufficient governance and scrutiny of the workforce planning process.

A wide range of views were offered on how consistent and appropriate application could be achieved, including that it is essential that patients and their relatives are assured that their care will be of consistently good quality. Getting staffing right was seen as key to providing this assurance. Otherwise, comments tended to address one of four main themes: National Standards; external scrutiny; organisational governance and workforce management tools. The last of these -workforce management tools - was the most frequently-raised.

Workforce Management Tools

Although the benefits of using workforce planning tools were recognised, it was seen as important to spend time understanding the challenges organisations face in using the existing tools. Discussion groups and individual respondents were particularly likely to make this suggestion. Other suggestions about issues to be addressed, or how any future approach should be framed, included that workforce planning should be applied across all multi-disciplinary teams but also consider opportunities for integrated working to improve client outcomes; this could include the sharing of good workforce planning practices across partnerships and beyond nursing and midwifery. It was also noted that better quality working environments aid in the recruitment and retention of staff and that health and social care career paths could be considered.

Individual respondents were particularly likely to have highlighted the issue that there should be closer working between local staff to increase confidence and support better and consistent application. It was also suggested that clinical and managerial staff competence and confidence in using the frameworks could be enhanced through the use of a clear workforce framework, including agreed timelines and processes for tool completion, analysis and triangulation and acting on any recommendations.

It was also suggested that the application and consistency of workforce management tools would be strengthened by clarifying their role in service planning and that, where a gap between current and safe and effective staffing levels is identified, organisations should be required to develop, publish and implement suitable risk management plans.

In terms of the tools themselves, respondents suggested that any approach should be based on nationally agreed staffing numbers in relation to patients and should consider individual care environments. It was also suggested that it is unlikely that a single tool will be sufficient, and a suite of tools may be required to take account of the many and varied contexts in which they will be used. For example, tools might be developed for hospital and community settings and for individual ward, theatre or community teams. Other comments included that the tools should:

- Allow for flexibility as staff and services respond to change and redesign.
- Consider projected demand, population levels and vulnerability and not be based on historically negotiated staffing provisions.

National standards and requirements

Developing nationally agreed workforce standards and performance targets was seen as positive and was particularly favoured by NHS body or Board and NHS based professional group or committee respondents. This included because patients and their relatives could be assured that their care would be consistently of good quality. It was suggested that a focus on quality care and improved outcomes should be at the heart of the safe and effective staffing agenda, rather than the emphasis being on the tools or processes to be used. Other comments included:

- Those using services have increasingly complex needs that will be best met by considering all the services and professions that have a contribution to make towards meeting those needs.
- There should be detailed guidance setting out the responsibilities for organisations to not only ensure enough staff are employed but that staffing levels are regularly monitored and adjusted according to local need. Provisions could then be made to develop and implement nationally agreed reporting mechanisms to support benchmarking, improvement and national scrutiny of safe and effective staffing.
- The Scottish Government should themselves use robust and evidence-based methodologies to develop a better understanding of the national need for nursing and midwifery staff, in terms of both numbers and skills.
- Based on that understanding, the Scottish Government should commission pre-registration places, as well as post-registration education and training.

External scrutiny

A number of respondents, including two out of five Health and Social Care Partnership respondents and three out of five NHS based professional group or committee respondents, favoured independent and external inspection, including through existing routes, as a means of quality assuring workload and workforce management and decisions. Specific suggestions included that:

- The approach could be based on national standards and agreed quality indicators.
- Organisations should have a clear duty to make available all workforce information to support this process, as well as to provide sufficient education and necessary support.

The existing scrutiny role of the Care Inspectorate, which can set conditions about staffing prior to service operation and examine the quality of staff at annual inspections, was highlighted. Health Improvement Scotland (HIS) was considered to have a key role in the provision of this type of scrutiny within the NHS and it was suggested that an annual national overview of safe and effective staffing within healthcare should be published, with improvement support also provided where necessary.

It was noted that HIS is in the process of developing a Quality of Care approach and is supporting the development of the Excellence in Care (EiC) nursing assurance framework[1]. Particular points made about this work included:

- The inclusion of workforce and leadership elements as an indicator of overall quality will, it is believed, increase the focus on both assurance and improvement which can drive a sustainable change.
- It is expected that this in turn will support NHS Boards, IJBs and localities to tailor improvement efforts targeting key areas such as skill mix, rostering, sickness absence, staff training, communication, teamwork and cultural barriers to safety.

In terms of routes through which organisations could report on safe staffing, the following were suggested:

- Via more sophisticated reporting through the EiC nursing assurance framework.
- Through the Local Delivery Planning Process.
- Via the NHS Boards' Annual report to the Scottish Government.

Organisational governance

With regard to the governance arrangements which would underpin the safe and effective staffing approach, comments included that it is essential that any duties in the Bill are placed on organisations and not individuals. Other elements which respondents felt should form part of the governance arrangements included:

- Directors of Nursing should have a key role in providing advice and assurance on safe nursing and midwifery staff levels, including in relation to any measures not being consistently or effectively applied.
- Internal audit processes will have a role to play.
- The role of the Nurse Member within an IJB was also noted as key, particularly in the context of multi-agency, integrated services.
- It was suggested that the statutory role of the Chief Social Work Officer within Scotland could serve as an example of good practice. The role's responsibilities in terms of effective discharge of duty and quality assurance were highlighted.

Finally, the importance of any Bill being sensitive to the different spheres of responsibility within professional structures was highlighted. In particular, it was suggested that it will be important to ensure that any legislation supports professional leaders to assist organisations to discharge their duties appropriately.

[1] [1] Excellence in Care - Scotland's National Approach to Assuring Nursing and Midwifery Care Event Report can be found at: http://www.gov.scot/Publications/2015/09/8281.

Question 3 - Our proposal is that requirements should apply to organisations providing health and social care services, and be applicable only in settings and for staff groups where a nationally agreed framework, methodology and tools exist.

3a - Do you agree that the requirement should apply to organisations providing health and social care services?

3b - Do you agree that the requirements should be applicable in settings and for staff groups where a nationally agreed framework, methodology and tools exist?

Table 5: Question 3a – Responses by type of respondent.
Do you agree that the requirement should apply to organisations providing health and social care services?

Type of respondent	Yes	No	Not answered	Total
Individuals	70	4	2	76
Organisations:				
Health & Social Care Partnership	*2*	*3*		*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*4*	*1*	*1*	*6*
Other			*3*	*3*
Other public body		*2*		*2*
Professional college, body, group or union	*9*		*3*	*12*
Total organisations	22	6	7	35
All respondents	**92**	**10**	**9**	**111**
% of all respondents	**83%**	**9%**	**8%**	**100%**
% of those answering the question	**90%**	**10%**		**100%**

A majority of those answering the question, 90%, agreed that the requirement should apply to organisations providing health and social care services. The majority of both individual and organisational respondents agreed (70 out of 74 respondents and 22 out of 28 respondents respectively). Health and Social Care Partnerships and Other public bodies were the only respondent types in which the majority of those answering the question did not agree.

Table 6: Question 3a – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
21	1	1	2	25

At the consultation events, 21 of the discussion groups agreed, one disagreed, one had a mixed view and two did not answer the question.

There were 40 further comments made through Citizen Space and 21 of the discussion groups made a comment across Questions 3a and b. For the purposes of the analysis presented below, their comments have been considered under the most appropriate sub-question.

The three most frequently-raised themes in relation to Question 3a were:

- Any future development requires to be cognisant of the health and social care integration agenda.
- The specific context and requirements of social care need to be understood.
- The focus should be firmly placed on achieving better patient outcomes.

Very much reflecting the level of agreement at the yes/no question, many of the further comments noted respondents' support for the requirements applying to organisations providing health and social care services. There was particular reference to this approach being in line with the developing health and social care integration agenda and there were concerns that, if all services and professional disciplines were not taken into account, any conclusions drawn from workforce planning would be skewed. The requirement to align with the developing integration agenda was most likely to have been raised at the discussion groups or by individual respondents. It was also noted that the NHS and their partners are under growing pressure due to an increasing ageing population with complex needs; in this context, the need to work together around recruitment, retention, learning and integrating services was seen as paramount.

Respondents who agreed with the proposal gave a range of reasons why the requirements should apply to organisations providing health and social care services. Those most frequently-raised were that all health and social care services should be included for reasons of patient safety and that the public would expect the same assurance regarding staff, skill and safety in all settings. There was a clear view that consistency is required, not least with the developing of the National Health and Social Care Standards. If interdisciplinary and interagency working are not considered, it was felt that decisions by a single discipline could negatively impact on others and inadvertently restrict service delivery or development.

Although most respondents agreed with the proposals, some issues to be addressed were highlighted, particularly by Professional college, body, group or union respondents. The nursing and midwifery professions were reported as having been through a long process to develop and apply national tools and frameworks for their workforce. It was suggested that this process is yet to be concluded and should not be disrupted. In particular, it was felt that the potential impact of the Bill for nursing and midwifery should not be weakened by diluting its content in an attempt to avoid any need for future revision.

It was noted that any legislation should be written in such a way to permit extension to other settings but that one sector's norm will not necessarily apply to another. It

was suggested that the Scottish Government may need to engage and collaborate to build collective support for the development of new tools applicable to other sectors and professions.

Other of the comments addressed which disciplines or types of service within health and social care should be covered. Points made included:

- All health care providers, sectors and areas of care should be covered. This was particularly likely to have been raised by the discussion groups or by individual respondents.
- All NHS clinical staff should be included. There was a concern that some staff who are not subject to nationally agreed frameworks could be excluded and that this would create a resource imbalance.
- The independent sector for patients who choose to self-pay or use private medical insurance is a key NHS partner, providing additional capacity at times of pressure. Safe staffing is an equally important aspect of independent healthcare quality standards and these services should be covered by the Bill.
- With the shifting of the balance of care, the third sector is playing an increasingly important role and one which warrants them being covered by the Bill.
- Services commissioned by either the NHS or local authorities should be covered.
- Nursing homes and other facilities for older people should be included.

Those who disagreed with the proposal frequently felt that that further consideration needs to be given to the role and requirements of the social care sector before any changes are made. In particular, it was suggested that the case for including social care services, and the benefit such an approach would bring, is yet to be made. It was also suggested that sectors should be determining their own needs rather than having requirements placed upon them.

A final observation was in relation to who would be included within the definition of ‘health and social care’. It was suggested that if some providers became subject to a legislative requirement then others, such as teachers or child minders, might need to be considered by default.

Table 7: Question 3b – Responses by type of respondent.
Do you agree that the requirement should be applicable in settings and for staff groups where a nationally agreed framework, methodology and tools exist?

Type of respondent	Yes	No	Not answered	Total
Individuals	69	7		76
Organisations:				
Health & Social Care Partnership	*1*	*3*	*1*	*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*5*		*1*	*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*7*	*2*	*3*	*12*
Total organisations	21	5	9	35
All respondents	**90**	**12**	**9**	**111**
% of all respondents	**81%**	**11%**	**8%**	**100%**
% of those answering the question	**88%**	**12%**		**100%**

A majority of those answering the question, 88%, agreed that that the requirements should be applicable in settings and for staff groups where a nationally agreed framework, methodology and tools exist. The majority of both individual and organisational respondents agreed (69 out of 76 respondents and 21 out of 26 respondents respectively). All of the Independent sector health or social care organisations, NHS based professional group or committees, NHS Bodies or Boards, Others and Other public body respondents who answered the question agreed. Health and Social Care Partnerships were the only respondent type in which the majority did not agree.

Table 8: Question 3b – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
17	5	1	2	25

At the consultation events, 17 of the discussion groups agreed, five disagreed, one had a mixed view and two did not answer the question.

There were 46 further comments made through Citizen Space and 21 of the discussion groups made a comment across Questions 3a and b. A number of the further comments simply referred back to those made at Question 3a.

The three most frequently-raised themes in Question 3b were:

- The need to ensure any approach is effective, robust and evidence based.

- That relevance and applicability are considered in relation to the social care sector.
- That future proposals should be cross-referenced with other existing developments in relation to workforce planning within the health and social care fields.

Some respondents noted that their support was conditional on the approach being effective and robust. Others noted the value of having a consistent approach and a degree of commonality in the governance arrangements across health and social care. As at previous questions, some respondents also commented on possible issues arising from not applying the approach across the whole care system. In essence, the concern was that staff groups or settings that are not included may be disadvantaged.

Those who agreed nevertheless raised a number of issues they felt should be considered if the proposals progress. These included that, in practice, Health and Social Work are still separate employers and there was a concern that it is difficult to see how the approach will work whilst this remains the case. Similarly, it was suggested that it will be important to consider the principles underpinning multi-disciplinary working when developing any tools and that to fail to do so could lead to skewing of staffing or resources and could affect the equity of care. It was also suggested that it needs to be clear how the tools will consider tasks that can be undertaken by more than one profession or in the context of multi-agency care.

A frequently cited view was that any approach needs to be evidence based, effective, robust and approved by both workforce planning professionals and the professional specialists representing any specific setting. Individual respondents were particularly likely to highlight this need and to go on to suggest that any agreed framework needs to offer some consistency whilst also allowing for diversity and variation. This issue was raised at discussion groups and by individual and organisational respondents. The need to take account of varied geographies and the challenges associated with delivering services in rural and island settings were cited as examples. Actual time spent travelling was given as a specific example of the type of issue to be considered if the approach is to be robust in a range of settings.

It was considered important to expedite tool development and validation in different settings. It was suggested that an agreed framework, methodology and timeframes for implementation should be established. However, it was also suggested that the application of any framework must still allow for local autonomy to make decisions about the services and resources that they provide.

A number of specific considerations were noted in relation to the arrangements extending to the care home sector. For example, it was suggested that the National Care Home Contract would need to be aligned with the methodology proposed and that, if covering the independent health care sector, the provision of legal standards and clear guidance to both regulator and providers would be beneficial.

Respondents made a number of points about the existing tools, including that they draw on different evidence bases. Examples given include the Community Nursing Service tool focusing on activity and the Health Visitors tool being based on Scottish Index of Multiple Deprivation data. It was suggested that many of the tools are currently designed for uni-disciplinary groups of staff and would benefit from a review to ensure they are compatible with an integrated care approach. It was also noted that there are no tools for mental health, learning disability or for addictions community nursing staff for example.

Other comments focused on the specifics of extending any approach to the social care sector. They included that:

- In social services, statutory provision is expressed in outcome-focused terms and care providers are free to select the tool that best suits their needs. Requiring social care services to apply the evidence-based workload and workforce planning methodology currently used in NHS Scotland is neither helpful or necessary given current practices.
- The Care Inspectorate, in collaboration with COSLA, Scottish Care, The Coalition of Care and Support Providers, Scotland Excel and NHS National Services Scotland, is actively exploring the development of a shared dependency tool specifically for care homes and which could be used to calculate staffing.

Respondents who did not agree with the proposal overall sometimes raised similar issues to those who had agreed. Specific points made included:

- There should not be a presumption that a national formula can be applied in singular, uniform ways to specific services and settings.
- It is important to avoid a narrow focus on ‘frontline’ staffing needs at the expense of the capacity required to support continuous quality improvement through clinical leadership, continuous professional development or service evaluation.
- A prescriptive approach runs the risk of partnerships focussing on process, rather than aiming for an ambitious vision for their future workforce.

There were reservations about whether a legislative requirement to use the tools is necessary, especially when tools such as the Critical Care Guidelines are already in place. It was suggested that aligning overall principles across sectors could be a more achievable and sufficient option.

Finally, there were a range of concerns about the current workforce planning tools, including that current limitations would not be resolved simply by making their use a statutory requirement. Other concerns included that the tools apply to a limited number of professional groups, are limited to certain settings, are focused primarily on staffing ratios, and are time consuming for already stretched clinical staff to use.

Question 4 - How should these proposed requirements apply or operate within the context of integration of health and social care?

There were 83 further comments made through Citizen Space and 22 of the discussion groups made a comment.

The three most-frequently-raised issues in relation to Question 4 were:

- The majority of current tools do not take multi-disciplinary or multi-agency working into account.
- The need for a whole-systems approach to workforce planning capturing the collective contribution of partners.
- That consideration is needed regarding the role, responsibilities and functions of the IJBs.

As at earlier questions, some of the further comments reiterated a view that the proposals do not represent the type of whole-system approach that is required. Health and Social Care Partnership respondents were particularly likely to have highlighted this issue. The proposed requirements were not viewed as supporting local flexibility and responsiveness. There was a particular concern that they will impair Health and Social Care Partnerships in developing and implementing new ways of working at a time when they are working with a reducing budget. In essence, some respondents simply felt the proposed requirements should not apply given the integration of health and social care.

Respondents who agreed with the proposed requirements being applied across health and social care sometimes pointed to the extent to which current work practises are influenced by integration. For example, it was suggested that nurses are increasingly working within joint teams. However, it was also noted that there is already a legislative framework for staffing levels in social care services, along with a scrutiny framework to ensure it is being applied effectively. There was a question as to how, if the proposals are taken forward, these two sets of requirements would work together. The discussion groups were particularly likely to highlight the importance of the proposals being aligned to the health and social care integration agenda.

Other comments considered the structural challenges posed by health and social care integration. The role, accountability and functions of IJBs were highlighted, including that IJBs are charged with the development of integrated workforce plans but, with the exception of Highland, do not employ staff. The employer could be: an NHS Board; a Local Authority; a regulated care service commissioned by the IJB; or an independent healthcare service. To was also noted that NHS nurses, for example, will continue to be employed by the NHS and staffing and governance decisions will continue to be the responsibility of the NHS. However, it was suggested that the decisions of the IJBs are already having an effect on the shape of the nursing and midwifery workforce, particularly if services are being reconfigured. It was suggested that the proposed legislation should place equal

duties on IJBs and NHS Boards regarding safe and effective staffing, particularly while the governance arrangements and position of the IJBs are evolving.

A number of other integration and multi-agency issues to be taken into consideration were identified, most frequently that the Care Inspectorate and Healthcare Improvement Scotland have an existing responsibility to jointly inspect the strategic commissioning arrangements of IJBs and to provide scrutiny related to staffing.

It was suggested that any workforce planning tools to be used across different sectors will need to capture the 'collective' contribution of the partners. There was an associated suggestion that their use will need to be supported by an agreement across all agencies to use, apply and respond to the outputs of tools. It was also suggested that care must be taken not to 'skew' potential resources towards the nursing and midwifery professions at the expense of other professional groups or sectors. A range of tools were seen as being required, allowing services to choose a tool which is appropriate to their type of service and the context in which they are delivering a service. It was also noted that safe and effective staffing needs to be defined and articulated as the interpretation of 'safe' will be different within the various health and social care contexts.

There was a suggestion that none of the existing nursing or midwifery tools, with the possible exception of the Emergency Medicine Tool, take account of the effect of multi-disciplinary or multi-agency working on staffing requirements. It was suggested that there will be a need to develop and test tools that would support transformational change work in Scotland. Further, it was suggested that any tool or methodology development should be conducted with a full understanding of the integration agenda, before any legislative change is made, and that all professional groups need to be fully involved. In particular, it was suggested that there needs to be high levels of staff engagement. Individual respondents and discussion groups were particularly likely to highlight this need.

Other comments focused on the tools themselves or their application. They included:

- Consistency in application will be important. The approach to be used could be set out within a joint framework agreement. This was a frequently-raised issue, particularly at discussion groups and by individual respondents.
- It will be important to build in flexibility to allow for challenge, innovation and changes to workforce practice based on emerging evidence. Any arrangements should be flexible and subject to review and adjustment.
- Principles, guidance and tools need to clearly inform how staffing levels - and configurations of staffing – will optimise services' clinical and cost-effectiveness, patients' access to care, and patients' experience and outcomes of care.
- It will be important to avoid any additional burden on smaller non-public sector services as this could render them unprofitable and place unmanageable pressure on them.

- In circumstances where there is no specific tool, service commissioners and regulators should reinforce safe staffing levels by way of ratios and minimum care standards. This could be enforced through contract compliance procedures and embedding workforce planning requirements.

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Chapter 3 - Requirements

The consultation paper moved on ask a number of questions about the approach to workforce planning.

Question 5 - A triangulated approach to workload and workforce planning is proposed that requires:

- **Consistent and systematic application of nationally agreed professional judgement methodology and review of tools to all areas where current and future workload and workforce tools are available.**
- **Consistent and systematic consideration of local context.**
- **Consistent and systematic review of quality measures provided by a nationally agreed quality framework which is publicly available as part of a triangulated approach to safe and effective staffing.**

Do you agree with the proposal to use a triangulated approach?

Table 9: Question 5 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	67	7	2	76
Organisations:				
Health & Social Care Partnership	*3*		*2*	*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*5*		*1*	*6*
Other			*3*	*3*
Other public body			*2*	*2*
Professional college, body, group or union	*6*	*1*	*5*	*12*
Total organisations	21	1	13	35
All respondents	**88**	**8**	**15**	**111**
% of all respondents	**79%**	**7%**	**14%**	**100%**
% of those answering the question	**92%**	**8%**		**100%**

A substantial majority of those answering the question, 92%, agreed with the proposal to use a triangulated approach. The majority of both individual and organisational respondents agreed (67 out of 74 respondents and 21 out of 22 respondents respectively). There was only one organisational respondent, from the Professional college, body, group or union group, who disagreed.

Table 10: Question 5 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
24			1	25

At the consultation events, 24 of the 25 discussion groups agreed and one discussion group did not answer the question.

There were 56 further comments made through Citizen Space and 22 of the discussion groups made a comment.

The three most frequently-raised themes in relation to Question 5 were:

- It will be important to value professional judgement.
- Developing a 'one size fits all' approach is unlikely to be successful.
- Sufficient consideration needs to be given to the local context in which the tools will be applied.

In their further comments, many organisational and individual respondents, along with a small number of the discussion groups, noted their support for the principle of using a triangulated approach. However, there was a suggestion that what triangulation means within the context of legislation needs to clearer, along with whether it is focused on workforce planning or on day-to-day operational delivery of safe services. Other comments noted aspects of the approach which were particularly welcomed or seen as a particular strength. For example, a Professional college, body, group or union respondent suggested that triangulation should support real time workforce decisions to be made more responsively.

Robust and consistent application

Other comments welcomed the focus on robust and consistent application and recognition of the complexity of the local context. Individual respondents and discussions groups were particularly likely to highlight these issues.

Examples given, in this case by a small number of Professional college, body, group or union respondents, included:

- That an appropriate level and mix of staffing will vary according to factors such as the local configuration of services, the case mix, geographical and environmental factors, demographic factors and the skill mix of the workforce.
- That taking a 'one-size-fits-all' approach is unlikely to work for all areas of Scotland (as represented by Health and Social Care Partnerships).
- That the professional judgement and quality elements also need to take account of local content.

While a small number of primarily organisational respondents felt that the tools do take account of the local context, a small number of others disagreed. Specific concerns included that they do not take account of local infrastructure issues, such as site location or challenges associated with having staff with the right skills

available in the right locations, particularly in rural and island settings. However, a small number of individual respondents had a concern that consideration of local context should not be used as a 'get out clause' and an excuse for ongoing, sub-optimal staffing levels because of, for example, of financial or recruitment pressures. A question was asked about who will judge whether the consideration of the local context has been robust and how they will make this judgement. Finally, a discussion group sought clarification as to what is meant by 'local', including in the context of nursing and midwifery services planning at locality, Health and Social Care Partnership, NHS Board, regional and national levels.

Professional judgment

A frequently-raised issue, particularly by individual respondents and discussion groups, was the value and importance of including professional judgement, although a small number of respondents highlighted that this element inevitably introduces a degree of subjectivity into the process and for some this had the potential to be a concern. With regard to the exercising of professional judgment and the triangulation approach more generally, consistency of application tended to be seen as key to the successful use of the tools. Further comments on the professional judgement element most frequently came from a small number of Professional college, body, group or union respondents and included:

- The professional judgment element is likely to interact with the requirements in the Code for nurses and midwives. The Scottish Government was encouraged to consider how these two requirements could be aligned.
- It should be informed by the most up-to-date evidence available. This should include the use of real time data, for example on acuity, dependency, caseload, available staffing numbers and skill mix.
- Specific guidance and/or training will be required. A specific suggestion was that those using the tools should have access to professional guidance from bodies such as the Royal College of Nursing.
- Further development of professional judgement quality measures would be helpful.
- Some element of scrutiny must be put in place.
- There should be a specific requirement to include local staff and trade unions in setting assumptions and making decisions. A specific comment was that ward managers' views must be taken into account.

Use and review of measures

In terms of the reviewing of quality measures and the nationally agreed framework, a series of questions was asked, particularly through the discussion groups. These included:

- What will the thresholds and judgements associated with the quality measures look like? It was suggested that they need further refinement.
- How often will the quality measures be reviewed and by whom? What system or approach to review will be used?

- Should there be different care quality indicators by speciality and/or for different parts of the country?

Other more general comments or suggestions often came from the discussion groups or Health and Social Care Partnership or NHS based professional group or committee respondents. In each case they were raised by one or a small number of respondents or discussion groups and they included:

- Which, if any, element of the triangulated approach will be the primary measure?
- The approach must have the principle of quality and links to positive patient outcomes at its heart.
- It would be helpful to clarify how the approach relates to EiC.
- Further evidence would be useful on the triangulated approach working in practice, including a better understanding of the feedback from those in the service who are currently using the tools and the actions taken as a result of using the tools.
- It will be important for the principle of triangulation to apply equally to real time service, service planning and student commissioning decisions.
- The primary legislation should not name specific tools and methodologies. This sort of detail should be included in secondary legislation or statutory guidance.
- There will be a resource-intensive but unfunded package of work required including awareness raising, collation and analysis of data, report writing and action planning.
- There is no national reporting template and such a template would ensure data is collated and considered systematically.
- National support for staff training in using the tools was being planned in 2014 but has yet to be delivered. Training on the correct use of the tools would be required.

Multi-agency or non-NHS contexts

Other comments focused on how the approach would translate into a multi-agency context or would work outwith NHS settings. Comments included:

- How the approach would work within a non-NHS setting, and particularly within care home settings, needs to be explore. This was highlighted by an independent sector health or social care organisation and was also covered at one of the discussion groups. It was noted that the development of a staffing tool is under way and it was suggested that this work needs to be linked into the workload and planning tools presently used in the NHS. One of the discussion groups suggested that some larger private companies may already be using an approach/tools developed to meet legislative requirements in England but that smaller companies may find this agenda challenging.

- The approach needs to work for multi-disciplinary teams and the types of community-based, integrated workforces of which nursing and midwifery will be a part if the shift in the balance of care is really to be made. This was raised by a Health and Social Care Partnership respondent.
- It is important to ensure that this approach is person-led and is able to assess and understand the needs of people and ensure the right staff are available to meet their needs in a way that works for them. This was raised by a Public body respondent.

Current tools

A small number of primarily organisational respondents, including a Health and Social Care Partnership and a small number of NHS based professional groups or committees, raised issues about the current tools themselves. These included that it is difficult to see how they could be applied to multi-disciplinary, multi-agency patient care. It was also noted that the tools have not been reviewed since 2014; those highlighting this issue felt that a review is now required and that the tools need to be updated to reflect current practice and be more user-friendly. One suggestion was that health care professionals with an understanding of the Scottish health care system should be involved in any further development work required.

In terms of factors which any tools should take into account, but which were not seen as featuring in current versions, the following were cited:

- Staff skill mix. A potential unintended consequence of increased use of unregistered nursing staff in order to ‘make up the numbers’ was highlighted.
- Levels of use of bank or agency staff.
- Shift patterns and rostering practice.
- Levels of patient dependency and the complexity of the care load.
- The potential need for short term adjustments to staffing compliments to meet a particular set of circumstances (for example a patient requiring 1:1 supervision).
- The amount of clinical time required to ensure staff maintain their statutory and mandatory training requirements.

One of the discussion groups suggested that the current tools do not give consideration to winter planning.

A small number of other comments focused on the potential the tools offer, particularly in relation to gathering information to inform and drive best practice and improved service delivery. Points raised included:

- Making decisions on safe staffing levels based on the use of the tools would be difficult to justify given the range and complexity of the factors to be taken into account.
- The tools reflect a period in time and do not present a comprehensive picture of service provision. Any suggestion that they offer the potential to deliver a national performance ‘dashboard’ should therefore be viewed with caution.

- The use of the tools could make available a range of reports on issues which impact of the quality of care delivery, such as ward skill mix and reasons for use of supplementary.

Finally, a small number of primarily individual respondents (essentially those who had answered No at Question 5 and then went on to make a further comment), raised concerns including that:

- The approach as described is neither measurable nor tangible.
- If the approach aims to remove variance, but then factors in professional judgment and contextual and local issues, national comparison may not be possible, and the level of effort required may therefore not be justified.
- Unless all professional groups can be included, conclusions for workforce and workload planning will be adopted based on results from an unrepresentative workforce and this would negate any benefit from a triangulated approach.
- It is not possible to make the types of generalised judgments that would appear to be a part of the approach. For example, the requirements of a mental health unit would be very different to those of an elective surgery unit.

Question 6 - Are there other measures to be considered as part of the triangulation approach to workload and workforce planning? If yes, what measures?

Table 11: Question 6 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	43	26	7	76
Organisations:				
Health & Social Care Partnership	*3*	*1*	*1*	*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*6*			*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*7*		*5*	*12*
Total organisations	24	1	10	35
All respondents	**67**	**27**	**17**	**111**
% of all respondents	**60%**	**24%**	**15%**	**100%**
% of those answering the question	**71%**	**29%**		**100%**

A majority of those answering the question, 71%, thought there are other measures to be considered as part of the triangulation approach to workload and workforce

planning. The majority of both individual and organisational respondents agreed (43 out of 69 respondents and 24 out of 25 respondents respectively). There was only one organisational respondent, a Health and Social Care Partnership, who disagreed.

Table 12: Question 6 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
21			4	25

At the consultation events, 21 of the 25 discussion groups agreed and four did not answer the question.

There were 73 further comments made through Citizen Space and all of the discussion groups made a comment (albeit in both cases some were only to refer back to their comments at the previous question). A very broad range of comments or suggestions was made and although some were more frequently-raised, most points were made by only one or a small number of respondents or discussion groups.

Nevertheless, the three most frequently-raised themes in relation to Question 6 were:

- That staffing cannot be considered in isolation from other factors ensuring good quality care.
- Education, recruitment and retention, and other work supply issues, need to be examined.
- Any approach should be deliverable and supported by sufficient training.

A small number of organisational respondents from across the range of respondent types made overarching comments, including that:

- Conflating workload and workforce planning is unhelpful.
- Staffing levels cannot be addressed in isolation from other factors that contribute to ensuring that safe, effective, patient-centred care is delivered.
- Workforce planning tools often do not fit with, or reflect, the service delivery realities of very small services in remote and rural areas.
- The potential for unintended consequences should be considered. Specifically, there was a suggestion that workload management or increased staffing in one area could lead to reductions in service or the skills mix in other areas or groups.
- Consideration should be given to whether workload can be shared across professions or is profession specific. This approach was suggested as incorporating all aspects of the triangulated approach while also making the link with outcomes.
- There is a danger that any inflexible legislation could become outdated as care delivery models change, and new evidence bases develop.

Whole-system issues

Moving on to other measures, some of those suggested also focused on whole-system issues that could impact on workforce planning. They were raised by a small number of discussion groups, organisational and individual respondents and included:

- Sustainability and attractiveness of health and social care career paths.
- Workforce supply issues, including: the possible impact of Brexit; succession planning and the demographics of the current workforce; and student numbers for nursing and midwifery and social care roles.

Other suggested measures were also systemic, potentially at both national or local level although respondents tended not to specify. Again, these issues were raised by small numbers of respondents from across the respondent types and also by a small number of discussion groups. They included:

- Integration of services and the needs of integrated management structures in particular.
- Multi-disciplinary working practices and impact.
- Productive working practices.
- Funding levels and affordability, including for both health and social care services. This was the most frequently-suggested measure and was raised primarily by discussion groups and organisational respondents.
- Available social care provision.
- Autonomy and accountability of Local Authorities, Health Boards and IJBs.
- Consideration of future plans, developments and changing circumstances likely to impact on patient/service user numbers or their needs. Local factors in particular.

Other of the suggested measures also related very clearly to the local context and tended to be raised by individual respondents or at the discussion groups. They included:

- The geography of the area and how this impacts on staff travel time. How the range of new and emerging technologies will then impact on staff travel time.
- Ward layout and use of single rooms.
- Use of mixed speciality wards.

System management and review

Other suggested measures related to system management and review. Again, these issues were raised by small numbers of respondents from across the respondent types and also by a small number of discussion groups. They included service user and patient experience feedback. This was the most frequently-raised of these issues and was highlighted by discussion groups, individual and organisational respondents. Other less frequently-raised issues were:

- Standards implementation.
- Benchmarking.
- Practice observation.
- Service evaluation and re-design. Specifically, supported staff engagement in service improvement/re-design.
- Significant adverse events and complaints.
- Consideration of future plans, developments and changing circumstances likely to impact on patient or service user numbers or needs. This would include local factors.

Staff skills and wellbeing

A set of suggested measures related to staff skills, development and management. They included workforce capability, skills and experience mix and specifically, the ratio of newly qualified to experienced staff. This was the most frequently-raised of these measures and was particularly likely to have been highlighted by discussion groups and individual respondents.

Other less frequently-raised points were:

- Learning and development opportunities.
- Clinical leadership and peer review.
- Time dedicated to staff supervision.
- Protected teaching, education and professional development time, including for those taking mentoring, link nurse or Training the Trainer roles.
- Professional Development Planning reviews and exit interviews.

Others focused specifically on staff-related planning and wellbeing measures. The most frequently-raised was staff sickness rates. This was highlighted by discussion groups, organisational respondents and an individual respondent. Other less frequently-raised points were:

- Funded establishment to in-post staffing level.
- Staff recruitment and retention, including staff turnover. Some of the existing challenges around recruiting and retaining staff in rural and remote areas were again highlighted.
- Supplementary staffing levels and the use of agencies/agency staff.
- Psychological safety.
- Planned leave or absences (such as maternity leave).
- Rates of aggression towards staff.
- Staff satisfaction levels.
- Day-to-day workload.
- Unpaid overtime or missed breaks.

Patient and service user population

Other suggestions focused on the profile of those using services, their needs or on measures of system capacity. The most frequently-suggested measure, including by organisational and individual respondents and at the discussion groups, was patient acuity and caseload management. It was sometimes suggested that this should be linked specifically to the patient population at the time of the report. It was also noted that some services are subject to peaks and troughs in demand throughout the year, with maternity series cited as an example. Other less frequently-raised suggestions were:

- Escalation procedures. This was about ensuring that services are able to respond promptly to sudden fluctuations in activity, or changes in staffing levels.
- Number of hospital beds. It was suggested that hospitals must balance the provision of staffed beds against anticipated demand.
- Bed occupancy.
- Some way of measuring any care deficit (in terms of what cannot be done today).

Other systems to be considered

A small number of comments referenced other guidelines, reporting systems or processes which should be considered. These included:

- The new National Health and Care Standards[2].
- Nursing and Midwifery Council and National Institute for Health and Care Excellence (NICE) guidelines.
- The proposed EiC or Quality Dashboard measures.
- NHS e-KSF (Knowledge and Skills Framework).
- IMATTER[3].
- Datix[4].

Use of the tools

Other of the further comments made more general points about the use of the tools rather than proposing specific measures. They tended to be made by individual respondents and included:

- The approach must be easy to use in real time.
- Adequate training must be provided.
- Providing expert support around data analysis would be helpful.

[2] Available at: http://www.gov.scot/Publications/2016/10/1545

[3] IMATTER is a staff experience continuous improvement tool designed with staff in NHSScotland to help individuals, teams and Health Boards understand and improve staff experience.

[4] Datix is software for patient safety, risk management and incident reporting.

- Results should be published and easily accessible.

Question 7 - Given existing staff governance requirements and standards are there sufficient processes and systems in place to allow concerns regarding safe and effective staffing to be raised?

Table 13: Question 7 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	32	41	3	76
Organisations:				
Health & Social Care Partnership	*5*			*5*
Independent sector health or social care organisation	*1*		*1*	*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*5*		*1*	*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*1*	*6*	*5*	*12*
Total organisations	18	6	11	35
All respondents	**50**	**47**	**14**	**111**
% of all respondents	**45%**	**42%**	**13%**	**100%**
% of those answering the question	**52%**	**48%**		**100%**

Views were mixed as to whether, given existing staff governance requirements and standards, there are sufficient processes and systems in place to allow concerns regarding safe and effective staffing to be raised. A small majority of respondents who answered the question, 52%, agreed. However, a majority of individual respondents and Professional college, body, group or union respondents disagreed (41 out of 73 respondents and six out of seven respectively). In contrast, all of the other organisational respondents who answered the question were in agreement.

Table 14: Question 7 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
13	7	2	3	25

Amongst the discussion groups, 13 groups agreed, two held a mixed view, and seven disagreed. The remaining three discussion groups did not answer the question.

There were 77 further comments made through Citizen Space and all of the discussion groups made a comment.

The three most frequently-raised themes in relation to Question 7 were:

- Systems are in place to support safe practice and raise concerns, but these are not resulting in a change in practice.
- Poor organisational cultures can make staff feel that they are not listened to.
- It would be beneficial to place a greater emphasis on current care and clinical governance structures.

Existing systems

While some did raise concerns, others highlighted the range of processes, systems and responsibilities which are already in place. Health and Social Care Partnerships, NHS based professional groups or committees and NHS bodies or Boards were most likely to have raised these issues. They included that the IJBs are required to have in place robust clinical and care governance processes, with clear professional leadership to support operational teams. It was also suggested that there are a range of routes through which staff can raise a concern, including the National Confidential Alert Line, through Whistleblowing Champions and through Confidential Contacts at NHS Board level. Other less frequently-made comments were:

- The Care Inspectorate is statutorily empowered to provide a comprehensive scrutiny framework which looks at the quality of provision across social care and social work. It has a particular interest in facilitating concerns, complaints and whistleblowing activities in social care and social work services, which would include any concerns regarding safe and effective staffing.
- Governance structures within organisations will also be relevant, for example having Employee Directors or Clinical Directors on Boards.
- In independent hospitals, concerns are escalated via clinical leaders to senior nursing management under Scottish Independent Hospitals Association members' clinical governance structures.
- There are already processes in place for safe and effective rostering policies which help ensure the right staff are in the right place at the right time. This includes risk assessment and monitoring and escalation guidance.
- Existing arrangements in place under the Public Interest Disclosure Act, and developing work in support of the duty of candour, will all support the raising of concerns about safe and effective staffing.
- Performance reports provide a mechanism for NHS Boards and Assurance Committees to triangulate service delivery and performance with other quality and efficiency metrics. As at the previous question, reference was made to Datix and unsafe staffing levels reports.

Impact of current approaches and working culture

However, the most frequently-made comment (primarily but not exclusively by those who did not think the current systems are sufficient), was that while the systems may be in place to allow to staff to raise concerns, this does not necessarily translate into staff feeling listened to or any action being possible and/or

taken. These issues were raised primarily by discussion groups and individual respondents. A number of individual respondents referred to concerns around staffing levels not resulting in additional staff being agreed or, even if agreed, being available.

A concern was that the operational culture may mean that processes are seen as little more than a 'tick box' requirement and it was suggested that no amount of systems and processes will control for a poor organisational culture. It was suggested that staff being listened to and responded to appropriately is key to safe and effective staffing. There were also a small number of discussion group or individual respondents who reported that, within their own organisations, an element of anxiety or fear means that staff do not feel able to raise any concerns they may have.

Small numbers of primarily individual respondents highlighted a range of other issues or concerns about how the current approach works. These included that:

- Current leadership models, particularly within IJBs, mean that Allied Health Professions (AHPs) may not be present at most senior levels of management or in a position to influence policy or legislative development. Consequently, some staff may have concerns that their perspectives will not be heard.
- The current criteria to monitor standards of healthcare in prisons are not ideal.
- If the workload planning tools do not adequately reflect service demands, any workload-related complaints will be measured against unrealistic caseload sizes. The individual practitioner then has to prove their concerns, potentially including proving they are not inefficient or lacking in clinical skills.
- There can be significant delays in dealing with concerns raised. In particular, the timeframes from referral to investigation are too long.
- Datix does not always get completed when services are short staffed.

Futures plans

Going forward, a Professional college, body, group or union respondent suggested that, whilst the Staff Governance Standard already applies to the NHS, there is resistance to any assumption that it will apply to other sectors. On a similar note, another Professional college, body, group or union respondent and an Other public body respondent suggested that any approach needs to work for all staff, including AHPs and those working in social services and that clarity with regard to the role of IJBs and Health and Social Care Partnerships would be welcome. It was also suggested that far greater emphasis must be placed on the role of care and clinical governance structures within the legislation to provide appropriate and equal oversight from staff and clinical governance perspectives.

Other suggestions, in each case made by only one or a small number of individual or organisational respondents, included:

- Organisational accountability needs to be built into the system. It may be that the focus of any further work on the nursing and midwifery workforce should be on supporting the development of open and transparent cultures and improvements around using the existing tools.
- Additional advice, support and education would be helpful in ensuring informed decisions and appropriate escalation during implementation and embedding of any new requirement. In particular, senior nurses and team leaders need clarity around escalation processes.
- Datix should be strengthened to ensure that concerns and responses are properly recorded and analysed.

Question 8 - If not, what additional mechanisms would be required?

There were 64 further comments through Citizen Space and 12 discussions groups made a further comment (over and above those made at Question 7).

The three most frequently-raised themes in relation to Question 8 were:

- There need to be clear pathways and processes for escalation of issues.
- Ongoing consultation and discussion with staff regarding their experiences is important.
- There is potential value in independent review or external scrutiny of service standards.

Although a range of suggestions were made, most comments were made by only one or a small number of respondents. Suggestions for change or future action included that there should be clear lines of management accountability for all staffing groups. It was also suggested that that leadership for AHP groups should be at the same senior level as for other health care groups, such as nursing. Another suggestion was that overall governance should sit within the Clinical Governance Committee and the Health and Safety Committee in the workplace or that there should be reporting to Staff Governance and Partnership Fora on incidents where staffing falls below agreed safe levels.

Reporting systems or tools

In terms of reporting systems or tools, the most frequently-made suggestion was that there should be clear pathways for escalation to appropriate decision makers. This point was most likely to be raised at the discussion groups. Other less frequently-made comments were:

- Existing mechanisms should be linked up to ensure that one does not have an unintended impact upon another. The example given was that the introduction of legislation could mitigate against work to develop open and transparent cultures.
- There should be an accessible, national reporting system. There should be a contact point outwith local teams which staff can go to.

- There should be a procedure within NHS primary and acute settings that ensures concerns about safe staffing levels, raised by family members, are recorded. It should set out what then happens to this information.
- Nursing and Midwifery Workload and Workforce Planning tools should be updated regularly to ensure that changes in service delivery, the impact of other evidence-based care, and /or national drivers are incorporated.
- Additional measures, such as those contained in the NICE safe staffing guideline for midwives working in maternity settings, should be adopted. In particular, the guideline recommends the use of 'midwifery red flags' to act as warning signs that delays in treatment or other serious incidents may have been triggered by staffing problems.
- There should be real-time analysis, for example using SafeCare.

Staff involvement

Other suggestions focused on how staff should be involved in the process. These issues were most likely to be raised at the discussion groups or by individual respondents, with the most frequently-raised being that there should be staff awareness raising and training on how to report concerns. Other less frequently-made suggestions were:

- There should be some form of independent staff forum at which concerns can be raised.
- There should be regular surveys of staff. Also, exit interviews might shed more light on why some staff feel that their career in the health and social care service has been unsustainable and what might have been improved. Listening to these messages could help improve staff retention.
- Measures should be taken to ensure Datix is always completed.
- There should be paper incident forms.

Scrutiny and review

Finally, there were a small number of suggestions around scrutiny and review. The most frequently-made was that there should be an element of independent review and external scrutiny and accountability. This was most likely to be raised by individual respondents. A specific suggestion was that there should be surveillance by a national body that has the power to take action if standards are not being adhered to. Other less frequently-made suggestions were:

- There should be full clinical governance reviews, including service and case note audits.
- Mechanisms relating to service measurement and evaluation, such as outcome measures and audits which evaluate service provision and inform safe and effective staffing across and within organisations, should be utilised.
- Performance against recommended staffing levels should be published.

Question 9 - Do you agree with the proposal to require organisations to ensure that professional and operational managers and leaders have appropriate training in workforce planning in accordance with current guidance?

Table 15: Question 9 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	72	4		76
Organisations:				
Health & Social Care Partnership	*4*		*1*	*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*6*			*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*8*		*4*	*12*
Total organisations	26		9	35
All respondents	**98**	**4**	**9**	**111**
% of all respondents	**88%**	**4%**	**8%**	**100%**
% of those answering the question	**96%**	**4%**		**100%**

A substantial majority of those answering the question, 96%, agreed with the proposal to require organisations to ensure that professional and operational managers and leaders have appropriate training in workforce planning in accordance with current guidance. All organisational respondents who answered the question agreed and only four individual respondents disagreed.

Table 16: Question 9 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
25				25

All of the discussion groups also agreed.

There were 51 further comments made through Citizen Space and 22 of the discussion groups made a comment.

The three most frequently-raised themes in relation to Question 9 were:

- Training would support consistent and transparent practice and help embed workforce principles.
- The impact of training on clinical duties should be considered.

- There are already tools, with associated training packages, in existence.

A number of the further comments suggested that having an agreed national approach will be key and that appropriate training would be essential. Discussion groups or individual respondents were most likely to make these points. Reasons given for the importance of training included that it would help ensure consistent and transparent practice. It was also suggested that it will support proactive rather than reactive practice, confidence in decision-making, and could help foster a more positive attitude towards the completion of workload planning tools.

A small number of respondents, including individual and organisational respondents and discussion groups, commented on the focus and coverage of the training, including that:

- Training requirements will vary according to staff role.
- There should be an emphasis on shared ownership, responsibility, application and interpretation of tools and best practice in relation to triangulation.
- Cross sector training could be considered.
- It should include guidance on why a safe and sustainable workforce is necessary and how to plan for future demographic change.
- Operational managers and leaders should learn about the issues of retention of staff and how to make careers more attractive and sustainable in their areas.
- It will be important to recognise that 'health' tools will not always fit a social care or integrated service. The Care Inspectorate and the Scottish Social Services Council could work together to ensure that refreshed guidance and training are available in the social care sector.

With regard to who should receive the training, the following points were made, primarily by a small number of NHS based professional groups or committees and NHS bodies or Boards respondents:

- The training would need to extend to all staff but to varying degrees. learnPro5 could support such an approach.
- The training could be included within pre-registration nursing training or as part of induction processes. There could then be annual updates to include changes to methods, tools, mandate and legislation.
- There should be particular support to middle managers and finance managers to understand implications of decision-making and the impact on outcomes for people, their families and carers as well as all staff.
- NHS band 7 staff do the majority of rotas and staffing plans on a daily basis and are often the ones held to account. Their training needs should be paramount.

[5] learnPro is cloud-based educational software which is used by the NHS.

- Training must extend to Trade Unions.
- There was also a question as to whether Board members should receive training?

There were also a small number of comments, primarily from organisational respondents, about the resources implications. They included that the resource implications could be considerable, including because nursing staff are taken away from clinical duties. It was suggested that there could also be major challenges in non-NHS settings, that there should be a national view of equitable access to resources, and that implementation of a full education and training programme should be included in the financial memorandum to the Bill.

Other points made about training included that, as it stands, the wording of the Bill is not sufficient to ensure that organisations can provide evidence of the competence of those given responsibility for workforce and workload planning, including their professional judgement. It was suggested that this should be reflected in the draft Bill. Other comments included:

- Training to support workforce planning in line with the Revised Workforce Planning Guidance (CEL32, 2011)[6] is still valid. However, there may be some lack of understanding when it comes to application of these tools, especially when working in multi-disciplinary teams.
- Leaders of multi-disciplinary teams should be required to consult with equally experienced and senior professional leaders from each of the disciplines they manage.

Question 10 - Do you agree with the proposal to require organisations to ensure effective, transparent monitoring and reporting arrangements are in place to provide information on how requirements have been met and to provide organisational assurance that safe and effective staffing is in place, including provision of information for staff, patients and the public?

[6] Available at: http://www.knowledge.scot.nhs.uk/workforceplanning.aspx

Table 17: Question 10 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	71	2	3	76
Organisations:				
Health & Social Care Partnership	*3*	*2*		*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*6*			*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*8*	*1*	*3*	*12*
Total organisations	25	3	7	35
All respondents	**96**	**5**	**10**	**111**
% of all respondents	**86%**	**5%**	**9%**	**100%**
% of those answering the question	**95%**	**5%**		**100%**

A substantial majority of those answering the question, 95%, agreed with the proposal to require organisations to ensure effective, transparent monitoring and reporting arrangements in place. The majority of both individual and organisational respondents agreed (71 out of 73 respondents and 25 out of 28 respondents respectively). Health and Social Care Partnerships, Professional college, body, group or union and individual respondents were the only respondent types in which anyone disagreed.

Table 18: Question 10 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
22	1		2	25

Twenty-two of the discussion groups agreed, one disagreed and two did not answer the question.

There were 49 further comments made through Citizen Space and all of the discussion groups made a comment.

The three most frequently-raised themes in relation to Question 10 were:

- Transparency is crucial in terms of both staff and public confidence.
- Any resulting information should be both easy to understand and contextualised.
- A number of external scrutiny bodies are in existence that may currently, or could, play a monitoring role.

As noted above, the most frequently-made point was that transparency will be crucial, including to give staff and the public confidence in the approach. Discussion groups and individual respondents were most likely to make this point. A number of discussion groups also commented that it will be important for public facing information to be easy to understand but also be set very clearly in context. Otherwise, the remaining comments were generally made by one or a small number of respondents only.

It was suggested that a having more complete overview of staffing requirements provides a mechanism to react to issues as they arise and provides another level of assurance. However, it was also suggested that monitoring and reporting in isolation will not necessarily provide full assurance. Echoing some of the issues covered at earlier questions (and at Question 2 in particular), the argument was that it is essential to look at what is happening in response to the use of the workforce planning tools – the 'so what' – and the subsequent impact.

Other comments addressed the focus of the monitoring and reporting elements and again were made by small numbers of respondents or were raised at a small number of the discussion groups. They included that the monitoring framework needs to be considered carefully as numerical information does not provide the whole picture. It was suggested that context will be important and that reports will need narrative as well as numbers. It was also suggested that they should not be overly long or complex. A specific suggestion was that a 'Red, Amber, Green' approach could be used. With regard to the overall reporting arrangements, comments included:

- An organisation's Board should have overall responsibility for meeting any reporting requirements.
- There should be a minimum requirement that a Board reviews its staffing, monitoring and reporting arrangements at least once every six months or more frequently in the event of concerns being raised.
- Reporting at IJB and NHS Board level would support effective scrutiny and assurance.
- Clarity would be needed as to the respective responsibilities of General Practices and Health Boards in the monitoring and reporting arrangements of staffing levels in a practice setting.
- The approach would need to be monitored to prevent any manipulation of figures to achieve financial gain.

A small number of comments related to how staff and managers will use the tools and included that staff and managers will need to be given the necessary time and resources to deliver the requirements. It was also suggested that requirements should be kept to a necessary minimum so as not to become a drain on resources. Other comments included that:

- Consideration should be given to helping leads to understand better their establishments.

- It will be important to take on board any learning from the use of the tools and to consult with staff on the impact of their use. This could include opportunities to share good news stories.
- Any developments in monitoring and reporting should be subject to full consultation with sufficient lead-in time before changes are introduced.

A small number of NHS body or Board and Other public bBody respondents highlighted existing external scrutiny, monitoring and reporting arrangements that are in place and/or could potentially be built on. Examples included:

- The Care Inspectorate expects all care services to be open and transparent in providing information to people experiencing care. With the new National Health and Social Care Standards, there will be a stronger focus on service providers and integration authorities undertaking regular assessment of needs, rights and choices.
- Performance reports to NHS Board Assurance Committees and to the full NHS Board. These will cover workforce metrics (sickness, vacancy rate, age profile, turnover etc).
- Local Delivery Plans are required to respond/refer to Everyone Matters priorities and in going forward could be extended to append a strategic staffing review for the forthcoming year.

However, an NHS body or Board respondent also noted that Boards will have different levels of development and maturity in relation to monitoring performance.

Chapter 4 - Future approach and priorities

The consultation paper sets out that the proposed new requirements would:

- Apply to organisations providing health and social care services, including but not limited to NHS Boards, Local Authorities and all organisations providing services regulated by the Care Inspectorate. It would also apply to organisations providing services on behalf of Integration Joint Boards.
- Be applicable only in settings and for staff groups where a nationally agreed framework, methodology and tools exist.

Requirements would apply at an organisational level and would not apply to individuals providing services.

Question 11 - Do you agree with our proposal to consider extending the requirement to apply nursing and midwifery workload and workforce planning approach to other settings and/or staff groups in the future?

11a - If yes, which staff groups/multi-disciplinary teams should be considered?

11b - If yes, which other clinical areas/settings should be considered?

Table 19: Question 11 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	66	9	1	76
Organisations:				
Health & Social Care Partnership	*2*	*3*		*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*4*	*1*		*5*
NHS Body or Board	*5*		*1*	*6*
Other			*3*	*3*
Other public body			*2*	*2*
Professional college, body, group or union	*7*	*1*	*4*	*12*
Total organisations	20	5	10	35
All respondents	**86**	**14**	**11**	**111**
% of all respondents	**77%**	**13%**	**10%**	**100%**
% of those answering the question	**86%**	**14%**		**100%**

A majority of those answering the question, 86%, agreed with the proposal to consider extending the requirement to apply nursing and midwifery workload and workforce planning approach to other settings and/or staff groups in the future. The majority of both individual and organisational respondents agreed (66 out of 75

respondents and 20 out of 25 respondents respectively). However, a majority of Health and Social Care Partnership respondents disagreed.

Table 20: Question 11 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
22	1		2	25

Twenty-two of the discussion groups agreed, one disagreed and two did not answer the question.

There were 98 further comments made through Citizen Space at 11a. and 75 comments made at 11b, although a number of these simply referred back to their previous comment. All of the discussion groups made a comment across 11a. and 11b. Many of the comments made did not distinguish between the two specific aspects covered under the sub-questions (i.e. which teams and which clinical settings should be covered), and hence a single analysis of all comments made is presented below.

The three most frequently-raised themes across Questions 11a and 11b were:

- A whole-systems, multi-disciplinary approach is required, rather than having a focus on particular professions or specialties.
- In terms of particular staff groups, all AHPs and medical staff were the most frequently-suggested.
- In terms of the clinical areas or settings respondents felt should be considered, the suggestions were again many and varied but the most frequently-identified was nursing and care homes.

As noted above, in addition to or instead of commenting on specific staff groups or settings, a number of respondents made general comments at this question.

These general comments tended to cover one of two broader issues. The first of these tended to be raised by organisational respondents and was that a whole-systems, multi-disciplinary approach is required, rather than having a focus on particular professions or specialties. A small number of these respondents identified problems they felt could result from not taking a whole-systems approach. These included that, within the landscape of integrated services, a legislative requirement covering one profession could result in that group being protected against budget-related staffing decisions. However, this could lead to significant reductions in numbers in ‘unprotected’ professional groups. Some of those raising this concern, including two Health and Social Care Partnership respondents, suggested that Health and Social Care Partnerships should be allowed time to develop integrated services and then to consider the staffing required.

The other main concern was raised by a smaller number of organisational respondents and was that that the approach overall, and specific tools being used, must be tested and established as being fit-for-purpose, including within a multi-agency, multi-professional context. It was also noted that using the same set of

tools with different staff groups may not work and that approaches which work within a medical model will not necessarily be suited to other services.

Finally, in terms of more general comments, and reflecting comments made at earlier questions (and at Question 3 in particular), a Public body respondent suggested that extending the approach to the care sector would replicate or confuse existing approaches.

In terms of which teams or settings should be covered, there were references to 'all', 'all areas', 'all health and social care settings', 'all clinical settings', 'all multi-disciplinary teams', 'all essential staff' etc, but the precise intentions of each respondent were not always clear. The analysis below focuses on the more specific references made.

Staff groups or teams

In terms of particular staff groups which respondents felt should be considered, the two most frequently-identified groups were:

- All AHPs. This was the most frequently-made suggestion and was made by a number of discussion groups and individual respondents, as well as across the range of organisational respondents.
- Medical staff. This was also a frequently-made suggestion across the discussion groups and individual respondents.

Many of the other suggestions made were for staff groups which fall into one of these wider definitions and included:

AHPs: Diagnostic or Therapeutic Radiographers; Dieticians; Occupational Therapists (OTs); Physiotherapists; Practice Development Nurses; Prosthetists, Orthotists and Orthoptists; Speech and Language Therapists.

Medical staff: GPs; Junior Doctors; and Paediatricians.

Nursing staff: Advanced Nurse Practitioners; Clinical Nurse Specialists; Community Psychiatric Nurses; Infection Control Nurses; and Practice Nurses.

Support staff: Administrative staff (with the majority of references suggesting this referred to NHS-based staff); Other facilities or ancillary staff, including porters or domestics.

Clinical or clinical support roles: Healthcare Support Workers; Laboratory staff; Pathologists; and Phlebotomists.

Social work or care roles: Social workers; and Social care staff, including homecare staff.

Other groups identified included: Clinical academic and research staff and healthcare scientists; Dentists; Psychologists and psychotherapists; and Pharmacists or clinical pharmacists.

Clinical areas or settings

In terms of the clinical areas or settings respondents felt should be considered, the suggestions were again many and varied. The suggestions tended to be raised at discussion groups or made by individual respondents, with the most frequently-identified settings being:

- Nursing and care homes.
- Outpatient departments.
- Home-based services, including Care at Home or Hospital at Home. Also, social care services, including homecare.
- Community-based services.
- Out of hours services.
- GP practices.
- Prisons.
- Mental health services, including community-based, Children's and Adolescent Mental Health Services and Forensic Mental Health Services.
- Community hospitals.
- All settings that provide healthcare, including health centres.

There were also smaller numbers of references to a broad range of other settings including: Operating Theatres and Surgical Departments; Day hospitals; Primary Care Emergency Centres; Contracted services such as nursing agencies; Hospices; Pharmacies; Laboratory services; Telehealth and Telecare services; School nursing services; Addictions services; Clinical Psychology and counselling services; all private health or care settings; Stepdown and intermediate care and rehabilitation services; Liaison teams; Integrated community teams; Social work services; Residential Children's Homes; Supported accommodation; Day Centres; and the Scottish Ambulance Service.

Chapter 5 - Risks and unintended consequences

The consultation paper then moved on to consider possible risks and unintended consequences associated with the proposals.

Question 12 - Are there any risks or unintended consequences that could arise as a result of the proposed legislation and potential requirements?

Table 21: Question 12 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	58	10	8	76
Organisations:				
Health & Social Care Partnership	*5*			*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*6*			*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*9*		*3*	*12*
Total organisations	28		7	35
All respondents	**86**	**10**	**15**	**111**
% of all respondents	**77%**	**9%**	**14%**	**100%**
% of those answering the question	**90%**	**10%**		**100%**

A majority of those answering the question, 90%, thought there are risks or could be unintended consequences arising as a result of the proposed legislation and the potential requirements to extend the requirement to other settings and/or staff groups in the future. A majority of individual respondents agreed (58 out of 68 respondents), and all organisational respondents who answered the question agreed.

Table 22: Question 12 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
21			4	25

Twenty-one of the discussion groups agreed there were risks or could be unintended consequences and four did not answer the question.

There were 91 further comments made through Citizen Space and all of the discussion groups made a comment. The main risks or unintended consequences identified are set out in turn below.

The three most frequently-raised risks in relation to Question 12 were:

- Insufficient funding to address additional staffing requirements.
- Difficulties in recruiting and retaining staff.
- Resources being drawn from one service to another if a whole-systems approach is not taken.

These three most frequently-identified risks are presented first. In each case a range of discussions groups, individual respondents and organisational respondents highlighted these issues as potential risks.

Insufficient funding to cover any additional staffing requirements identified. The risk identified was that services would need to be reduced or closed if financial constraints mean there are insufficient resources to staff up to the safe and effective levels.

Specific risks suggested included: smaller services in particular may be considered unsustainable; the number of hospital bed could be reduced; and social care providers could leave the sector. It was also suggested that in England and Wales safe staffing levels for nursing has had an impact on funding for AHPs.

Difficulties in recruiting and retaining staff. Being unable to fill posts and reach and then maintain establishment level requirement was also identified as a risk. In particular, a number of respondents noted that some NHS and other services are already experiencing significant difficulties in filling key positions; the associated concern was that organisations will not be able to deliver the numbers indicated through triangulated workforce planning processes.

It was also suggested that:

- The possible problem could be further exacerbated if the requirements are too prescriptive in terms of the skills and experience profile of staff.
- The approach may have an especially adverse impact on sustaining inpatient care in local communities, particularly in smaller units in remote and rural areas where a flexible approach is often required.
- It could lead to increased use of Bank or Agency staff.

Resources could be drawn away from one service to another. The risk identified here was around a whole-systems approach not being taken and particularly to the approach extending only to specific health services at the outset. The concern was that the budgets within integrated services may be skewed towards meeting the (potentially increased) staffing costs of those services which are covered by the tools at the expense of those services which are not. Specifically, that the existence of a legally-enforced approach could skew the

priorities, funding and approach towards compliance at the expense of the staff groups or service settings outside of the scope of regulation.

Other less-frequently-identified risks are set out below. These risks tended to have been identified by smaller numbers of primarily organisational respondents.

Too narrow a focus. The fundamental risk identified here was that the legislation will not improve the staffing available to provide safe and effective care. This was linked to a view that the Bill is unlikely to help to improve patient outcomes if it is not designed explicitly to do so.

Poor timing. This was connected with a concern that the changes would result in a significant administrative and cost burden at a time when NHS and Local Authority services, along with other key stakeholders, are in the early stages of health and social care integration. It was suggested that now is the time to focus on service re-design and high quality, person-centred provision rather than administration.

Multiple systems and approaches cause confusion. It was suggested that if the proposed requirements are extended to social care settings, there will be the risk of duplicating existing arrangements or creating competing regulatory frameworks. It was also suggested that there could also be confusion as to the applicable requirements for nurses working in social care settings.

The approach and tools are not fit-for-purpose. The risks identified here tended to centre around the current tools not being fit-for-purpose, that they could become out of date easily and challenges associated with producing a single set of tools which would work for all.

On the first point, the fundamental concern was that the legislation could be used to justify insufficient and unsafe staffing if incorrect methodologies are used. An example given was that the growing and ageing population might be overlooked.

In terms of the existing tools, the perceived risk was that, by focusing on tools which are already available, and particularly by referring to them directly in legislation, a less than ideal set of arrangements could be ‘locked in’. Work to improve the current approaches could then be stifled.

The other concern was that it may not be possible to produce a single approach or set of tools which works across the range of possible service delivery contexts and specialisms. For example, it was suggested that a single tool might not be able to consider the huge workload and workforce variation found even between GP practices.

Nursing and midwifery staff could be accountable but unable to affect the necessary changes. The specific concern or fear for those involved, was that they will be held accountable for failing to deliver the numbers and profile of staffing required under the safe and effective arrangements. The key reasons underpinning these concerns were that: in certain areas or specialties, it is simply not possible to recruit the necessary staff; and that the funding may not be made available to support the establishment suggested by the workforce planning tools.

It was suggested that exposing nurses and other staff to such risks is unfair and could impact on their Nursing and Midwifery Council registration. It was also suggested that there could be a risk of litigation, for example if members of the public feel they, or someone else, has been harmed because staffing levels were not safe.

Insufficient resources invested in infrastructure, training and time to use the tools. The risks identified centred around poorly understood or used tools consuming resources without delivering any tangible benefits. There was also a concern that increased administration time would take staff away from clinical duties and that ICT systems will not allow for efficient and effective record keeping.

Lack of 'buy in' from staff. In particular, it was suggested that if not funded or policed appropriately, the approach could be seen by staff as just another 'tick box' exercise.

Other risks identified included:

- A shift from patient or service user outcomes to being service provider driven, with staff numbers alone seen as a measure of patient safety.
- The potential for professions or services that do not have validated tools being disadvantaged in relation to their ability to influence allocation of resources.
- Innovation and transformation of services being restricted, especially the use of technology, volunteers and emerging non-clinical roles to enhance services.

Question 13 - What steps could be taken to deal with these consequences?

Ninety-one Citizen Space respondents made a comment at Question 13, as did all of the discussion groups. Some of the comments addressed directly the risks and consequences raised at the previous question. Others raised additional issues. Below, the steps identified are set out under the risk they would deal with.

The three most frequently-identified themes in relation to Question 13 were that to mitigate risks:

- Ensuring adequate funding is in place for health and social care services will be important.
- Any future workforce planning legislation needs to take into account the integrated practices of the Health and Social Care Partnerships.
- Collaboration with educational establishments should be improved.

Insufficient funding to cover any additional staffing requirements identified. This was the most frequently-commented on issue by some margin and was raised at discussion groups and by individual and organisational respondents. Suggested steps included ensuring that health and social care services are adequately funded.

Specifically, any additional costs associated with ensuring safe and effective staffing should be covered.

Other steps were raised by smaller numbers of respondents and primarily by organisational respondents or at the discussion groups.

Too narrow a focus. Suggested steps included:

- Rethinking the scope of the Bill to ensure it underpins existing activity in the highest performing organisations. However, it was suggested that there would be consequences inherent in taking such as approach, including risking increased problems for poor-performing organisations.
- Ensuring that a wide range of opinions are canvassed during the consultation process and that the consultation period is sufficient to allow all views to be considered and the legislation to be amended accordingly.

Poor timing. Suggested steps included:

- Focusing on alternatives to ensuring high-quality, person-centred care rather than introducing safe and effective staffing legislation for nursing, midwifery and other staff groups.
- Promoting local governance and accountability related to quality care provision.

Multiple systems and approaches cause confusion. Suggested steps included that the proposed legislation and potential requirements should not be extended to social care settings at this time.

Resources could be drawn away from one service to another. Suggested steps included:

- Naming nursing, midwifery and organisations commissioning/delivering NHS functions on the face of the Bill but ensuring that the Bill permits future regulation to expand its scope. The Bill could be accompanied by a timetable for expansion.
- Ensuring any legislation takes account of the integrated working practices of the Health and Social Care Partnerships. This should include the scope for role re-configuration and development and skill mix review.
- Introducing regulations protecting ‘other disciplines’ work forces.

The approach and tools are not fit for purpose. Suggested steps included:

- Not naming tools or methodologies in primary legislation. Instead, detail could be set out in regulation and/or statutory guidance.
- Making it clear what the expectations on organisations are and what the consequences will be of a failure to comply with the requirements. Putting in place a communication strategy around statutory use of the tools.

- Including a duty on the Scottish Government to review tools regularly in line with emerging evidence and in partnership with professional and trade union organisations.
- Agreeing a national definition of what safe staffing and sustainable careers look like in partnership with medical colleges and healthcare staff.
- Constructing the approach based on real time analysis of staffing.
- Ensuring that any measurement for safe and effective staffing includes the total contribution to patient care not just nursing and midwifery.
- Ensuring there are robust processes in place around risk assessment.
- Considering whether the existing requirements for GP practices would achieve the same aim. If the existing measures are not enough, whatever new tool is introduced must work for all practices across Scotland and there must be a clear and agreed process outlining the responsibilities of the practice and the Health Board.
- Linking in with the National Care Home Contract Reform process, especially the Cost of Care Calculator work and workforce.

Difficulties in recruiting and retaining staff. Suggested steps included:

- Making links to student commissioning, including applying the tools to defining student numbers. Communicating with further education facilities.
- Making careers sustainable and attractive by supporting multi-disciplinary learning and working, encouraging varied and flexible careers and integrating health and social care workforces.
- Giving all staff access to opportunities for continuing professional development.
- Improving conditions and pay levels.
- Investing in a programme to better utilise the diversity of the 'labour pool' in areas of high unemployment.

Nursing and midwifery staff could be accountable but unable to affect the necessary changes. Suggested steps included:

- Accountabilities for delivering safe and effective staffing must be organisational. The Bill must reflect the different spheres of influence of professional leadership at different levels.
- The Bill should ensure that Senior Charge Nurses/Community Team Leaders are non-case holding and that they are provided with the education and support they require.
- Setting a 'cap' on claims against individual members of staff and/or the NHS.

Insufficient resources invested in infrastructure, training and time to use the tools. Suggested steps included:

- Providing training in the use of the tools.
- Ensuring staff have dedicated time to use the tools.
- If a tool is introduced and General Practices are to use it, then it must be accessible using existing ICT systems. A burden to fund access to additional ICT systems should not be placed on Practices.

Lack of 'buy in' from staff. Suggested steps included putting in place open communication and transparent processes for informed decision-making to promote public and staff confidence.

Chapter 6 - Monitoring requirements

The penultimate part of the consultation paper looked at the proposals for performance and monitoring processes.

Question 14 - Do you agree with the proposals to use existing performance and monitoring processes to ensure compliance with the legislative duty and associated requirements?

Table 23: Question 14 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	47	24	5	76
Organisations:				
Health & Social Care Partnership	*1*	*2*	*2*	*5*
Independent sector health or social care organisation	*2*			*2*
NHS based professional group or committee	*5*			*5*
NHS Body or Board	*6*			*6*
Other			*3*	*3*
Other public body	*1*		*1*	*2*
Professional college, body, group or union	*4*	*2*	*6*	*12*
Total organisations	19	4	12	35
All respondents	**66**	**28**	**17**	**111**
% of all respondents	**59%**	**25%**	**15%**	**100%**
% of those answering the question	**70%**	**30%**		**100%**

A majority of respondents, 70% of those who answered the question, agreed with the proposals to use existing performance and monitoring processes to ensure compliance with the legislative duty and associated requirements. The majority of both individual and organisational respondents agreed (47 out of 71 respondents and 19 out of 23 respondents respectively). However, a majority of Health and Social Care Partnership respondents disagreed.

Table 24: Question 14 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
15	5		5	25

Fifteen discussion groups agreed, five disagreed and five did not answer the question.

There were 55 further comments made through Citizen Space and all of the discussion groups made a comment. Comments made at this question tended to be brief.

The three most frequently-identified themes in relation to Question 14 were:

- The implications of legislation on social care and Health and Social Care Partnerships needs to be better understood
- The role of existing scrutiny bodies, for example the Care Inspectorate, needs to be considered.
- Clear lines of accountability will be required across both professions and organisations.

A small number of respondents, including a Health and Social Care Partnership and a Professional College, Body, Group or Union respondent, had fundamental concerns stemming back to their wider concerns about the approach being proposed, including the intention to legislate. A small number of individual respondents noted that they have limited knowledge of the current arrangements and/or required further information before being able to comment further.

Those who disagreed most frequently had concerns that the current approach is not fit for purpose. A number of those who agreed or did not answer the question also made support conditional on there being improvements to the existing processes. Those raising these concerns ranged across the discussion groups and individual and organisational respondents.

In terms of elements of the approach which respondents felt need to be changed or refined, suggestions included that processes need to be streamlined as much as possible. Specific suggestions, made by only a small number or one respondent, included:

- A national reporting template should be developed for nursing and midwifery. It should include quality outcomes and be tailored to the particular context by, for example, taking account of service user needs or configuration of available space.
- The approach will also need to be appropriate to non-NHS settings.
- The approach used needs to take the views of those using services into account.
- The EiC dashboard could be used for monitoring.
- It will be important for any systems used to be integrated.
- Monitoring should be an administrative task, but with managerial and/or clinical oversight.

A small number of NHS body or Board respondents also commented on the issue of accountability, including whether the proposals would have implications across the spectrum of professional accountability structures and codes of conduct. There was a connected question as to what role organisations such as the Nursing and

Midwifery Council, General Medical Council and Scottish Social Services Council would play. On the more general point of where responsibility for monitoring should lie, comments included that reporting should be required through Board Clinical Governance mechanisms and as part of local and national performance reviews.

With specific reference to inspection of care sector services, an Other public body respondent noted that the Care Inspectorate acts as the improvement and scrutiny regulator and that they assess workforce planning/experience at the point of registration and also assess the application of workforce planning during regular inspections. It was also noted that, from April 2017, the Care Inspectorate and Healthcare Improvement Scotland will inspect jointly the strategic commissioning arrangements of integration authorities. An NHS body or Board respondent suggested there is scope for some external assurance to sit within Healthcare Improvement Scotland's wider quality of care review process.

Following on from the consideration of where responsibilities may lie, there were also comments around compliance. A small number of NHS body or Board respondents noted that the primary purpose of monitoring should be to act as a driver for action. They suggested that there is no point in monitoring information that tells an organisation there is a risk if no action is taken to mitigate that risk. It was suggested that organisations should report on risks of implementation or taking the decision not to implement outcomes and subsequent recommendations.

Other comments considered transparency and were made by individual and organisational respondents and at a small number of the discussion groups. Suggestions included that more robust external scrutiny, possibly including on-site inspection, is required. However, it was also suggested that any approach to inspection needs to recognise that, although not all inspectors may have a clinical background, they will need an understanding of the services being inspected. It was also suggested that greater clarity is required about where and when information on safe staffing is presented to the public. There were also questions around what if any penalties are envisaged for non-compliance. It was suggested that consideration will need to be given to trigger points and escalation routes in the case of non-compliance but that it is essential that these are not exclusive of an improvement approach.

Finally, an NHS body or Board respondent suggested that it is important to remember that compliance alone does not necessarily equate to good outcomes and that the key issue is what the information tells us about quality and safety in the local setting.

Question 15 - In what other ways could organisations' progress in meeting requirements be monitored?

There were 68 further comments made through Citizen Space and 24 discussion groups made a comment. As at the previous question, a number of the comments were brief. The three most frequently-identified themes at Question 15 were:

- There are existing scrutiny or governance processes which could be drawn on.
- Staff feedback, including anonymous feedback and any data on staff morale, should be used.
- There would be value in external reporting to a central body or the Scottish Government.

Comments sometimes focused on key features of any regime. Each issue tended to be raised by only a small number or one organisational or individual respondent or at one of the discussion groups. They included that it should be:

- Mandatory.
- Based on reporting to a central body or government.
- Focus on reporting by exception where standards are breached.
- Have an external component, for example through NHS boards acting as critical friends to each other or via existing external inspection processes.
- Include a benchmarking element.
- Offer support to implement tools and learn from others through sharing experiences.

In terms of structures, and where responsibility should lie, suggestions included through:

- Clinical Governance Committees.
- Health and Safety Committees.
- Staff Governance Committees.
- Area Partnership Forums.
- A National Oversight Group.

Other suggestions included that that each area should identify an executive lead and that there should be internal, local routes for flagging and escalating concerns.

In terms of specific routes through which progress could be monitored, suggestions included through:

- Scottish Standard Time System reports direct to the Information Services Division (ISD) Scotland.
- HEAT Targets7 reports.
- EiC.
- National databases such as Lanquip or Datix.
- Local and Regional Delivery Plans.

[7] HEAT Targets are set out by NHS Scotland and the Scottish Government's Health Directorates. There are four groups of Targets, collectively known as HEAT targets; these are: **H** - Health Improvement, **E** – Efficiency, **A** - Access to treatment, and **T** – Treatment.

- Service Improvement Plans.
- Annual Reports. Specifically, every IJB is required to publish an annual performance report from July 2017, reporting on the legislative requirements encapsulated within the 23 National Integration Indicators.
- Health Board Performance monitoring.
- Automated monitoring, for example through dashboards.
- Local governance or risk management reporting.

In terms of the types of information which could be considered, it was suggested that it will be important to establish a core data set for all Boards. Specific suggestions as to the type of information or data which could be used included staff feedback, including anonymous feedback and including any data on staff morale. This was the most frequently-made point at this question and was particularly likely to have been highlighted by individual respondents. Patient feedback was the other frequently-made suggestion. Other less frequently-made suggestions were:

- National Performance Indicators.
- Data on staffing levels and availability.
- Other evidence such as delayed discharge numbers, waiting times, falls, infection control measures, care at home, and reducing hospital admissions.
- Practice observation.

It was also suggested that it will be important to use narrative to set any analysis developed in context.

Question 16 - What should the consequences be if organisations do not comply with requirements?

There were 80 further comments made through Citizen Space and all of the discussion groups made a comment.

The three most frequently-identified themes at Question 16 were:

- The focus should be on improvement and on being supportive rather than punitive.
- There should be corporate or political liability where improvements are not made.
- Actions must be set within the context of reducing public sector resources.

Some of the comments made general points about the overall approach to dealing with compliance failure. These comments included that the focus must be on safety and that non-compliance needs to be viewed alongside the organisation's approach to ensuring safety and outcomes for patients or service users. The most frequently-made suggestion was that any approach should be supportive rather than punitive and should concentrate on supporting improvement. In particular, it was suggested that there is a danger that negative consequences of not complying will inhibit a

culture of openness and honesty. This range of issues was raised at discussion groups and by individual and organisational respondents.

However, it was also suggested that there should be consequences if an organisation continues to fail. This was most likely to be suggested by individual respondents or raised at a discussion group. It was also suggested that if harm is a consequence of not meeting the requirements set out in legislation, then some corporate and political liability should be considered. Other comments included that:

- Accountability should be to the Scottish Government.
- Naming and shaming may be required.
- Health and Safety legislation may be relevant.
- In the care sector, this needs to be tied into contractual requirements and breaches within the National Care Home Contract.
- The tools used should be kept under review to ensure that they are not contributing to any non-compliance.

In terms of processes which should be gone through or activities which should be triggered by non-compliance, the approach used by the Care Inspectorate was cited by a small number of organisational respondents. It was noted that the Care Inspectorate employs requirements and recommendations[8] and, if a service consistently fails to achieve an acceptable quality of care, it has powers to enforce closure by applying to the Courts to cancel a registration. The arrangements set out in Section 22 of the Public Finance and Accountability (Scotland) Act 2000 were also highlighted. The Section 22 arrangements place duties on NHS Healthcare Improvement Scotland in the first instance to raise concerns in similar ways to the Auditor General through an annual review process. It was suggested that using a similar approach would give the Scottish Parliament the information to scrutinise failures and ensure that commissioning and delivery organisations, along with those setting the context in which they work such as the Scottish Government, can be called to account publicly for failures in safe and effective staffing.

Other process-related comments, which tended to be made by a small number of individual respondents or be raised at a discussion group, were:

- It is the Board, Chief Executive or Senior Management Team who should be held accountable. Where leadership is poor or failing there should be consequences, and this should be stated explicitly in Executive and Non-Executive job descriptions.
- There should be peer review opportunities before any other external scrutiny processes are initiated.

[8] A requirement is a statement which sets out what a care service must do to improve outcomes for people who use services. A recommendation is a statement that sets out actions that a care service provider should take to improve or develop the quality of the service, but where failure to do so would not directly result in enforcement. These must also be outcomes-based and if the provider meets the recommendation this would improve outcomes for people receiving the service.

- There should be external examination which identifies why the non-compliance has occurred and then supports the service to achieve compliance.
- There may be a role for some form of ‘special measures’ to bring in external support.
- Failure to act should be met with a time-limited improvement notice.
- Information about the failures should be published, for example on the Care Inspectorate website.

In terms of actions which organisations should be required to take, suggestions included developing an action, improvement or recovery plan. Parallels with the Healthcare Environment Inspectorate (HEI) Inspections regime were noted. A small number of the discussion groups suggested there should be thorough investigation/process reviews to determine why a standard has not been met.

It was also noted that services need to be safe and that immediate action may be required, for example by stopping delivering the affected service or re-provisioning of the service. A similar suggestion was that there could be a requirement to reduce bed numbers until any problems are rectified.

In terms of any specific consequences or penalties which should result from non-compliance, suggestions included financial penalties or fines. This was a frequently-made suggestion and tended to be made by individual respondents. However, others felt that financial penalties were not the answer. It was suggested that they could simply encourage a downward spiral for those organisations which are already struggling to comply. Organisational respondents tended to be the ones of this view. Other comments included:

- Care organisations should receive lower grades at future inspections.
- As noted above, there should be consequences for senior management and/or the Board of the organisation.

Finally, there were questions as to the consequences for the Scottish Government in terms of: appropriate funding and resource allocation; commitments to student numbers; and other workforce supply issues.

Chapter 7 - Equality consideration

The nine protected equality characteristics are age, sex, gender reassignment, sexual orientation, race, religion or belief, pregnancy and maternity, disability, and marriage and civil partnership.

Question 17 - Do you anticipate any of the proposed options outlined in this consultation will have a direct or indirect positive or negative impact on any protected equality characteristics?

Table 25: Question 17 – Responses by type of respondent.

Type of respondent	Yes	No	Not answered	Total
Individuals	11	59	6	76
Organisations:				
Health & Social Care Partnership	*2*	*2*	*1*	*5*
Independent sector health or social care organisation		*2*		*2*
NHS based professional group or committee	*1*	*4*		*5*
NHS Body or Board	*1*	*5*		*6*
Other	*1*		*2*	*3*
Other public body		*1*	*1*	*2*
Professional college, body, group or union	*5*	*4*	*3*	*12*
Total organisations	10	18	7	35
All respondents	**21**	**77**	**13**	**111**
% of all respondents	**19%**	**69%**	**12%**	**100%**
% of those answering the question	**21%**	**79%**		**100%**

A majority of those answering the question, 79%, did not anticipate any of the proposed options outlined in this consultation will have a direct or indirect positive or negative impact on any protected equality characteristics. The majority of individual and organisational respondents (59 out of 70 and 18 out of 28 respectively) did not expect the proposals to impact on any protected equality characteristics. However, the majority of Professional college, body, group or union respondents did expect the proposals to have an impact.

Table 26: Question 17 – Discussion Groups

Yes	No	Mixed Views	Not answered	Total
6	15		4	25

Fifteen discussion groups did not anticipate any impact, six did and four did not answer the question.

There were 29 further comments made through Citizen Space and 17 discussion groups made a comment. Comments tended to be brief.

The three most frequently-identified themes in relation to Question 17 were:

- The potential impact on individuals using services in the event of service closure.
- The disproportionate impact on women because of the number of women working in the care sector.
- The need to engage with affected staff as well as specialist equality advisors.

Comments made by those who did not anticipate the proposals would have any impact included that there should be engagement with affected staff and equality and diversity advisors.

Those who did think there would be an impact sometimes identified which types of people or groups they anticipated being affected. They sometimes, but not always, also identified the nature of the anticipated impact. The suggestions included:

- All or many of those within protected characteristics groups. Further comments included that they will be affected if services are threatened with closure.
- Women, because they make up such a significant proportion of the affected workforces. It was suggested that the impact could be positive or negative depending on whether staffing is increased or decreased, and grades increased or decreased.
- Pregnant women, if midwifery services are affected or if there is downward pressure on requests for flexible working from women who are pregnant or have caring responsibilities.
- Older people and people with a disability could be affected positively if staffing levels increase.
- Children and adults with Down's Syndrome and their families. It was felt that, provided implementation is monitored and action taken when agencies fail to comply, the proposals will improve quality of life. However, it was also suggested that greater attention should be given to training to ensure that the proposed options have a positive impact on expectant or new parents and people with Down's Syndrome. The particular issues raised were around the terminology used by some healthcare professionals and experiences of ante/post-natal care.

Although not a protected characteristic group, it was also suggested that other staff members are affected by variations in policy on providing cover when a member of the team is on maternity leave.

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Annex 1 – Organisational respondents

Aberdeenshire Heath and Social Care Partnership
Allied Health Professional Directors Scotland Group (ADSG)
Allied Health Professions Federation Scotland
BMA Scotland
Care Inspectorate
Chartered Society of Physiotherapy
Chief Officers Health and Social Care Scotland
COSLA
Down's Syndrome Scotland
Glasgow Heath and Social Care Partnership
Inverclyde Heath and Social Care Partnership
Midlothian Health and Social Care Partnership
NHS 24
NHS Ayrshire and Arran
NHS Education for Scotland
NHS Fife's LBC group - SCNs, SCMs; Team Leaders
NHS Healthcare Improvement Scotland
NHS Orkney
NHS Tayside
NHSGGC Mental Health AHP Advisory Committee
Nursing and Midwifery Council
Royal College of Occupational Therapists
Royal College of Physicians of Edinburgh
Scottish Care
Scottish Executive Nurse Directors
Scottish Independent Hospitals Association
Scottish Social Services Council (SSSC)
Senior Professional Nursing Group (HSCP's) – NHS Greater Glasgow & Clyde
Social Work Scotland
The Royal College of Emergency Medicine (Scotland)
The Royal College of Midwives
The Royal College of Nursing
The Royal College of Speech and Language Therapists
Together for Short Lives
UNISON Scotland

Annex 2 – Discussion group results at quantitative questions

Table 1: Question 1 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	3	1	1		5
Edinburgh	3			1	4
Glasgow	6		1		7
Inverness	4				4
Orkney	1	1			2
Shetland	1				1
Stornoway	2				2
All groups	**20**	**2**	**2**	**1**	**25**

Table 2: Question 2 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	5				5
Edinburgh	3			1	4
Glasgow	7				7
Inverness	4				4
Orkney	2				2
Shetland	1				1
Stornoway	1			1	2
All groups	**23**			**2**	**25**

Table 3: Question 3a – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	4		1		5
Edinburgh	2			2	4
Glasgow	7				7
Inverness	3	1			4
Orkney	2				2
Shetland	1				1
Stornoway	2				2
All groups	**21**	**1**	**1**	**2**	**25**

Table 4: Question 3b – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	2	3			5
Edinburgh	3			1	4
Glasgow	6		1		7
Inverness	3	1			4
Orkney	1			1	2
Shetland	1				1
Stornoway	1	1			2
All groups	**17**	**5**	**1**	**2**	**25**

Table 5: Question 5 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	5				5
Edinburgh	4				4
Glasgow	6			1	7
Inverness	4				4
Orkney	2				2
Shetland	1				1
Stornoway	2				2
All groups	**24**			**1**	**25**

Table 6: Question 6 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	4			1	5
Edinburgh	3			1	4
Glasgow	5			2	7
Inverness	4				4
Orkney	2				2
Shetland	1				1
Stornoway	2				2
All groups	**21**			**4**	**25**

Table 7: Question 7 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	4			1	5
Edinburgh	3	1			4
Glasgow	1	3	1	2	7
Inverness	1	2	1		4
Orkney	1	1			2
Shetland	1				1
Stornoway	2				2
All groups	**13**	**7**	**2**	**3**	**25**

Table 8: Question 9 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	5				5
Edinburgh	4				4
Glasgow	7				7
Inverness	4				4
Orkney	2				2
Shetland	1				1
Stornoway	2				2
All groups	**25**				**25**

Table 9: Question 10 – Responses by location of discussion group..

	Yes	No	Mixed view	Not answered	Total
Aberdeen	5				5
Edinburgh	3			1	4
Glasgow	6	1			7
Inverness	3			1	4
Orkney	2				2
Shetland	1				1
Stornoway	2				2
All groups	**22**	**1**		**2**	**25**

Table 10: Question 11 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	4	1			5
Edinburgh	3			1	4
Glasgow	6			1	7
Inverness	4				4
Orkney	2				2
Shetland	1				1
Stornoway	2				2
All groups	**22**	**1**		**2**	**25**

Table 11: Question 12 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	5				5
Edinburgh	4				4
Glasgow	4			3	7
Inverness	4				4
Orkney	2				2
Shetland	1				1
Stornoway	1			1	2
All groups	**21**			**4**	**25**

Table 12: Question 14 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen	2	2		1	5
Edinburgh	3			1	4
Glasgow	4	2		1	7
Inverness	3			1	4
Orkney	2				2
Shetland	1				1
Stornoway		1		1	2
All groups	**15**	**5**		**5**	**25**

Table 13: Question 17 – Responses by location of discussion group.

	Yes	No	Mixed view	Not answered	Total
Aberdeen		5			5
Edinburgh		1		3	4
Glasgow	3	3		1	7
Inverness	1	3			4
Orkney	1	1			2
Shetland	1				1
Stornoway		2			2
All groups	**6**	**15**		**4**	**25**

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