Health and Care (Staffing) (Scotland) Act 2019: Statutory Guidance

June 2023

Scottish Government
Riaghaltas na h-Alba

1. Foreword

As Cabinet Secretary for NHS Recovery, Health and Social Care, it is my priority to ensure our health and care services are safe, effective and efficient, delivering the care that matters and that people value.

When I took on this role, I pledged to deliver improvements in workforce planning and digital innovation. Implementation of the Health and Care (Staffing) (Scotland) Act 2019 is a key step in this journey. It will put in place the systems and processes we need to enable better workforce planning, better transparency of risk and better accountability. The Act covers a wide variety of health care and care services and the provisions are designed to be flexible in order to take into account local context and the delivery of different models of care, along with supporting innovation.

Health and care services data is vital to improving services, designing policies and supporting the delivery of key priorities and, under the Act, there are various obligations for organisations to report on, and publish, information about how they have met their requirements. We, as the Scottish Ministers, also have obligations under the Act, regarding presenting information to Parliament.

This statutory guidance is intended to support organisations in meeting their requirements under the Act and I encourage individuals and organisations to provide feedback to ensure the guidance can achieve this. I want to express my thanks to all of our NHS and care staff who have contributed not only to the drafting of this guidance but have been great advocates for this legislation. I am truly thankful for your dedication and service to the people of Scotland and look forward to working with you to help our health and care services flourish post-pandemic.

Michael Matheson
Cabinet Secretary for NHS Recovery, Health and Social Care

2. Overview of Consultation

We want to hear your views on the Statutory Guidance that will be issued by the Scottish Ministers to accompany the Health and Care (Staffing) (Scotland) Act 2019. Specifically, we would like to hear whether the guidance is clear and readable and enables you to understand the duties placed on relevant organisations by the Act.

2.1 About the Act

The requirements of the Act will take effect from April 2024. The aims of the Act are to enable safe and high quality care and improved outcomes for people experiencing health care or care services through the provision of appropriate staffing. This requires the right people, in the right place, with the right skills, at the right time.

The Act places duties on:

- Health Boards;
- Special Health Boards providing direct patient care (i.e. the State Hospital, NHS24, Scottish Ambulance Service and the National Waiting Times Centre);
- NHS National Services Scotland (NHS NSS, which is referred to in the Act as “the Common Services Agency for the Scottish Health Service);
- local authorities;
- integration authorities;
- care service providers;
- Healthcare Improvement Scotland;
- the Care Inspectorate (referred to in the Act as “Social Care and Social Work Improvement Scotland”); and
- the Scottish Ministers.

2.2 Impact on staffing and staff training

Organisations providing health care and care services will have to ensure appropriate staffing and staff training. Those providing health care services also have duties including around:

- assessing staffing in real-time;
- identifying, mitigating and escalating risks;
- seeking clinical advice on staffing;
- ensuring adequate time is given to clinical leaders for staffing responsibilities; and
- reporting the use of high-cost agency workers.

The common staffing method will have to be followed for specific types of health care, provided in specific locations and by specific employees. Organisations will have to consider the need for appropriate staffing when planning or securing health care or care services from third parties and will also have various reporting requirements.

2.3 Compliance with the Act

Healthcare Improvement Scotland will be responsible for monitoring compliance with the Act in the health care sector, along with monitoring and reviewing the common staffing method and staffing tools. The Care Inspectorate may also develop staffing methods for use in the care sector and any staffing method developed must include the use of staffing level tools. The Scottish Ministers can put in place a legal requirement for specified types of care service providers to use such a staffing method.

2.4 The statutory guidance

The draft Statutory Guidance has been prepared by various working groups comprising representatives from the Scottish Government and external stakeholders, including Health Boards, Special Health Boards, NHS NSS, local authorities, integration authorities, Healthcare Improvement Scotland, the Care Inspectorate, professional bodies, trade unions and professional regulatory bodies. We are

grateful for their time and input. We would now like widen our consultation as it is important that all those with an interest in health care and/or care services can provide their opinions prior to the guidance being finalised.

Once the Act comes fully into force, relevant organisations will have to comply with the requirements and, in doing so, must have regard to the statutory guidance issued by the Scottish Ministers. It is therefore important that this guidance is clear, understandable, user-friendly, and provides practical information on what organisations need to do.

3. Introduction

3.1 Introduction

This is statutory guidance ("guidance") issued by the Scottish Ministers under sections 3 and 10 of the Health and Care (Staffing) (Scotland) Act 2019 (referred to throughout the guidance as "the Act"); sections 12IN and 12IV of the National Health Service (Scotland) Act 1978 (referred to throughout the guidance as "the 1978 Act") (inserted by sections 4 and 6 of the Act); and section 82A of the Public Services Reform (Scotland) Act 2010 (inserted by section 12 of the Act). The Act will be fully in force by 01 April 2024 and this statutory guidance will apply from that date.

This chapter provides an introduction to the Act, the full text of which can be found here, and the guidance itself. The guidance will support relevant organisations in meeting requirements placed on them by the Act and by relevant secondary legislation and has been informed by consultation with stakeholders. Links to other relevant publications can be found throughout the document; note that when using these links, individuals should take into account any amendments to publications that have been made since the guidance was published.

Relevant organisations are required to have regard to the parts of the guidance that are applicable to them and the guidance should be read together with the relevant sections of the Act and the associated secondary legislation. The guidance does not constitute legal advice and an organisation should obtain independent legal advice if uncertain about the requirements of the Act.

3.2 The Health and Care (Staffing) (Scotland) Act 2019

The Health and Care (Staffing) (Scotland) Act was passed by Parliament on 02 May 2019 and received Royal Assent on 06 June 2019. The aim of the Act is to provide a statutory basis for the provision of appropriate staffing in health and care services, enabling safe and high-quality care and improved outcomes for service users and people experiencing care. This requires the right people, in the right place, with the right skills, at the right time.

The provisions in the Act build on arrangements already in place for local and national workforce planning and will support a rigorous, evidence-based approach to decision-making relating to staffing requirements and consideration of service delivery models and service redesign. The Act is not prescriptive in stipulating numbers or skill mix of professions, does not prescribe minimum staffing levels or fixed ratios and does not seek to preclude the use of innovative new models of care delivery. Rather it seeks to support local decision-making, flexibility and the ability to redesign and innovate across multi-disciplinary and multi-agency settings.

The Act will also promote transparency in staffing and support an open and honest culture, where staff are engaged in relevant processes, informed about decisions relating to staffing requirements and feel safe to raise any concerns.

3.3 Who does the Act apply to?

The Act places different duties / obligations on different parties, such as:

- Health Boards;
- Special Health Boards providing direct patient care (i.e. the State Hospitals Board, the Scottish Ambulance Service Board, NHS 24 and the National Waiting Times Centre Board);
- the Common Services Agency for the Scottish Health Service (referred to throughout as “NHS National Services Scotland”);
- persons providing a care service (a service mentioned in section 47(1) of the Public Services Reform (Scotland) Act 2010);
- local authorities and integration authorities;
- Healthcare Improvement Scotland (referred to in the guidance as “HIS”); and
- Social Care and Social Work Improvement Scotland, referred to throughout this document as the “Care Inspectorate”.

The Act also places obligations on the Scottish Ministers, for example in terms of reporting to the Scottish Parliament on staffing in health and care services and in taking reasonable steps to ensure there are sufficient numbers of registered healthcare professionals.

With regard to integration authorities, organisations should be familiar with, and refer to, requirements under the Public Bodies (Joint Working) (Scotland) Act 2014 and the associated statutory guidance to the 2014 Act.

The Act does not list which groups of staff or staff roles are included in the provisions, with the exception of the section 12IJ duty to follow the common staffing method, which is restricted to the types of health care, locations and employees listed in section 12IK of the Act. However we have published a separate comprehensive list of staff roles subject to the 2019 Act. This list does not form part of the statutory guidance but will sit alongside it and be a 'living document' which can incorporate new roles / professions over time as appropriate.

3.4 How is the guidance laid out?

The guidance aims to roughly follow the order of the different requirements as set out in the Act, with the first chapters addressing health care and the following chapters, care services:

- Chapter 4 covers the guiding principles in health care;
- Chapter 5 covers the responsibilities of Health Boards, relevant Special Health Boards and NHS National Services Scotland when planning or securing health care from a third party;
- Chapter 6 covers the duty on Health Boards, relevant Special Health Boards and NHS National Services Scotland to ensure appropriate staffing;
- Chapter 7 covers the duty on Health Boards, relevant Special Health Boards and NHS National Services Scotland to report on the use of high-cost agency workers;
- Chapter 8 covers the duties on Health Boards, relevant Special Health Boards and NHS National Services Scotland to have real-time staffing assessment and risk escalation processes in place, along with arrangements to address severe and recurrent risks;
- Chapter 9 covers the duty on Health Boards, relevant Special Health Boards and NHS National Services Scotland to seek clinical advice on staffing;

- Chapter 10 covers the duty on Health Boards, relevant Special Health Boards and NHS National Services Scotland to ensure that adequate time is given to clinical leaders;
- Chapter 11 covers the duty on Health Boards, relevant Special Health Boards and NHS National Services Scotland to ensure appropriate training for staff;
- Chapter 12 covers the duty on Health Boards, relevant Special Health Boards and NHS National Services Scotland to follow the common staffing method, for the listed types of health care, locations and employees;
- Chapter 13 covers the various requirements on Health Boards, relevant Special Health Boards and NHS National Services Scotland to report on staffing;
- Chapter 14 details the duties of Healthcare Improvement Scotland (HIS);
- Chapter 15 covers the guiding principles in care services, along with the duty on care service providers to ensure appropriate staffing and staff training;
- Chapter 16 covers the responsibilities on local authorities and integration authorities when planning or securing care services from a third party and the associated reporting requirements;
- Chapter 17 details the responsibilities of the Care Inspectorate with regard to developing staffing methods for the care services sector; and
- A glossary of terms used in the guidance can be found at the end.

4. Guiding Principles in Health Care

4.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections of the Act:

- section 1: Guiding principles for health and care staffing (as these principles apply to staffing for health care); and
- section 2: Guiding principles etc. in health care staffing and planning.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

4.2 Who does this chapter apply to?

The following organisations must comply with the requirements contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

This chapter of the guidance relates to the guiding principles as far as they apply to staffing for health care. The guiding principles apply equally to the provision of care services and care service providers must take these into account when arranging staffing. Guidance on the application of the guiding principles to care services can be found in chapter 15.

4.3 In what settings and to which staff does this chapter apply?

These sections apply to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by

the Act). They are not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method.

Accountability for the obligations imposed in sections 1 and 2 of the Act remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

4.4 What is this chapter about?

This chapter covers the requirements on relevant organisations to have regard to the guiding principles when carrying out the section 12IA duty to ensure appropriate staffing in health care, and when planning or securing the provision of health care from another person under a contract, agreement or arrangement made under or by virtue of the 1978 Act. It should be read in tandem with chapter 6 which covers the section 12IA duty to ensure appropriate staffing. Further details about planning or securing health care from others can be found in chapter 5.

The principles, alongside the section 12IA duty to ensure appropriate staffing in health care, underpin the outcomes that the Act is seeking to deliver. They explain what people using health care and those who work there can expect; the requirements on relevant organisations; and actions required of those who are involved in making decisions about staffing

The guiding principles have been developed to ensure that decisions made in relation to staffing are aligned with wider health and care policy.

4.5 What are the guiding principles in section 1 of the Act?

The Act states that the main purposes of staffing for health care and care services are:

- to provide safe and high-quality services; and
- to ensure the best health care or (as the case may be) care outcomes for service users.

The Act then lists principles to be met, in so far as they are consistent with the main purposes, when relevant organisations are arranging staffing.

4.6 What is meant by “safe”?

When judging whether or not a service is “safe”, safe does not mean “no-risk”. Depending on the service, safe may not even mean low risk; risks are an inevitable part of all health care services. In many services, for example where an enablement approach is taken, a level of risk is required and needs to be managed by both service users and staff to support people to achieve outcomes. Positive risks, as defined in the Health and Social Care Standards, mean making balanced decisions about risks and benefits, recognising that risks to safety are inevitable and can sometimes result in benefits.

However, the Act requires relevant organisations to have appropriate staffing in place to enable provision of safe and high-quality services, and so reduce risk to service users. Patients / service users should not be put at unnecessary risk as a result of staffing which fails to provide high-quality health care services.

It is important to note that while the guiding principles are focused on outcomes for service users and the reference to “safe” is drafted with service users in mind, this cannot be separated from the wellbeing of staff themselves. An unsafe staffing environment can create unsafe services. Conversely, improving the wellbeing of staff can improve the safety of service users and so the two are inextricably linked. See also 4.13 about the wellbeing of staff below.

4.7 What is meant by “high-quality”?

The provision of high-quality care that is right for the individual service user is one of the headline outcomes under the Health and Social Care Standards and as such the guiding principles should be read alongside those Standards. As the Standards make clear, care can only be “high-quality” if it provides support or services that are right for the individual, taking into account their own particular characteristics.

High quality care, as detailed in the Health and Social Care Standards should include consideration of the dignity and respect of service users, including respect for and promotion of their human rights; compassionate care and support; inclusion

in care of service users; responsive care which adapts to the needs of the service user and care which improves wellbeing.

4.8 What principles need to be met in arranging staffing?

The factors principles to be met are:

- improving standards and outcomes for service users;
- taking account of the particular needs, abilities, characteristics and circumstances of different service users;
- respecting the dignity and rights of service users;
- taking account of the views of staff and service users;
- ensuring the wellbeing of staff;
- being open with staff and service users about decisions on staffing;
- allocating staff efficiently and effectively; and
- promoting multi-disciplinary services as appropriate.

All of these principles need to be read in the context of achieving the overarching outcome of safe and high-quality services and the best health care outcomes for service users. The focus of the guiding principles should always be to look at how these impact on patients and service users. No one factor is more important than another and they should all be considered together when determining staffing.

The guiding principles closely follow the principles set out in section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014 (legislation.gov.uk)and therefore the Statutory guidance accompanying the 2014 Act is relevant.

4.9 Improving standards and outcomes for service users

Outcome measures of the quality of services being provided, such as those detailed in the Health and Social Care Standards, should be considered; identifying trends, and exploring whether staffing has had an impact. The emphasis should be on identifying how standards and outcomes for service users could be improved.

4.10 Taking account of the particular needs, abilities, characteristics and circumstances of different service users

No two service users are the same and the outcomes that matter to a particular person will vary. Relevant organisations need to ensure a holistic person-centred approach which involves service users in decision making about meeting their individual needs. This could include the range of support the service user has, or does not have, through family, friends and the wider community and would be relevant, for example, in ensuring carer involvement in the discharge of cared-for persons from hospital under the Carers (Scotland) Act 2016. Staffing decisions also need to reflect the ability of service users, for example the extent to which they can participate in their own health or care needs

4.11 Respecting the dignity and rights of service users

Service users can expect to experience health care services which are underpinned by a Human Rights Based approach in which users' rights are respected, protected and fulfilled; they are involved in decisions that affect them; informed of their rights and entitlements; and provided with a form of redress if they believe their rights are being denied. Service users should be treated with dignity and, as far as possible, be in control and able to express themselves about their requirements.

4.12 Taking account of the views of staff and service users

The views of staff and service users are crucial to ensuring service users' dignity and rights are respected and standards and outcomes are improved. Organisations should be able to demonstrate how the views of service users and staff have been gathered and how they have informed decision-making.

4.13 Ensuring the wellbeing of staff

There is a link between the safety of service users and the wellbeing of staff delivering the service. Increased staff wellbeing can reduce sickness absence, burnout and work-related stress, meaning that staff are available to care for service users. Healthy, engaged staff are also better able to provide safe and high-quality services. In some situations, staff will be working in challenging environments or as lone workers, which can increase risks to their wellbeing. In order to provide safe and high-quality services, appropriate measures and checks need to be in place to maintain staff wellbeing.

An environment where staff feel able to raise issues with patient safety, mistakes or areas of concern is vital to their wellbeing. This involves creating a culture of transparency, continuous improvement and open communication and an environment where it is clear to staff that the relevant organisation(s) have a culture of system improvement rather than blaming individuals. Staff need to feel safe to raise concerns at all times regarding any risks resulting from staffing.

4.14 Being open with staff and service users about decisions on staffing

As well as taking into account the views of staff and service users, organisations must be open with staff and service users about decisions on staffing. Organisations should foster the development of an open culture which allows and encourages staff to raise issues and be supported in finding new ways to overcome risks without fear of adverse consequences.

4.15 Allocating staff efficiently and effectively

Staffing arrangements should allocate staff so they have the greatest impact on providing safe and high-quality services that result in the best outcomes for patients and service users. This could include effective rostering and / or use of real-time staffing resources which ensure staff with the right knowledge and skills are in the right place at the right time to meet the needs of service users.

4.16 Promoting multi-disciplinary services as appropriate

Staffing arrangements should consider the use of multi-disciplinary services where such services do not exist. Consideration should also be given to whether or not a multi-disciplinary service is “appropriate”.

However, this principle should not be interpreted as requiring relevant organisations to prioritise multi-disciplinary services over and above other services. This principle must be consistent with the main purposes of the guiding principles, namely the provision of safe, high-quality services and to ensure the best health care outcomes for service users. Organisations should consider multi-disciplinary service models as well as uni-professional models in terms of opportunities / benefits when deciding what is suited to the needs of the person receiving care.

The unique role of each profession in a multi-disciplinary service should continue to be recognised and promoted within the context of ensuring the highest quality of care is provided to service users. This consideration is central to determining whether a service is “appropriate” or not. Where a multi-disciplinary approach is not deemed appropriate, best practice would be to provide clear rational for the decision-making process that led to this decision.

Section 1 also includes a number of definitions, some of which reference existing legislation. The definition of “multi-disciplinary services” makes it clear that this refers to health care or care services delivered together by individuals from different professional disciplines. This may, or may not, be in close proximity, but always in collaboration.

4.17 How are the guiding principles applied in health care (section 2 of the Act)?

Section 12IA of the 1978 Act places a general duty on relevant organisations to ensure appropriate staffing. Section 2 of the Act states that in carrying out this duty, relevant organisations must have regard to the guiding principles for health and care staffing. This means that whenever relevant organisations are putting in place staffing arrangements to comply with the duty to ensure appropriate staffing, they must take into account the guiding principles.

The guiding principles must also be considered when relevant organisations are planning or securing the provision of health care from a third party provider, whether that be under a contract, agreement or other arrangement made under or by virtue of the 1978 Act. Further guidance on this can be found in chapter 5.

The relevant organisation is also expected to provide information to the Scottish Ministers on the steps they have taken to have regard to the guiding principles in meeting the general duty to ensure appropriate staffing and when commissioning health care services. More details on these requirements can be found in Chapter 13.

4.18 Other relevant guidance and legislation

The Health and Social Care Standards, the principles set out in section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014, and the Healthcare quality strategy for NHSScotland all continue to apply. The guiding principles sit alongside, and complement, these.

The Scottish Government published the Health and Social Care Standards in June 2017, which set out what the public should expect when using health, social care or social work services in Scotland. The standards seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld. The objectives of the standards are to promote improvement, encourage flexibility and enable innovation in how people are cared for and supported. All services and support organisations, whether registered or not, should use the standards as a guideline for how to achieve high quality care. From 1 April 2018, the standards have been taken into account by Healthcare Improvement Scotland, the Care Inspectorate and other scrutiny bodies in relation to inspections and registration of health and care services.

5. Planning or Securing the Provision of Health Care from Others

5.1 Which sections of the Act is this chapter about?

This chapter provides further detail on section 2 of the Act: Guiding principles etc. in health care staffing and planning (as they apply to the planning and securing of health care from others)

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

5.2 Who does this chapter apply to?

The following organisations must comply with the requirements contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as " relevant organisations" in this chapter.

Local authorities and integration authorities have similar requirements when planning or securing the provision of care services from others and should go to Chapter 16 for guidance.

5.3 In what settings and to which staff does this chapter apply?

This section applies to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act). It is not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method.

Accountability for all the duties covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

5.4 What is this chapter about?

Section 2(2) of the Act places a requirement on relevant organisations when planning or securing the provision of health care from third parties to have regard to the guiding principles for health and care staffing and the need for that third party to have appropriate staffing arrangements in place. The effect is to make these matters considerations for relevant organisations in their decision-making in planning services, assessing needs, and in selecting and contracting with service providers. This requirement is deliberately general and flexible to allow for the wide variety of legal arrangements which it covers: the Act refers to a “contract, agreement or arrangements”.

The aim of this duty is to ensure that patients / service users receive safe and high-quality care and the best outcomes irrespective of whether that care is being provided directly by the relevant organisation, or by a third party on their behalf.

Guidance on the guiding principles for health and care staffing can be found in chapter 4 and guidance on what constitutes appropriate staffing arrangements can be found in chapter 6.

Requirements of the Act clearly encompass only one of the many factors that will need to be considered when planning or securing any particular service and onwards throughout the larger commissioning cycle. As such this chapter should be read alongside existing guidance on commissioning health and social care services (for example, Strategic Commissioning Plans Guidance).

Sections 2(3) and 2(4) of the Act state that relevant organisations must report annually on the steps they have taken to comply with this requirement. Guidance on this reporting can be found in chapter 13.

5.5 What commissioning arrangements are included?

This section of the Act applies to the planning and securing of any health care by relevant organisations from any third party provider. This could be from a private or third sector provider, from another Health Board or through national agreement. Examples of scenarios covered by this chapter include:

- Relevant organisation has arrangements or contracts with a GP practice to provide GP services;
- Relevant organisation has arrangements or contracts with an independent optometrist / pharmacist / dentist to provide services;
- Relevant organisation commissions health care from a Special Health Board, e.g. from the National Waiting Times Centre; and
- Relevant organisation commissions health care from an independent health care provider, e.g. a private hospital is commissioned to carry out 30 hip operations on behalf of a Health Board.

As the above examples illustrate, as well as the planning or securing the provision of health care from or with an independent health care provider, or another Health Board, this duty also applies to the provision of services to relevant organisations by independent contractors, for example, General Practitioners. The majority of General Practitioners are not employed by Health Boards, but are independent contractors who have agreements with relevant organisations to provide health care to the patients on their lists. Arrangements are also in place for the provision of services by dentists, optometrists, and pharmacists.

The relevant organisation will need to carry out due diligence, as part of planning or securing the service, to consider both the guiding principles and the need for the provider to have appropriate staffing arrangements in place. Examples of factors relevant organisations could consider, where relevant, when planning or securing services, in order to comply with the requirements placed on them include:

- Healthcare Improvement Scotland (HIS) inspection reports for independent health care providers;

- What is known about the particular needs, abilities, characteristics and circumstances of different service users. This could include any equalities or health inequalities impact assessments which have been carried out;
- HIS reports for Health Boards; and
- Other relevant inspections, for example in respect of contractors on the dental lists for their areas, Boards are to inspect (at intervals not exceeding three years) all practice premises located within their areas;

Such matters should be used in a manner which is compliant with applicable procurement rules.

The requirement to have regard to the guiding principles and the need for appropriate staffing arrangements when planning or securing the provision of health care from a third party sit alongside the staff governance, clinical governance and financial governance requirements which already apply to relevant organisations.

Whilst the Act does not require relevant organisations to add additional clauses to any standard contracts or agreements they use, relevant organisations will need to consider how they stipulate and obtain evidence of appropriate staffing when commissioning services.

5.6 Other relevant guidance and legislation

The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 (legislation.gov.uk) (including relevant amendments)
The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 (legislation.gov.uk) (including relevant amendments)
The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006 (legislation.gov.uk) (including relevant amendments)
The National Health Service (General Dental Services) (Scotland) Regulations 2010 (legislation.gov.uk) (including relevant amendments)
The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (legislation.gov.uk) (including relevant amendments)

6. Duty to Ensure Appropriate Staffing in Health Care

6.1 Which sections of the Act is this chapter about?

This chapter provides further detail on section 12IA of the 1978 Act, the duty to ensure appropriate staffing (referred to here as the "section 12IA duty"), which is inserted by section 4 of the Act.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

6.2 Who does this chapter apply to?

The following organisations must comply with the duty contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

6.3 In what settings and to which staff does this chapter apply?

The section 12IA duty applies to all NHS functions provided by all professional (chapter 3, introduction provides more details on professional disciplines covered by the Act). It is not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method.

Accountability for the section 12IA duty covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

This chapter will also be applicable to those who are planning or securing the provision of health care from others. Under section 2, relevant organisations, when

planning or securing the provision of health care from others, must have regard to the need for the person for whom the provision of health care is to be secured to have appropriate staffing arrangements in place. Guidance on planning or securing provision of health care from others can be found in chapter 5.

6.4 What is this chapter about?

The duty to ensure appropriate staffing in health care services is one of the two 'general' duties created by the Act. The other is the section 7 duty on care service providers to ensure appropriate staffing. The duty to ensure appropriate staffing is to enable the provision of safe and high-quality services which meet the needs of service users through having appropriate staffing, with the right person, with the right skills, available in the right place, at the right time, to provide care. The 'general' duty to ensure appropriate staffing must be carried out having regard to the guiding principles of the Act and this guidance chapter should be read in tandem with Chapter 4.

Most of the other duties and requirements of section 4 of the Act exist *directly* to support the delivery of the section 12IA duty. Because of this, relevant organisations must comply with these other duties / requirements in order to comply with the overarching section 12IA duty. The relevant sections of the 1978 Act (all inserted by section 4 of the Act) are all explained in more detail in further chapters of this guidance:

- section 12IB Duty to ensure appropriate staffing: agency workers (chapter 7);
- section 12IC Duty to have real-time staffing assessment in place (chapter 8);
- section 12ID Duty to have risk escalation process in place (chapter 8);
- section 12IE Duty to have arrangements to address severe and recurrent risks (chapter 8);
- section 12IF Duty to seek clinical advice on staffing (chapter 9);
- section 12IH Duty to ensure adequate time given to clinical leaders (chapter 10);
- section 12II Duty to ensure appropriate staffing: training of staff (chapter 11); and

- section 12IJ, 12IK and 12IL Duty to follow the common staffing method, including training and consultation of staff (chapter 12).

The section 12IA duty sits alongside the staff governance, clinical governance and financial governance requirements which already apply to relevant organisations. The duty must be complied with in addition to the existing duty on these organisations in section 12L of the 1978 Act to “put and keep in place arrangements for the purposes of workforce planning”.

The Act sets out provision around reporting, on at least a quarterly basis, by individuals with lead clinical professional responsibility for a particular type of health care to members of the relevant organisation in the section 12IF duty to seek clinical advice on staffing. This reporting to include that individual’s views as to the relevant organisation’s compliance with the duty to ensure appropriate staffing. Reporting on the section 12IA duty will also be required as part of 12IM reporting on staffing.

What follows is more detailed guidance on the meaning of the language in Act, which will support its effective application in practice by relevant organisations.

6.5 12IA(1): What is meant by “at all times”?

Health care is a 24/7 service, so ‘at all times’ should be taken as having its normal, everyday meaning. Peaks and troughs in acuity and demand over any time period (e.g. a day, a week, a year) do not affect the requirement to comply with the duty. Relevant organisations should demonstrate that they have made every effort to adjust staffing accordingly, for example by redistributing staff to areas under greater pressure.

6.6 12IA(1): What is meant by "suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for…"?

This provision is intended to ensure the right skills mix (both within and between professions), as well as the right numbers of staff, are in place to meet the requirements of the duty.

Relevant organisations should be able to demonstrate clearly that they have considered the levels of practice, training, education, experience and professional regulatory responsibilities of all of the staff within a team providing health care.

In ensuring these requirements are fulfilled, it would normally be the case that the unique knowledge, skills, competence and capability of each member of staff concerned are respected and that each member of staff is equipped, expected and enabled to work across the breadth of their expertise, to the top of their skill level and to the appropriate professional standards. This does not preclude staff having to work below their skill level on occasion, for example to address a peak in activity, but this should not be the norm. It should also include required qualifications and/or competencies, including those produced by the various Royal Colleges, NHS Education for Scotland and Scottish Government, competency frameworks agreed through local Health Board governance frameworks and other relevant programmes and initiatives that may, from time to time, be applicable.

6.7 12IA(1): What is meant by "the health, wellbeing and safety of patients"?

Staffing should always be available, both in terms of numbers and skills mix, to ensure that patients receiving care achieve their best possible health and wellbeing outcomes. This should be read in the context of the national health and wellbeing outcomes framework and the Health and Social Care Standards, along with other standards and outcomes published by Scottish Ministers under the 1978 Act and the Public Services Reform (Scotland) Act 2010.

The duty to ensure the safety of patients is not intended to imply that the relevant organisation(s) are under a duty to remove all risks. The section 12IA duty however

requires relevant organisations to have appropriate staffing levels in place to enable provision of safe and high-quality services and so reduce risk to service users.

6.8 12IA(1): What is meant by "the provision of safe and high-quality health care"?

When judging whether or not a service is "safe", safe does not mean "no-risk". Depending on the service, safe may not even mean low risk; risks are an inevitable part of all health care services. In many services, for example where an enablement approach is taken, a level of risk is required and needs to be managed by both service users and staff to support people to achieve outcomes. Positive risks, as defined in the Health and Social Care Standards, mean making balanced decisions about risks and benefits, recognising that risks to safety are inevitable and can sometimes result in benefits.

However, the section 12IA duty requires relevant organisations to have appropriate staffing in place to enable provision of safe and high-quality services, and so reduce risk to service users. Patients / service users should not be put at unnecessary risk as a result of staffing which fails to provide high-quality health care services.

Provision of high-quality health care requires the right people, in the right place, with the right skills at the right time, and with the appropriate amount of time available, to ensure the best health care outcomes for service users.

The provision of high-quality care that is right for the individual service user is also one of the headline outcomes under the Health and Social Care Standards and, as such, the section 12IA duty should be read alongside these. The Standards state that high quality care should include consideration of the dignity and respect of service users, including respect and promotion for their human rights; compassionate care and support; inclusion in care of service users; responsive care which adapts to the needs of the service user; and care which improves wellbeing.

6.9 12IA(1): What is meant by "in so far as it affects either of those matters, the wellbeing of staff"?

The section 12IA duty requires that the wellbeing of staff is considered **in so far as it affects** staffing for the health, wellbeing and safety of patients and the provision of safe and high-quality health care. In practice, this has wide-ranging effects.

There is a link between the safety of service users and the wellbeing of staff delivering the service. Increased staff wellbeing can reduce sickness absence, burnout and work-related stress, meaning that staff are available to care for patients. Healthy, engaged staff are also better able to provide safe and high-quality services. In some situations, staff will be working in challenging environments or working as lone workers. In order to provide safe and high-quality services, checks need to be in place to maintain staff wellbeing.

An environment where staff feel able to raise issues with patient safety, mistakes, or areas of concern is vital to the wellbeing of staff. This involves creating a culture of transparency, continuous improvement and open communication and an environment where it is clear to staff that the relevant organisation(s) have a culture of system improvement rather than blaming individuals. Staff need to feel safe to raise concerns about the risks resulting from staffing at all times.

As noted above, the duty to ensure appropriate staffing sits in the context of the guiding principles. However, relevant organisations must also consider how it sits alongside existing requirements in relation to the health, wellbeing and safety of staff (e.g. health and safety law, a contract of employment, or a local agreement between staff and an employer).

6.10 12IA(2) What do relevant organisations have to have regard to when determining appropriate staffing?

Section 12IA(2) sets out what, at a minimum, relevant organisations should take into account when setting staffing levels so that they comply with the duty to ensure appropriate staffing. In determining what, in a particular kind of health care provision, constitutes appropriate numbers, regard is to be had to:

- the nature of the particular kind of health care provision;
- the local context in which it is being provided;
- the number of patients being provided it;
- the needs of patients being provided it; and
- appropriate clinical advice.

For those areas where the section 12IJ duty to follow the common staffing method also applies, there is clearly an overlap in the list of factors relevant organisations must take into account when implementing the common staffing method, and the factors which they must have regard to when applying the section 12IA duty. Appropriate use of the common staffing method should therefore help relevant organisations demonstrate compliance with the section 12IA duty.

6.11 What is meant by "the nature of the particular kind of health care provision"?

This simply means the different types of health care that any health care service provides, for example, a high dependency unit or a neonatal unit, a service for older people or a service for children, prisoner health care, therapeutic interventions (art and music therapy), hospital at home etc. This covers all types of health care and is not limited to the types of health care listed in the Act in relation to the section 12IJ Duty to follow the common staffing method.

6.12 What is meant by the "the local context in which it is being provided"?

The policy memorandum for the original Bill set out that context could include environmental factors, service delivery models or other factors which may justifiably impact on the number of staff the particular clinical area requires. For example, in a small service a calculation may suggest 1 WTE (whole-time equivalent) is required, however for safety reasons it is likely that 2 WTEs would require to be on shift. Other factors could include, for example:

- Patient demand (both met and unmet);
- Service structures (e.g. the existence of GP clusters or the impact of trauma centres on local services);

- Workforce (e.g. access to consultant-level medical staff or out of hours clinicians);
- Geography (e.g. the impact of delivering services in island communities);
- Socio-economic profile (e.g. access to services by people in areas of multiple deprivation); and
- Clinical (e.g. the particular health needs of a defined community).

This list is not exhaustive but the relevant organisation(s) should be able to demonstrate how local context has been taken into account in setting appropriate staffing.

6.13 What is meant by "the number of patients being provided it"?

Relevant organisation are expected to be able to demonstrate that they have undertaken the necessary analysis of met and unmet need in determining the number of patients requiring provision of any service.

6.14 What is meant by "the needs of patients being provided it"?

No two patients are the same and the outcomes that matter to a particular patient will vary. Those providing health services need to consider patients themselves, rather than just their needs in isolation. For example, this could reflect the range of support the patient has, or does not have, through family, friends and the wider community. Staffing decisions also need to reflect the ability of patients, for example the extent to which they can participate in their own health care needs.

6.15 What is meant by "appropriate clinical advice"?

The provision of clinical advice is central to securing appropriate decision-making and actions that will ensure the health, wellbeing and safety of patients, the provision of safe and high-quality health care and, in relation to these, the wellbeing of staff. This provision in the duty to ensure appropriate staffing underlines the centrality of clinically-informed decision-making to delivering on the intent of the Act.

Relevant organisation(s) have a duty under section 12IF to seek clinical advice in making decisions and putting in place arrangements in relation to staffing for health care under the Act. More detail on the section 12IF duty can be found in chapter 9.

6.16 Other relevant guidance and legislation

The Health and Social Care Standards, the principles set out in section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014, and the Healthcare quality strategy for NHSScotland all continue to apply.

The Scottish Government published the Health and Social Care Standards in June 2017, which set out what the public should expect when using health, social care or social work services in Scotland and should be referred to when determining what constitutes high-quality health care under the section 12IA duty. The standards seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld. The objectives of the standards are to promote improvement, encourage flexibility and enable innovation in how people are cared for and supported. All services and support organisations, whether registered or not, should use the standards as a guideline for how to achieve high quality care. From 1 April 2018, the standards have been taken into account by Health Improvement Scotland, the Care Inspectorate and other scrutiny bodies in relation to inspections and registration of health and care services.

7. Agency Reporting

7.1 Which sections of the Act is this chapter about?

This chapter provides further detail on section 12IB of the 1978 Act, duty to ensure appropriate staffing: agency workers, which is inserted by section 4 of the Act.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

7.2 Who does this chapter apply to?

The following organisations must comply with the duty contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

7.3 In what settings and to which staff does this chapter apply?

Duties contained in this section apply to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act). They are not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method.

Accountability for all the duties covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

7.4 What is this chapter about?

Section 12IB of the Act relates to the use of agency workers by relevant organisations where they are needed in order to comply with the section 12IA duty to ensure appropriate staffing. It states that amount to be paid to secure the services of an agency worker during a period should not exceed 150% of the amount that would be paid to a full-time equivalent employee of the relevant organisation to fill the equivalent post for the same period.

However, where, in a quarterly reporting period, a relevant organisation does pay an amount higher than 150%, the relevant organisation must report to the Scottish Ministers as soon as possible after the end of that reporting period:

- the number of occasions in that period on which it has paid more than 150%;
- the amount paid on each occasion (expressed as a percentage of the amount that would be paid to a full-time equivalent employee of the relevant organisation to fill the equivalent post for the same period); and
- the circumstances that have required the higher amount to be paid.

7.5 What is an agency worker?

The Act defines an agency worker as being "within the meaning of the Agency Workers Regulations 2010". Any staff directly employed by the relevant organisation are not included within this meaning.

7.6 What must be reported?

Section 12IB of the 1978 Act requires relevant organisations to report on the number of occasions that it has paid more than 150% of the amount that would be paid to a full-time equivalent employee of that organisation to fill the equivalent post for the same period. The report should therefore detail the number of single shifts where it has required to exceed this amount to secure the services of any agency worker.

The cost of using an agency worker should be compared to the equivalent employee for whom the agency worker is covering. To ensure than an accurate and equitable

comparison can be made, the calculation of the amount that would be paid to a full-time equivalent employee of the relevant organisation should include:

- the gross pay of an employee at the top of the equivalent band or grade;
- the cost paid by the relevant organisation for the employer national insurance contribution;
- the cost paid by the relevant organisation for the pension contribution;
- any other expenses that are recoverable by the employee in respect of working during that shift; and
- the cost paid by the relevant organisation for any apprenticeship levy.

To calculate the cost of securing the services of an agency worker, the total amount paid to secure that worker for the shift should be used.

7.7 What is meant by "the circumstances that have required the higher amount to be paid"?

In order to standardise the information received from across all relevant organisations, the circumstances will be picked from a defined list included in the reporting template.

7.8 What are the dates for the quarterly reports?

Quarterly reporting periods run from:

- 01 April to 30 June;
- 01 July to 30 September;
- 01 October to 31 December; and
- 01 January to 31 March, of each year.

Reports should be submitted by the end of one month following the end of the reporting period, i.e. by 31 July, 31 October, 31 January and 30 April respectively.

7.9 What will the format of the report be?

To promote consistent reporting across relevant organisations, the Scottish Government will provide a report template. Each relevant organisation should submit one report to cover all NHS functions and professional disciplines.

7.10 Will these reports be published?

The Act states that Scottish Ministers must publish in such a manner and at such intervals they consider appropriate:

- information from relevant organisations on the amount spent on all agency workers; and
- the reports received from relevant organisations under this section (12IB) of the 1978 Act.

Reports will undergo suitable quality assurance procedures prior to publication, along with ensuring all requirements regarding data protection legislation are adhered to. This will include consideration of whether personal information regarding individuals could be determined and anonymising data.

8. Real Time Staffing Assessment and Risk Escalation

8.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections of the 1978 Act, each of which are inserted by section 4 of the Act:

- section 12IC: Duty to have real-time staffing assessment in place (referred to as “section 12IC duty”);
- section 12ID: Duty to have risk escalation process in place (referred to as “section 12ID duty”); and
- section 12IE: Duty to have arrangements to address severe and recurrent risks (referred to as “12IE duty”).

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

8.2 Who does this chapter apply to?

The following organisations must comply with the duty contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the ‘Agency’); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as “relevant organisations” in this chapter.

8.3 In what settings and to which staff does this chapter apply?

Duties contained in these sections apply to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act). They are not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method.

Under professional codes of conduct, all staff have a responsibility to identify and escalate any concerns or risks. Under the Act, relevant organisations must encourage and enable staff to identify and escalate risks caused by staffing levels. Individuals in leadership / management positions then also have a role in mitigating and managing risks, including escalation up through the organisation as appropriate. Under the section 12IH duty to ensure adequate time given to clinical leaders, relevant organisations must provide individuals with lead clinical professional responsibility for a team of staff with sufficient time and resources to do this, alongside their other professional duties.

Accountability for all the duties covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

8.4 What is this chapter about?

The purpose of the duties under sections 12IC, 12ID and 12IE of the 1978 Act is to ensure that relevant organisations have in place robust arrangements to deliver the duty to ensure appropriate staffing in the day-to-day running of all NHS services. This will be assessed through effective identification, reporting, escalation and mitigation of risks caused by staffing numbers and skill mix which are below that required to meet patient or service user need.

Whilst these duties will help inform longer term planning of staffing, and ultimately inform workforce planning at a local and national level, this is not the sole aim. The duties are also intended to go beyond an annual setting of staffing, to support a dynamic, real-time staffing response to emerging and actual risks to the safety and quality of care being provided to patients and service users. This is essential if the legislation is to have the desired effect.

As noted in the guidance chapters on the guiding principles in health care and on the section 12IA Duty to ensure appropriate staffing, risk is an inevitable part of all health care and care services, but requires to be mitigated as far as is possible to enable provision of safe and high-quality services.

The provision of clinical advice is central to ensuring appropriate decisions on managing staffing risks which could impact negatively on:

- the health, wellbeing and safety of patients;
- the provision of safe and high-quality health care; and, in relation to these
- the wellbeing of staff.

Specific provisions around clinical advice in this chapter should be read alongside guidance on the section 12IF duty to seek clinical advice on staffing (see chapter 9).

The Act sets out provision around reporting, on at last a quarterly basis, by individuals with lead clinical professional responsibility for a particular type of health care to members of the relevant organisation in the section 12IF duty to seek clinical advice on staffing, including on that individual's views as to the relevant organisation's compliance with its duties under section 12IC (duty to have real time staffing assessment in place), section 12ID (duty to have risk escalation process in place), and 12IE (duty to have arrangements in place to address severe and recurrent risks. Relevant organisations will also have to include an assessment on how they have carried out these duties in their annual report to the Scottish Ministers under section 12IM reporting on staffing.

8.5 Applying duties in relation to "arrangements"

Under the Act, relevant organisations have a duty to put in place arrangements for:

- the real-time assessment of its compliance with the section 12IA duty to ensure appropriate staffing (section 12IC);
- the escalation of risks identified during real-time assessment of staffing levels that were not possible to mitigate (section 12ID); and
- collating information on escalated risks and identifying and addressing risks considered to be severe and / or recurrent (section 12IE).

Both real-time staffing assessments and risk escalation arrangements (including arrangements for severe and recurrent risk) are intended to support the delivery of the section 12IA duty to ensure appropriate staffing at all times. These arrangements

are required to be in place and maintained with the express purpose of ensuring appropriate staffing for:

- the health, wellbeing and safety of service users;
- the provision of safe and high-quality health care; and
- in so far as it affects either of those matters, the wellbeing of staff.

As such, complying with the Act in relation to real-time staffing assessment and risk escalation will not be met simply by having processes in place, but by demonstrating that these are embedded in practice and inform staffing discussions and decisions to effectively support delivery of the section 12IA duty to ensure appropriate staffing.

Rather than prescribing specific arrangements, the Act allows for a level of local flexibility. This permits relevant organisations to build on their own existing local processes and acknowledges that, for example, what is appropriate for urban and for rural organisations may be different. Whilst the Act sets out minimum requirements in relation to arrangements, this guidance sets out further information on how organisations should interpret and monitor risk and what should be included in all processes. This will provide a level of national assurance and consistency, whilst continuing to allow organisations to account for local context.

Whatever arrangements are put and kept in place, best practice would be for them to:

- be developed with staff, including the full engagement of local and/or area clinical and partnership forums, clinical governance committees and risk management committees in line with current clinical and staff governance guidance;
- be agreed, and regularly reviewed, at board level in the relevant organisation(s), with the opportunity for board-level clinical leaders to note any opposition to the arrangements, in keeping with other provisions of the Act; and
- be communicated in clear and accessible language to all staff.

These requirements should be considered within the context of existing governance structures and processes within relevant organisations, which may already fully support delivery of the duties in the Act, or could easily be amended to do so. Where structures and processes do not exist or are insufficient, new ones must be designed and implemented in line with the Act and this accompanying guidance.

The expectation is that staffing assessment and risk escalation arrangements, once agreed, should be set out and readily available to staff. This includes the relevant organisation's agreed arrangements for all elements, including but not limited to:

- risk identification;
- risk notification;
- discharging the roles of an individual with lead professional responsibility, a senior decision-maker (e.g. local guidance on who these are in particular circumstances), and the board;
- risk assessment;
- giving clinical advice;
- escalation of risks;
- arrangements for the identification, notification and mitigation of severe and recurrent risk (e.g. indication and examples of the types of risks which should be reported straight to board level);
- arrangements for the collation of risk data over time to allow identification of recurrent risk (e.g. the level at which risks identified are escalated to, and will be collated by, the relevant organisation);
- decision-making (e.g. how disputes should be handled, how staff will be notified and how individuals can challenge decisions and request review);
- mitigating actions;
- staff feedback (e.g. specific detail on timings and methods for feedback);
- encouraging and enabling staff to use the arrangements (e.g. expectations for how staff will support this throughout the organisation);
- raising awareness among staff of arrangements (e.g. how this will be incorporated in induction for new staff, for those who are taking on new responsibilities linked to risk assessment and escalation, and when any changes are made to arrangements); and

- ensuring time and resource is available to those with particular responsibilities in assessing and mitigating risk (e.g. by making clear links to the relevant organisation's duties under the section 12IH duty to ensure adequate time given to clinical leaders and the section 12II Duty to ensure appropriate staffing: training of staff).

It is expected that the quarterly reports on compliance under the section 12IF duty to seek clinical advice on staffing would include a review of whether there are any issues with arrangements. Actions to review the arrangements should be taken forward on the basis of recommendations made by the lead clinical professional(s) making that report and feedback from staff who are using it on a daily basis.

8.6 Who is "an individual with lead professional responsibility (whether clinical or non-clinical)"?

Under section 12IC (duty to have real-time staffing assessment in place) and 12ID (duty to have risk escalation process in place), individuals with lead professional responsibility (whether clinical or non-clinical) have specific responsibilities for the mitigation and escalation of risks identified by members of staff.

Within this part of the Act, an individual with lead professional responsibility (whether clinical or non-clinical) is someone who has a leadership role in a particular setting in relation to staffing.

An individual with lead professional responsibility will be dependent on the local context in which the service is operating and on the professional and clinical governance structures in place within the organisation. An individual should however be of sufficient seniority and have an agreed understanding within the organisation, supported by the relevant organisation's arrangements, of their authority to act to mitigate identified risk(s).

Examples of who this may be in practice are given below, however this list is not exhaustive:

- the senior charge nurse or team leader of a nursing team or their deputy in charge of the shift;
- the consultant in charge of a medical team or delegated individual in charge for the day;
- the AHP team leader or delegated deputy;
- the operational / general manager of a team or service; and
- team leader of a multi-agency team.

The Act has been drafted to allow for more than one person to have lead professional responsibility in any given setting. For example, a consultant in charge, a general manager or a senior charge nurse to receive notification of risk on a particular ward and act appropriately to assess, mitigate, accept or escalate risks arising and record as necessary their decision and/or action. The relevant organisation's arrangements should set out clearly how staff will know who to notify, and the process for managing communication and disagreement effectively between different individuals with lead professional responsibility in any setting.

Different sections of the Act describe different types of leadership relevant to the duties set out in the legislation:

- section 12IC duty to have real-time staffing assessment in place and 12ID duty to have risk escalation process in place – "individual with lead professional responsibility (whether clinical or non-clinical)";
- section 12IH duty to ensure adequate time given to clinical leaders – "individual with lead clinical professional responsibility for a team of staff". This individual must be a clinician; and
- section 12IF duty to seek clinical advice on staffing and section 12IJ duty to follow the common staffing method – "individual with lead clinical professional responsibility for the particular type of health care". This individual must also be a clinician.

There may be times when these leaders may be the same individual; however this is not necessarily the case.

8.7 Who can provide “appropriate clinical advice”?

Individuals with lead professional responsibility (whether clinical or non-clinical), where involved in the mitigation of staffing risk, and more senior decision-makers reaching a decision on risk, must “seek and have regard to appropriate clinical advice, as necessary…”. This will be necessary when the lead professional or more senior decision-maker:

- is not a clinician;
- is assessing risk, or making a decision, in relation to a clinical workforce for which they are not professionally responsible; and/or
- is making a decision in a speciality/setting in which they are not an expert and/or do not normally work.

Clinical advice will be “appropriate” when it is relevant to the particular risk, and is provided by an individual with clinical expertise in the relevant clinical area and responsibility for the particular clinical workforce engaged in the risk.

Clinical advice may need to be sought from more than one individual. The lead professional / more senior decision-maker must have regard to this advice and, where it is conflicting, should use their professional judgement to make a decision to mitigate, escalate or accept the identified risk(s). For escalated risks, the clinician providing clinical advice may record disagreement with that decision and request a review from any decision-maker up to, but not including, members of the relevant organisation.

8.8 Who constitutes a “more senior decision-maker”?

A more senior decision-maker is the individual who receives notifications of risk once they have been escalated by the individual with lead professional responsibility. Decision-makers can keep escalating risks to a “more senior decision-maker” up to the level of the board of the relevant organisation(s), as appropriate. The intent is that decision-making on risk takes place at appropriate levels within the relevant organisation.

Who constitutes a “more senior decision-maker” will be dependent on the local context in which the service is operating and on the professional and clinical governance structures in place within the organisation. An individual should however be of sufficient seniority and have an agreed understanding within the organisation, supported by the relevant organisation’s arrangements, of their authority to act to mitigate identified risk(s).

Examples of who this may be in practice are given below, however this is not an exhaustive list:

- a clinical nurse manager or associate director of nursing;
- a clinical director or associate medical director;
- clinical midwifery manager or head of midwifery;
- the head of an AHP department or director of AHPs;
- a service manager or a general manager in either a hospital or community setting; and
- the Chief Operating Officer or general manager of a hospital or community team.

The individual with lead professional responsibility and each more senior decision-maker will need to assess how far through the professional or management structure to escalate a risk, at each step, depending on the severity and/or repeated nature of the identified risk and, at times (e.g. out of hours), the availability of staff. The relevant organisation’s arrangements should support decision-makers in applying their professional judgement to individual circumstances.

The relevant organisation’s arrangements must set out clearly how staff will know who to escalate to, and the process for decision-makers to assess and act on escalated risk.

8.9 What constitutes “awareness-raising”?

Relevant organisations are under a duty to raise awareness of the real-time staffing assessment and the risk escalation arrangements among all staff.

Although it is imperative that relevant organisations focus resources on awareness raising, such as written and online internal communication, presentations and discussions at the point of implementation, this duty is not time limited. As such, a rolling programme of information and updates will be required to keep both existing and new staff up to date.

8.10 What constitutes "encouraging and enabling staff"?

Relevant organisations are under a duty to both encourage and enable staff to use the real-time staffing arrangements. Relevant organisations should be able to demonstrate active, ongoing promotion of the arrangements to all staff and will need to emphasise the importance of staff identifying and notifying risks in a timely manner so that the relevant organisation can deliver safe, high-quality patient care. A culture of transparency, continuous improvement and open communication – set from the top of the relevant organisation(s) - will support staff to feel safe to raise concerns about risk resulting from staffing. Ongoing feedback to staff on decisions made, and on the impact of these on the safety and quality of care, will also encourage staff to continue to notify risks.

Enabling staff to use the arrangements will require relevant organisations to:

- have in place easy access to the agreed arrangements in clinical settings;
- systems for notifying risks which are accessible to frontline staff in real time; and
- time available on any shift for staff to notify concerns, engage in mitigation effectively and consider feedback.

8.11 What constitutes "adequate time and resources"?

Relevant organisations must ensure individuals with lead professional responsibility, and more senior decision-makers, have adequate time and resources to discharge their functions around risk. For clinical staff, this duty should be read alongside the guidance on the section 12IH duty to ensure adequate time given to clinical leaders (see chapter 10), which provides guidance on adequate time and resources.

For those individuals who are not “clinical leaders” (as referred to in the section 12IH duty to ensure adequate time is given to clinical leaders), relevant organisations must ensure individuals have the time and resources to carry out their responsibilities in relation to staffing-related risks. This is necessary for the relevant organisation to assure itself that it is appropriately supporting these staff to play their part in meeting the organisation’s legal duties.

8.12 What constitutes “training”?

Training duties in these sections of the Act refer to:

- training for individuals with lead professional responsibility (whether clinical or non-clinical) in how to implement the relevant organisation’s real-time staffing arrangements covering:
    - risk identification by staff;
    - risk notification by staff;
    - mitigation of risk;
    - seeking clinical advice in relation to mitigation;
    - staff awareness raising; and
    - encouraging and enabling staff to use the arrangements on risk identification and notification;
- training for individuals with lead professional responsibility (whether clinical or non-clinical), and more senior decision-makers, in the relevant organisation’s risk escalation arrangements covering:
    - risk reporting, onward reporting and further escalation;
    - seeking clinical advice;
    - mitigation of risk;
    - notification of decisions;
    - recording disagreement with a decision;
    - requesting review of a final decision; and
    - raising staff awareness.

Although not explicit in the Act, the expectation is that training in the relevant organisation’s real-time staffing assessment and risk escalation arrangements would

include training in identifying and addressing risks which are classified, by the relevant organisation, as severe and/or recurrent.

The effective and efficient application of these arrangements is essential to the Act's aim of ensuring appropriate staffing at all times. This should hold even if a relevant organisation is using current procedures as the basis for compliance, as the particular duties of the Act will still require understanding among those with responsibilities for delivery around real-time risk management.

The duty to train relevant staff is not time limited. As such, a rolling programme of training will be required to keep both existing and new staff up to date.

8.13 How should powers to disagree with a decision be actioned?

Any staff involved in relation to the real-time staffing assessment or risk escalation in:

- identifying a risk;
- attempting to mitigate a risk;
- giving clinical advice in relation to mitigation of risk;
- reporting a risk (including onward reporting), or
- giving clinical advice on a risk;

must be notified of every decision made and the reasons for it. Relevant organisations should put in place arrangements for this.

Where staff disagree with that decision, they may formally record it and may choose to request a review of the decision. The only exclusion from this is where the final decision has been made by the members of the relevant organisation: these decisions may not be reviewed at the request of individual staff. The relevant organisation's arrangements should set out how staff can record disagreement and formally request a review (see also 12F duty to seek clinical advice on staffing for information on recording and explaining decisions with conflict with clinical advice). It would be good practice for a relevant organisation to review the numbers and reasons for formal disagreements as part of governance arrangements.

Relevant organisations should have a template for recording disagreement, which will protect staff who choose to raise objections formally.

8.14 What factors should be considered when assessing real-time staffing requirements?

This section of the guidance is intended to support relevant organisations in setting out what individuals with lead professional responsibility (referred to here as "lead professional"), more senior decision-makers and the board of the relevant organisation should consider when assessing risk caused by staffing levels. It should also support the relevant organisation to consider how they will set thresholds for risks being identified as severe or recurrent. The list of factors below was developed by the Scottish Government, in collaboration with clinical and workforce representatives, during the parliamentary passage of the Health and Care (Staffing) (Scotland) Bill.

Where the lead professional / decision maker is not a clinician and/or where decisions are being made in relation to a workforce for which the lead professional / decision-maker is not professionally responsible, that individual must seek and have regard to clinical advice from an appropriate person. Who these persons may be is set out more fully in chapter 9 and in 8.7 above.

When assessing actual or potential risks arising, the relevant organisation should take account of, but not limit their consideration to, the following factors:

- Workforce:
    - assessment of number of staff on duty;
    - identification and planning for known roster/rota gaps in all staff groups (e.g. staff on training);
    - assessment of skills and experience of staff on duty including capacity and capability of staff to undertake role e.g. restricted duties, mental and physical wellbeing of staff on duty;
    - consideration of appropriate roster management;
    - consideration of impact of supplementary staffing;
    - location of staff on duty e.g. in community geographical spread of visit;

    - consideration of impact of staffing deficits in relevant staff groups across the multi-disciplinary team e.g. AHP or medical support available in a general ward, or support available for clinicians to perform clinical interventions or procedures;
    - consideration of the regulatory requirements for staff; and
    - ability to fulfil time and resource requirements for clinical leadership roles.
- Workload:
    - the number, dependency, acuity and complexity of patient/service users who require care;
    - staff workload across sectors, where services are delivered across acute and primary care services e.g. maternity services, or the impact on community nursing or AHP workload to support earlier discharge from hospital;
    - any specific clinical issues which increase staffing requirements, including, but not limited to, infection, pandemic, specialist clinical interventions, high level of child protection cases, winter pressures, enhanced supervision requirements for service users, number of patients with cognitive impairment, high levels of discharge from acute to primary care settings, high levels of palliative care patients/service users in the community;
    - any escorting or transfer requirements;
    - cross cover arrangements for other clinical areas and sites;
    - the impact of unplanned staff leave or absence;
    - the location and spread of the service user group in the community and the impact of this on staff travel time; and
    - skills deficits.
- Environmental concerns:
    - infection control restrictions;
    - consideration of the impact of any equipment / systems failures / availability;
    - the physical environment e.g. single rooms / temporary wards etc.;

- any workplace disruption e.g. planned building works or emergency repairs;
- any travel disruption e.g. weather, roadworks; and
- consideration of staff with caring responsibilities e.g. impact of school or day centre closures or reduced social care due to adverse weather etc.

8.15 What factors should be considered in the risk mitigation process?

This section of guidance is intended to support relevant organisations in setting out what individuals with lead professional responsibility (referred to here as "lead professional"), more senior decision-makers and the board of the relevant organisation should consider when mitigating risk. The following list of factors was developed by the Scottish Government in collaboration with clinical and workforce representatives, during the parliamentary passage of the Health and Care (Staffing) (Scotland) Bill. .

Where the lead professional / decision-maker is not a clinician and/or where decisions are being made in relation to a workforce for which the lead professional / decision-maker is not professionally responsible, that individual must seek and have regard to clinical advice from an appropriate person. Who these persons may be is set out more fully in chapter 9 and in 8.7 above.

When mitigating actual or potential risks arising, the relevant organisation could consider, but not limit their consideration to, the following factors:

- Immediate (on the day) including out of hours and weekends:
  - any need for staff redeployment between clinical areas, taking into account the need to ensure redeployed staff have the appropriate skills and knowledge in the area they are being moved to;
  - the use of any supplementary staffing;
  - any need for reduction in clinical activity (elective activity / planned community visits);

    - any need to transfer clinical activity (emergency admission divert / divert activity to different teams in the community or different acute sites);
    - the prioritisation of clinical workload (e.g. prioritising admission avoidance / supported discharge / palliative care and child protection activity); and
    - the acceptance of all or part of the risk(s).
- Short term (approximate timescale of 1 week):
    - any known short term absence beyond immediate;
    - any known increased patient/service user dependency;
    - the need to redeploy staff with appropriate skills and knowledge for a period of time where risk is known to be sustained for a few days; and
    - any environmental factors which have been identified during the assessment and are thought to be short term e.g. bad weather or equipment / systems failures that can be corrected quickly.
- Medium term (approximate timescale of 1 month):
    - any medium term absence;
    - the need to redeploy staff to meet skills mix deficit;
    - any environmental factors; and
    - roster management to ensure most appropriate rostering in place in a timely manner.
- Long term (in excess of 1 month):
    - any long term absence e.g. maternity leave/long term sickness/absence;
    - the need for a review of staffing establishment to ensure planned staffing is appropriate in the long term following the section 12IJ duty to follow the common the staffing method for those areas where it applies;
    - the need to plan for long-term solutions to trends in risks identified;
    - review service delivery models or patient pathways to reduce risk, e.g. virtual consultation; and
    - roster management to ensure most appropriate rostering in place in a timely manner.

8.16 What is a severe or recurrent risk?

The Act does not define what a severe or recurrent risk is. Relevant organisations will need to use their own systems of classification to determine what these are, drawing on current published guidance such as the NHS Scotland risk assessment matrices contained within Learning from adverse events: a national framework.

To be able to respond effectively and timeously to severe and recurrent risk, relevant organisations will need to set out, in their arrangements, how information on risk escalated to a defined level (as agreed by the members of the relevant organisation's Board) will be collated, analysed and recorded to highlight severe and/or recurrent risk(s). This should include reporting to the Board in appropriate cases.

8.17 Other relevant guidance and legislation

Staff Governance Standard — NHS Scotland Staff Governance
Clinical and care governance framework: guidance - gov.scot (www.gov.scot)
Healthcare quality strategy for NHSScotland - gov.scot (www.gov.scot)
Standards - The Nursing and Midwifery Council (nmc.org.uk)
Ethical guidance - GMC (gmc-uk.org)
Learning from adverse events: a national framework

9. Duty to Seek Clinical Advice on Staffing

9.1 Which sections of the Act is this chapter about?

This chapter provides further detail on section 12IF of the 1978 Act Duty to seek clinical advice on staffing (referred to here as "the section 12IF duty"), which is inserted by section 4 of the Act.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

9.2 Who does this chapter apply to?

The following organisations must comply with the duty contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

9.3 In what settings and to which staff does this chapter apply?

The section 12IF duty applies to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act). It is not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method..

Accountability for the section 12IF duty remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

9.4 What is this chapter about?

This chapter relates to section 12IF of the Act. It sets out that the following requirements should be implemented by relevant organisations:

- to put, and keep in place, arrangements for seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under the various sections of the Act; and
- to put, and keep in place, arrangements for recording and explaining decisions which conflict with that clinical advice.

Seeking and having regard to clinical advice on staffing is required when putting in place arrangements on staffing under:

- section 12IA Duty to ensure appropriate staffing;
- section 12IB Duty to ensure appropriate staffing: agency workers;
- section 12IC Duty to have real-time staffing assessment in place;
- section 12ID Duty to have risk escalation process in place;
- section 12IE Duty to have arrangements to address severe and recurrent risks;
- section 12IH Duty to ensure adequate time given to clinical leaders;
- section 12II Duty to ensure appropriate staffing: training of staff; and
- sections 12IJ, 12IK and 12IL: relating to the common staffing method.

These requirements should be considered within the context of existing organisational governance structures and processes which may already fully support delivery of the duties in the Act, or could easily be amended to do so. Where structures and processes do not exist or are insufficient, new ones must be designed and implemented in line with the requirements of the Act and this accompanying guidance.

The provision of clinical advice is central to securing appropriate decision-making and actions that will ensure the health, wellbeing and safety of patients, the provision of safe and high-quality health care and, in so far as it effects either of these, the wellbeing of staff. Relevant organisations will be required to report on the operation of this duty in their annual reports under section 12IM reporting on staffing.

9.5 What arrangements must the relevant organisation(s) make in relation to clinical advice?

The relevant organisation will, in practice, have a written procedure(s) on:

- how it will seek and have regard to clinical advice on staffing;
- how it will deal with decisions which conflict with that advice;
- reporting by individuals with lead clinical professional responsibility to the members of the relevant organisation about their views on the organisation's compliance with various staffing duties imposed by the Act;
- individuals with lead clinical professional responsibility enabling and encouraging other employees to give views on the operation of these arrangements, and recording these views in their reports to members of their organisation;

Arrangements should support clinicians and other decision-makers, up to the level of the board, to manage conflict in decisions and actions related to staffing.

Local arrangements should be:

- developed with staff, including the full engagement of local and/or area clinical and partnership forums, clinical governance committees and risk management committees;
- agreed, and regularly reviewed, at board level in the relevant organisation(s), with the opportunity for board-level clinical leaders to note any opposition to the arrangements, in keeping with other provisions of the Act; and
- communicated in clear and accessible language to all relevant staff.

The arrangements must cover the relevant organisation's procedures for seeking and having regard to clinical advice when making staffing decisions and in putting in place arrangements in relation to staffing under the Act. In relation to situations where a decision is made which is contrary to the advice given, the arrangements must cover the:

- identification of risk(s) caused by the decision;
- mitigation of risk(s), so far as possible;

- notification of the decision, including reasons for it, to the clinician(s) who gave advice; and
- recording of any disagreement by the clinician(s) who gave advice.

Procedures should also include:

- recording and explaining decisions which conflict with clinical advice;
- at least quarterly compliance reporting to the board of the relevant organisation(s) by the individuals with lead clinical professional responsibility for a particular type of health care (these will be the board-level clinicians);
- enabling and encouraging employees to give views on the duty to seek clinical advice, and the recording of those views;
- raising awareness among the board-level clinicians giving quarterly reports of how to implement these procedures; and
- ensuring these board-level clinicians have adequate time and resources to implement the procedures.

9.6 Who can give clinical advice on staffing?

There are numerous uses of the term “appropriate clinical advice” throughout the Act. Though applied slightly differently, depending on the sections of the Act under consideration, a standard definition is included in section 12IO of the 1978 Act (inserted into the 1978 Act by section 4 of the Act):

> *“appropriate clinical advice” means advice obtained from the appropriate level and area of clinical professional structures depending on the particular circumstances of each case (for example from an individual holding a senior executive role in the provision of nursing services)”*

Clinical advice, provided by a professional registered with a professional regulatory body, will be “appropriate” when it is relevant to the particular decision or risk, and is provided by someone with sufficient seniority, clinical expertise in the relevant clinical area, and responsibility for the particular clinical workforce affected by, or engaged in, the decision or risk. Local procedures required to operationalise this legislation should clearly set out specific guidance for relevant staff on how clinical advice should be sought, and from whom, within the context of local structures.

In any of the circumstances where the relevant organisation is obliged to seek appropriate clinical advice, it is possible that this advice may need to be sought from more than one individual. Where that advice is conflicting, the decision-maker at the appropriate level within the relevant organisation will be required to use their professional judgement to make a decision.

Where a decision conflicts with **any** of the clinical advice given (whether advice was obtained from one or more individuals), the decision-maker must record and explain this, identify any risks caused by their decision, mitigate these (in so far as is possible), and notify the clinician(s) who provided the advice in conflict with the decision.

Any clinician who gave advice may formally record their disagreement with a decision taken. In the case of the section 12IC duty to have real time staffing assessment in place and the section 12ID duty to have risk escalation process in place only, a clinician providing advice (among others) may also request a review from any decision-maker up to, but not including, a final decision made by the members of the relevant organisation.

9.7 When must clinical advice be sought, and regarded, in decision-making?

It is a requirement for relevant organisations to seek and have regard to appropriate clinical advice in making decisions, and putting in place arrangements in relation to staffing under:

- section 12IA: Duty to ensure appropriate staffing;
- section 12IB: Duty to ensure appropriate staffing: agency workers;
- section 12IC: Duty to have real-time staffing assessment in place;
- section 12ID: Duty to have risk escalation process in place;
- section 12IE: Duty to have arrangements to address severe and recurrent risks;
- section 12IH: Duty to ensure adequate time given to clinical leaders;
- section 12II: Duty to ensure appropriate staffing: training of staff; and

- sections 12IJ, 12IK and 12IL relating to the common staffing method.

The Act does not define or restrict the scope of 'clinical advice' but such advice may include agreement with the decision, suggesting an alternative action to mitigate any risk identified, acceptance of risk associated with the decision and therefore no further action, identification of significant risk to decision-makers to enable further exploration of the decision and acceptable solution to be found.

As well as seeking clinical advice in relation to these decisions, the relevant organisation must also comply with the other requirements contained in section 12IF. This includes the procedure to be followed for decisions which conflict with clinical advice, and quarterly board-level compliance reporting. These are explained more fully in this chapter.

As an example, a relevant organisation would need to seek and have regard to appropriate clinical advice in determining what constitutes sufficient time and resource for clinical leaders to discharge their responsibilities (under the section 12IH duty to ensure adequate time given to clinical leaders). If a clinical leader felt that the time made available to them (or others) was, or had become, insufficient, they would raise this through the organisation's appropriate local mechanisms. The individual responsible for making a decision on whether to increase the time available would need to seek appropriate clinical advice (either their own or from a relevant individual) which the relevant organisation must have regard to. If the organisation made a decision that conflicted with this advice it would have to record and explain that decision. This would include setting out what risks were arising and how these would be mitigated, as well as informing the individual who provided the clinical advice, who would be allowed to formally record any disagreement.

9.8 What must relevant organisations do if decisions are made that conflict with clinical advice given?

The relevant organisation is under a duty to record and explain decisions on staffing that conflict with clinical advice given. It must have an accompanying procedure(s) for:

- identifying any risks caused by a decision;
- mitigating such risks, as far as possible;
- notifying decisions to the person giving clinical advice; and
- the person giving clinical advice to formally record disagreement with the decision.

9.9 How can clinicians record disagreement?

The relevant organisation's arrangements must make clear the local process for any clinician giving advice to formally record their disagreement with any decision or arrangement on staffing, on which they have given advice, when that decision conflicts with the clinical advice they gave. Section 12IC (duty to have risk escalation process in place) also provides information about disagreeing with decisions taken on risk (see chapter 8 for further details).

The clinician who gave this advice will also need to continue to follow any requirements regarding action to take when disagreeing with decisions or arrangements on staffing, on which they have given advice, that are required by their managerial or professional structures, e.g. General Medical Council (GMC) requirements for GMC-registered doctors.

The quarterly compliance report(s) should include appropriate information on decisions taken contrary to clinical advice. As well as allowing the board of the relevant organisation(s) to assess the appropriateness of operational decision-making on staffing, this will support evaluation of compliance with the duty to have regard to clinical advice

9.10 How will clinicians give a clinical assessment of compliance with the health provisions in the Act?

The Section 12IF of the Act sets out that **quarterly reports, at a minimum,** on compliance with the Act, are to be provided to the board of the relevant organisation(s) by individuals with lead clinical professional responsibility for a particular type of health care and that the board must have regard to these reports. The report must include assessment of compliance with the duties relating to:

- section 12IA: Duty to ensure appropriate staffing;
- section 12IB: Duty to ensure appropriate staffing: agency workers;
- section 12IC: Duty to have real-time staffing assessment in place;
- section 12ID: Duty to have risk escalation process in place;
- section 12IE: Duty to have arrangements to address severe and recurrent risks;
- section 12IF: Duty to seek clinical advice on staffing;
- section 12IH: Duty to ensure adequate time given to clinical leaders;
- section 12II: Duty to ensure appropriate staffing: training of staff; and
- section 12IJ, 12IK and 12IL, relating to the common staffing method.

This approach is in keeping with ensuring board-level assessment and decision-making on the duties within the Act, since responsibility rests at board level.

The intent in this section of the Act is for compliance reports to members of the relevant organisation to be prepared and presented by the Executive-level clinicians on the board who have responsibility for clinical professions in the workforce in their board remit – currently the Executive Directors of Medicine and Nursing. These reports must cover all staff groups covered by the Act, and the Executive level clinicians should liaise as necessary with heads of other professions when preparing these reports.

The relevant organisation(s) must also ensure that those board-level clinical leaders are provided with a procedure to enable and encourage employees from across all clinical professions and settings to give views on the operation of the duty to seek clinical advice, and to record those views and incorporate them into their quarterly report.

For example, the Executive Nurse Director has executive level responsibility for the Allied Health Professional (AHP) workforce. As such, they should be supported by the board to seek the views of AHP staff. It would not be sufficient for the Executive Nurse Director to engage only with nursing staff in gathering views to inform the report.

Views from across professions and settings should be recorded in compliance reports. Although this does not mean every comment must be included, the board-level clinicians compiling the report should ensure that the full breadth of views are reflected – and these should inform conclusions and recommendations made.

Relevant organisation(s) should note that quarterly reporting is the minimum requirement. There may be good reason – such as notification of severe and recurrent risk outside the quarterly timetable or receipt of reports from external scrutiny or audit bodies – which may prompt further compliance reports to the board from the lead clinicians.

9.11 What constitutes "awareness-raising"?

Relevant organisations are under a duty to raise awareness among the "individuals with lead clinical professional responsibility for particular types of healthcare" (i.e. board-level clinicians) in how to implement arrangements relating to decisions in conflict with clinical advice, on reporting to the board of their organisation on compliance with wider health-related duties and on enabling and encouraging other employees to give views on the operation of clinical advice arrangements.

Awareness raising could take place in different ways, for example, written and online internal communication, presentations and discussions.

9.12 What constitutes "encouraging and enabling other employees"?

Relevant organisations must have arrangements in place to support the board-level clinicians who are preparing compliance reports to enable and encourage other employees to give views on the operation of the duty to seek clinical advice and record such views in their reports.

To enable staff to give views on the duty to seek clinical advice, relevant organisations should have in place easy access to the agreed arrangements in clinical settings. Relevant organisations should be able to demonstrate active, ongoing engagement of staff in giving views on the operation of the duty to seek clinical advice. This requirement to seek views on the operation of the clinical advice

duty is in addition to requirements in the guiding principles to take into account staff views, and in the section 12IJ duty to follow the common staffing method to encourage and support employees to give views on staffing and to take them into account.

The purpose of this legislation is to improve the safety and quality of services through appropriate staffing. In practice, it will rely on staff feeling safe to speak up. A culture of transparency, continuous improvement and open communication – set from, and modelled by those at, the top of the relevant organisation(s) – will support all staff to feel safe to give their open and honest views on the operation of this section of the Act and to record disagreements on staffing decisions on which they provided clinical advice. Ongoing feedback to staff that makes clear that their views are being presented to, and considered by, the board of their relevant organisation – and that their views are informing improvement – will also encourage staff to continue to share views and record disagreement, as necessary. To further support staff in this, they should have access to professional structures, clinical networks etc.

9.13 What constitutes “adequate time and resource”?

“Individuals with lead clinical professional responsibility for particular types of healthcare” in the context of this section (i.e. board-level clinicians) will require both time, as well as resources to implement the arrangements under section 12IF. This should take into account the other staff required for them to carry out this function. For example, time for a Director of Pharmacy to seek and report views from the hospital-based pharmacy workforce would be a legitimate resource need for the Executive (Board) Medical Director. Similarly, administrative time for an AHP leader to gather views from community-based AHPs across the area would be a legitimate resource.

What is “adequate” for these board-level clinicians will be different by setting and by the context of reports required and by any concerns around compliance. However, the relevant organisation(s) should be able to evidence that the board-level clinician’s advice on the time and resource set aside to discharge their functions in this section has been considered, and that effective discharge of the duties is supported by adequate time and resource. Chapter 10 on the section 12IH duty to

ensure adequate time given to clinical leaders provides more information on determination of time and resources.

9.14 How does the clinical advice duty link to other requirements in the Act relating to clinical advice?

There are a number of requirements relating to clinical advice throughout the Act, in addition to this overarching duty to seek clinical advice:

- the section 12IA duty to ensure appropriate staffing requires relevant organisations to have regard to appropriate clinical advice (see chapter 6);
- the section 12IC duty to have real-time staffing assessment in place requires an individual with lead professional responsibility (whether clinical or non-clinical) to seek and have regard to clinical advice, as necessary, when mitigating a risk (see chapter 8);
- the section 12ID duty to have risk escalation process in place places a requirement on decision-makers to seek and have regard to clinical advice, as necessary, in reaching a decision on risk, including on how to mitigate it (see chapter 8);
- the section 12IE duty to have arrangements to address severe and recurrent risks requires appropriate clinical advice to be sought and had regard to in carrying out the mitigation of risks that are considered to be severe and / or liable to materialise frequently (see chapter 8); and
- the section 12IJ duty to follow the common staffing method requires relevant organisations to take into account appropriate clinical advice (see chapter 12).

This chapter should be read in conjunction with chapters detailing these other clinical advice requirements to ensure that the clinical advice requirements in all the duties are met. For example, where a staffing decision is made under the section 12ID risk escalation duty that goes against the clinical advice, the individual who gave the advice must be notified of the decision, and they must be able to record their disagreement and request a review. At the same time, the duty in this chapter (under section 12IF) on clinical advice also requires that any risks caused by that decision are identified and mitigated so far as possible.

9.15 Other relevant guidance and legislation

Staff Governance Standard — NHS Scotland Staff Governance

Healthcare quality strategy for NHSScotland - gov.scot (www.gov.scot)

Clinical and care governance framework: guidance - gov.scot (www.gov.scot)

Excellence in Care (healthcareimprovementscotland.org)

Standards - The Nursing and Midwifery Council (nmc.org.uk)

Ethical guidance - GMC (gmc-uk.org)

Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project - gov.scot (www.gov.scot)

Quality improvement | NHS Education for Scotland

10. Adequate Time for Clinical Leaders

10.1 Which sections of the Act is this chapter about?

This chapter provides further detail section 12IH of the 1978 Act, duty to ensure adequate time given to clinical leaders, which is inserted by section 4 of the Act.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

10.2 Who does this chapter apply to?

The following organisations must comply with the duty contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

10.3 In what settings and to which staff does this chapter apply?

The duty contained in this section applies to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act). It is not limited to the types of health care listed in section 12IK of the Act in relation to the section 12IJ Duty to follow the common staffing method.

Accountability for all the duties covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

10.4 What is this chapter about?

Most of the duties and requirements of section 4 of the Act exist to directly support the delivery of the duty under section 12IA of the 1978 Act to ensure appropriate staffing in health care. The section 12IH duty to ensure adequate time given to clinical leaders recognises the duties and responsibilities that clinical leaders have under the Act in their relevant organisations.

This section of the 1978 Act is intended to ensure that clinical leaders receive the right amount of time and resources to discharge their responsibilities under the duty to ensure appropriate staffing, alongside all the other professional duties and responsibilities they have. These include the clinical leadership and management functions that support the delivery of high quality care. This section should be considered within the context of existing staff and clinical governance arrangements, and professional structures.

The Act sets out further provisions around a minimum requirement for quarterly reporting by individuals with lead clinical professional responsibility for a particular type of health care to members of the relevant organisation under the section 12IF duty to seek clinical advice on staffing, which would include reports on compliance with the duty to ensure adequate time is given to clinical leaders. Relevant organisations will also have to detail how they have carried out this duty in their annual report to the Scottish Ministers under section 12IM reporting on staffing.

This chapter provides guidance on how relevant organisations should go about establishing the right amount of time and resources required for clinical leaders to support compliance with the section 12IA duty to ensure appropriate staffing, and their wider professional duties.

Arranging staffing which provides safe, high-quality health care, appropriate for the health, wellbeing and safety of patients, and, as far as it affects either of those matters, the wellbeing of staff, requires clinical leaders who have the time and resources to lead. This applies to both the planning of services and the real-time delivery of health care.

10.5 Who are the 'clinical leaders' in this section of the Act?

This section of the Act is specific to individuals with clinical professional responsibilities for a team of staff (referred to in this guidance as a "clinical leader"), for example consultant medical staff, Allied Health Professional (AHP) team leaders, senior charge nurses/midwives and pharmacy department heads. In this context, clinical leadership includes clinical oversight and/or expertise as well as direct clinical intervention work.

Managers who do not have clinical leadership roles are not included in this duty on relevant organisations to provide adequate time. For example, a social worker who leads a multi-professional community team which includes AHPs and nursing staff would not be in scope as they are not a clinician. However, the AHP who has lead clinical professional responsibility for the AHPs working in that team would be in scope and the relevant organisation(s) would be required to factor in sufficient time and resources for them to undertake their functions in relation to that role.

In practice, there may well be more than one individual with lead clinical professional responsibility for a team of staff in any given area e.g. medical clinical leader, AHP clinical leader and nurse clinical leader. The Act applies to all such leaders, and will require the relevant organisation(s) to make a determination of sufficient time and resources for each leader.

10.6 What are the functions of clinical leaders which relevant organisations must consider in calculating "adequate time"?

The Act places equal weight on the responsibilities of clinical leaders to operationally deliver on the relevant organisation's duty in the Act to ensure appropriate staffing and "their other professional duties". Therefore, relevant organisations will need to factor in their full range of duties within the determination of "sufficient time and resources".

Those clinical leaders referred to in section 12IH will, or are likely to, have a role to play in relation to functions referred to in, or arrangements that will be put in place under, the following sections of the 1978 Act on behalf of the relevant organisation:

- 12IA Duty to ensure appropriate staffing;
- 12IB Duty to ensure appropriate staffing: agency workers;
- 12IC Duty to have real-time staffing assessment in place;
- 12ID Duty to have risk escalation process in place;
- 12IE Duty to have arrangements to address severe and recurrent risks;
- 12IF Duty to seek clinical advice on staffing;
- 12IH Duty to ensure adequate time given to clinical leaders;
- 12II Duty to ensure appropriate staffing: training of staff;
- 12IJ, 12IK, 12IL relating to the use of the common staffing method; and
- 12IM Reporting on staffing.

Three key aspects of the clinical leader's wider professional duties are emphasised in the section 12IH duty, and these must be included within the determination of sufficient time and resources for clinical leaders. However, it should be noted that this list is not exclusive of other considerations which the relevant organisation(s) and / or the clinical leader may believe to be relevant. The three areas which must be included by relevant organisation(s) are:

- time to supervise the meeting of the clinical needs of the patients in their care;
- time to manage, and support the development of, the staff for whom they are responsible; and
- time to lead the delivery of safe, high-quality and person-centred health care.

These areas are further explained below.

10.7 Time "to supervise the meeting of the clinical needs of the patients in their (team's) care"

The supervisory functions of a clinical leader would include, but not be limited to:

- oversight of care delivery, including enhancing patient experience;
- addressing the needs of patients' families and carers;
- clinical supervision and observation of clinical practice;
- reviewing clinical records;
- supporting reflective practice with individual members of staff;

- supporting improvement in individual practice and ensuring a culture of reflective practice is embedded in the team;
- inspiring patient confidence by setting and maintaining high standards of patient care;
- using patient and carer feedback to support service improvement;
- ensuring observations of care, assess culture, patient experience and the advancement of clinical care; and
- education of staff where required.

10.8 Time "to manage, and support the development of, the staff for whom they are responsible"

Staff management and development may differ, depending on the role and management responsibilities of the clinical leader. For example, a senior charge nurse is responsible for management of staff, budget and the environment, whereas a lead consultant may be responsible for management of staff but neither budget nor environment. The type of activity undertaken, depending on remit, may include:

- direct management of staff (including effective rostering, staff appraisals and personal development plans, ensuring appropriate development opportunities for staff, recruitment of staff and investigation and management of staff performance);
- budget management (including understanding the budget, ensuring the most effective use of resources, effective rostering, managing supplies and procurement);
- investigation of adverse events;
- management of complaints and feedback;
- investigation and management of staff performance;
- ensuring appropriate clinical governance and complying with standards;
- ensuring a safe environment (e.g. ensuring a clean environment and ensuring health and safety risk assessments are undertaken and updated; and
- attending management meetings.

10.9 Time "to lead the delivery of safe, high-quality and person-centred health care"

The clinical leader has a key role in driving quality improvements in the team – leading on quality planning, quality control, quality assurance and quality improvement. In practice they will do this by:

- leading collection and analysis of quality and safety measures and patient outcome information;
- supporting the delivery of subsequent improvement activity;
- escalation of concerns in relation to delivery of care;
- acting as a role model for colleagues and setting the standard for the care delivered;
- reviewing patient experience information;
- contributing to and influencing decisions about the service or profession;
- leading change within their area;
- reflecting implementation of evidenced-based practice changes and contribution to research;
- identifying opportunities for redesign where appropriate;
- maintaining the psychological safety within the team;
- keeping their own professional skills and competencies up to date, including contributing to professional forums or other networks; and
- generally contributing to the delivery of the organisation's objectives.

As noted above, these lists are not exhaustive and **should be considered alongside the many specific functions which individual clinical leaders will undertake under the Act** – such as implementing real-time staffing assessment and risk escalation procedures, running the common staffing method, or contributing to reporting on compliance.

10.10 Does this section include both time and resources?

Yes. Although the title of the section refers to "adequate time", the section itself refers to "sufficient time and resources" for clinical leaders to discharge their

responsibilities in relation to the duty to ensure appropriate staffing and their other professional duties.

Resources may include:

- HR support;
- finance/management accountant support;
- administrative support;
- facilities support;
- clinical governance / improvement support;
- quality improvement support;
- management support;
- access to skills building opportunities and coaching;
- health and safety support;
- organisational learning, education and development support;
- clinical supervision;
- access to appropriate IT and systems; and
- IT training and support.

The resource for a clinical leader may well therefore be the time of other staff required for them to carry out this function

10.11 How should relevant organisations determine "sufficient time and resources"?

The determination of sufficient time and resources for each clinical leader should be undertaken in dialogue between the relevant organisation and the clinician, abiding by the guiding principle to "take account of the views of staff" in discharging duties under the Act, considering their role, responsibilities, resources and local context. This should be set in the context of existing staff and clinical governance arrangements within the relevant organisation.

In keeping with the emphasis in the Act on multi-disciplinary working, these provisions should be set in the context of the needs of different clinical professions in

supporting the relevant organisation to comply with the duty to ensure appropriate staffing.

The starting point for the discussion will necessarily vary to reflect the different roles, responsibilities and structures of different professions. This should take account of a range of factors such as local context, service delivery model and the size and nature of the team when determining what constitutes sufficient time and resources. Guidance produced by professional regulatory bodies can also be used. The discussion should take place as part of the existing arrangements through which a clinical leader's time is agreed. Where there is a job planning process in place this could be used. Where there is not, consideration could be given to establishing one. The decision on sufficient time and resources may need to be reviewed if the service delivery model or team format changes.

Where any relevant organisation sets out a particular local factor, or factors, to include in calculations for any profession within their remit, these should be: developed in partnership; be subject to 12IF duty to seek clinical advice on staffing; and agreed with the board-level clinical leader(s) with responsibility for the particular professions.

The determined time and resources for leadership should be clearly articulated to all staff who have professional clinical leadership responsibilities within a team. It would be good practice for the relevant organisation to keep a record of its discussions with the individual clinical leader in determining and agreeing sufficient time and resources. Where agreement cannot be reached between the relevant organisation(s) and the clinical leader, the clinical leader may use provisions to disagree with the clinical advice given on adequate time and resources, set out in 12IF duty to seek clinical advice on staffing.

Once an allocation of time / resource is agreed, this should be protected for the individual clinician to carry out their leadership functions. Whilst there may be times of particular clinical pressure when additional time may be required to deliver patient care directly, these should be the exception and not the rule. Both the relevant

organisation(s) and the clinical leader should be able to request a review of the determined time / resource.

The section 12IC duty to have real-time staffing assessment in place requires relevant organisations to put and keep in place arrangements of the real-time assessment of its compliance with the duty imposed by section 12IA, including having a procedure for the identification and notification of any risks caused by staffing levels to the health, wellbeing and safety of patients, the provision of safe and high-quality health care or, in so far as it affects either of those matters, the wellbeing of staff. If an inability to meet the determined time or resources for clinical leadership for any particular individual is considered a risk, then this procedure for risk identification should be followed, along with 12ID duty to have risk escalation process in place and 12IE duty to have arrangements to address severe and recurrent risks, as appropriate.

10.12 How does a relevant organisation evidence compliance?

The relevant organisation should set out:

- how it has determined who has lead clinical professional responsibility for each team;
- how it has determined what sufficient time and resources are for the clinical leader to be able to discharge their responsibilities as part of the organisation's overall duty to ensure appropriate staffing. This includes, but is not limited to, supervision of meeting the clinical needs of the patients in their care, managing and supporting development of the staff for whom they are responsible, and leading the delivery of safe, high-quality and person-centred care;
- any associated risk assessment that was carried out;
- how clinical advice was sought and had regard to, and; and
- how the calculated time and resource is kept under review.

10.13 How should this be factored into staffing establishments?

The outputs of the discussions between relevant organisation(s) and individual clinical leaders will form the basis of the evidence used to ensure staffing

establishments effectively incorporate the time and resources required for clinical leaders, and, in doing so, will support organisations to deliver on their duties under the Act.

For the health care settings covered by the section 12IJ duty to follow the common staffing method (i.e. those listed in section 12IK of the 1978 Act), the common staffing method requires that the role and professional duties of any individual with lead clinical professional responsibility for the particular type of health care must be taken into account when determining the staffing establishment. The output from the speciality-specific staffing level tool may not currently include all the workload of the clinical leader's role as defined in section 12IH of the 1978 Act. In these cases the proportion of their time devoted to this role is over and above the number produced by the staffing level tool. Further information on the operation of specific tools can be found at Staffing (workload) tools and methodology and each user guide details if the tool takes into consideration the workload associated with the clinical leader's role.

Consideration of the requirements of the leadership role under the section 12H duty must also be factored into the professional judgement aspect of the common staffing method. Consideration should also be given to the contribution to clinical leadership and supervision of individuals who are not included in the staffing establishment for that area.

In health care settings not covered by the common staffing method (i.e. in those areas where there is not currently a staffing level tool) the staffing establishment agreed, after consideration of appropriate clinical advice, must include the proportion of time allocated for the lead clinical professional role within that team, as well as the time and staff required for direct patient care. Consideration should also be given to the contribution to clinical leadership and supervision of individuals who are not included in the staffing establishment for that area.

10.14 Other relevant guidance and legislation

Staff Governance Standard — NHS Scotland Staff Governance
Clinical and care governance framework: guidance - gov.scot (www.gov.scot)
Standards - The Nursing and Midwifery Council (nmc.org.uk)

Ethical guidance - GMC (gmc-uk.org)

Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project - gov.scot (www.gov.scot)

Excellence in Care (healthcareimprovementscotland.org)

Quality improvement | NHS Education for Scotland

11. Staff Training and Engagement

11.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections that are inserted into the 1978 Act by section 4 of the Act:

- section 12IC(2)(d), (e) and (f): raising awareness, encouraging and enabling staff and training associated with the duty to have real-time staffing assessment in place;
- section 12ID(2)(h) and (i): raising awareness and training associated with the duty to have risk escalation in place;
- section 12II: duty to ensure appropriate staffing: training of staff; and
- section 12IL: training and consultation of staff (in relation to the use of the common staffing method).

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

11.2 Who does this chapter apply to?

The following organisations must comply with the duty contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

11.3 In what settings and to which staff does this chapter apply?

Section 12IC(2)(f) requires that individuals with lead professional responsibility for particular types of health care are trained in implementing the arrangements put in place under section 12IC – the procedures for the identification, notification and mitigation of risk and raising awareness among, and enabling and encouraging use

by, staff of these procedures. This training requirement applies to all individuals with lead professional responsibility, whether they are clinical or non-clinical. Chapter 8 provides further information on who **"**an individual with lead professional responsibility (clinical or non-clinical)" is.

Section 12IC(2)(d) also requires relevant organisations to raise awareness amongst staff of the procedures for identification, notification and mitigation of risk, and encourage and enable staff to use these. This applies to all staff covered by the Act (chapter 3, introduction provides more details on professional disciplines covered by the Act) in all NHS functions.

Section 12ID(2)(i) requires that those with lead professional responsibility for particular types of health care and other senior decision-makers are trained in how to implement the arrangements put in place by the organisation under the section 12ID duty to have risk escalation process in place. This training requirement applies to all individuals with lead professional responsibility, whether they are clinical or non-clinical, as well as to senior decision-makers. Again, chapter 8 provides further information on who **"**an individual with lead professional responsibility (clinical or non-clinical)" is.

Section 12ID(2)(d) requires the arrangements put in place by relevant organisations to include raising awareness of these procedures amongst staff. This applies to all staff covered by the Act (chapter 3, introduction provides more details on professional disciplines covered by the Act) in all NHS functions.

Section 12II requires relevant organisations to ensure that, in complying with the duty imposed by section 12IA (the duty to ensure appropriate staffing), relevant organisations must ensure that employees have appropriate and relevant training, to ensure that suitability qualified and competent individuals from such a range of professional disciplines as necessary are working in such numbers as are appropriate for the health, wellbeing and safety of patients and the provision of safe and high-quality health care. Section 12II also requires that adequate time and resource is provided to undertake that training.

This applies to employees in all professional disciplines covered by the Act (chapter 3, introduction provides more details on professional disciplines covered by the Act) in all NHS functions. It would also apply to non-clinical disciplines such as those in management who have responsibilities in relation to risk escalation and staffing decisions.

Section 12II only applies to employees of the relevant organisation. Employee is defined in section 12IO of the Act as:

> *"an individual in paid employment by, as the case may be, a Health Board, the Agency or (where an integration scheme under Part 1 of the Public Bodies (Joint Working) (Scotland) Act 2014 applies) a local authority, whether under a contract of service or apprenticeship or under a contract for services"*

Section 12IL requires that staff who are expected to use the common staffing method are trained in its use; this would include any part of the common staffing method, e.g. use of staffing level tools, providing clinical advice, identifying or mitigating risks or making decisions as a result of its use. This requirement only applies to the health care types, locations and employees covered by 12IJ duty to follow the common staffing method. Further information about this requirement can be found in that chapter 12.

Section 12IL also requires relevant organisations to encourage and support employees to give their views on its staffing arrangements, and to take into account and use those views to identify best practice and areas for improvement. This applies to all types of health care, locations and employees covered by the common staffing method – those listed in section 12IK. Again, more information is provided in chapter 12.

Accountability for all the duties covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

11.4 What is this chapter about?

This chapter sets out the requirements to train and engage with staff in health care settings. The requirements should be considered within the context of existing staff governance, education and training strategies, and regulatory frameworks' rules and standards .

The purpose of requirements of the provisions detailed above is to ensure that relevant organisations provide staff with appropriate information and training to enable the organisation to implement the duties in the Act effectively. It is also to ensure that staff are suitably qualified and are able to maintain competence to provide safe, high-quality, person-centred care in their role.

The Act sets out provision around quarterly reporting by individuals with lead clinical professional responsibility for a particular type of health care to members of the relevant organisation under the section 12IF duty to seek clinical advice on staffing, on the extent to which that individual considers that the relevant organisation is complying with various duties introduced by the Act (see chapter 9 for further information). This would include compliance with the relevant duties relating to staff training and engagement. Relevant organisations will also have to include an assessment on how they have carried out these under section 12IM reporting on staffing (see chapter 13 for further details).

11.5 What information and training is required?

In relation to sections 12IC, 12ID and 12IL:

- dependent on an individual's role, and their knowledge and skills, training requirements should be identified through existing Personal Development Plan (PDP) and job planning / appraisal processes;
- training in this section will apply to non-clinical staff as well as clinical staff, where their role requires involvement in decisions relating to staffing and / or risk escalation;
- training required for section 12IL will be dependent on the individual's involvement in the use of the common staffing method;

- National learning resources are available to support training (Health and care staffing in Scotland : a knowledge and skills framework);
- A range of training methods could be used, which might include but not be restricted to:
    - Being informed of the process and protocols;
    - Written briefings/newsletters;
    - Briefing sessions;
    - Formal training sessions; and
    - Informal training, e.g. work shadowing and observing practice.

The duty to train relevant staff is not time limited. As such, a rolling programme of training, including refresher training, will be required to keep both existing and new staff up to date. Levels of knowledge and skill required by any individual member of staff may move between informed, skilled, advanced and expert depending on their role at any given point in their career.

In relation to section 12II:

- This will be dependent on individual circumstances but should include training to ensure employees can continue to discharge the role for which they are employed.
- Training requirements will form part of the PDP and appraisal processes.
- Training offered will be informed and prioritised using existing local education and training plans and existing regulatory professional requirements.
- When individual members of staff are released for training should be considered in the context of the ability to maintain services, existing contractual arrangements and staffing models. For example, the ability or inability to release multiple staff for training at the same time.
- Staff must be afforded adequate time and resources to undertake appropriate and relevant training.

Section 12IC duty to have real-time staffing assessment in place requires relevant organisations to have a procedure for the identification, by any member of staff, of

any risks caused by staffing levels to the health, wellbeing and safety of patients, the provision of safe and high-quality health care or, in so far as it affects either of those matters, the wellbeing of staff. If an inability to meet the requirements for provision of training for an employee(s) is considered a risk, then this procedure for risk identification should be followed and, where appropriate, procedures to escalate the risk under section 12ID and procedures under section 12IE (duty to have arrangements to address severe and recurrent risks).

11.6 How does a relevant organisation evidence compliance?

The relevant organisation should set out:

- a training strategy and governance structure that meets the requirements in the Act,
- Personal development activity report which identifies if planned training plans have been achieved; and
- Record of training activity in relation to the Act.

11.7 Other relevant guidance and legislation

Note that this statutory guidance relates to staff training and engagement requirements under the Act. It does not replace any other requirements or guidance regarding education and training for the health and social care workforce.

12. Common Staffing Method

12.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections of the 1978 Act, each of which are inserted by section 4 of the Act:

- section 12IJ: Duty to follow the common staffing method (referred to in the text as the "section 12IJ duty");
- section 12IK: Common staffing method: types of health care; and
- section 12IL: Training and consultation of staff.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

12.2 Who does this chapter apply to?

The following organisations must comply with the duties contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'),
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospital Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

12.3 In what settings and to which staff does this chapter apply?

Unlike other sections of the Act, the sections regarding use of the CSM **only apply** to the types of health care provided at the locations and by the kinds of employees listed in section 12IK. Relevant organisations **must** apply the CSM where they operate health care services described in 12IK and are required to report on this internally in (as a minimum) quarterly reports under section 12IF Duty to seek clinical advice on staffing and in their annual reports to the Scottish Ministers under section 12IM Reporting on staffing. The types of health care, locations and employees stated in 12IK align with the current availability of a speciality-specific staffing level tool

since the use of such a tool is an integral part of the CSM. It is noted, however, that for those types of health care, locations and employees that are not currently listed in section 12IK, and therefore are not required to apply the CSM, relevant organisations will still have to ensure appropriate levels of staffing in order to comply with the section 12IA duty.

The Act allows the Scottish Ministers to amend the list in section 12IK to add, remove or change the description of a type of health care, the location where it is provided and the kind of employees who provide it, thereby adding, removing or changing those services required to apply the CSM. It is currently the intention that services covered by the CSM will be expanded in the future, as more staffing level tools are developed. However, any amendments to section 12IK of the Act will require secondary legislation to be enacted and until this happens, application of the CSM to services other than those listed in section 12IK is not mandatory. It is therefore possible that a service may have developed, and be using, a speciality-specific staffing level tool but would not be required to apply the CSM.

For those types of health care, locations and employees that are not currently listed in section 12IK, and therefore are not required by the Act to apply the CSM, the various components of the CSM may still be useful in planning appropriate staffing. There is no reason why the various aspects of the CSM cannot be used in any health care service where deemed beneficial. For example, a service may not have a speciality-specific staffing level tool available but may still find it useful to use the professional judgement tool, consider measures of quality, local context and current and funded staffing, along with comments made by patients and staff, when determining appropriate staffing. For the avoidance of doubt however, use of the CSM outside the services listed in section 12IK is not mandatory and will not be reported on in annual reports to the Scottish Ministers under section 12IM (Reporting on staffing).

The types of employees covered by the CSM in section 12IK includes all grades / bands and it is important to note that the Act makes it clear that in the application of the CSM, references to registered nurses, midwives and medical practitioners include other individuals providing care for patients and acting under their

supervision or discharging duties delegated by them. This means health care support staff who support delivery of the types of services covered by the CSM are included in the requirements.

Individuals who are engaged in a course of studies in order to be admitted to the register of members maintained by the Nursing and Midwifery Council under section 60 of the Health Act 1999 or the register of medical practitioners maintained by the General Medical Council under section 2 of the Medical Act 1983 (with the exception of persons who are already provisionally registered under section 15 of that Act) are specifically excluded from the “employees” listed in 12IK. This means that these excluded groups must be supernumerary to the number of staff required to deliver care. Students are in clinical areas in a learning capacity, not to support the delivery of the service and may in fact add to the workload of staff who are directly involved in their supervision and learning. This exclusion does not extend to positions such as apprentices and ‘earn and learn’ models.

Accountability for all the duties covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

12.4 What is this chapter about?

This chapter is about the use of the CSM to help determine what changes (if any) are needed to the “staffing establishment” and / or the way in which a particular type of health care / location provides its services.

The purpose of the CSM is to ensure a consistent approach to decision-making across NHS Scotland which:

- uses all available evidence within the context in which the service is being delivered;
- ensures that clinical advice is sought and had regard to; and
- ensures that any risk associated with staffing is identified and mitigated as far as possible when determining staffing requirements, with a clear

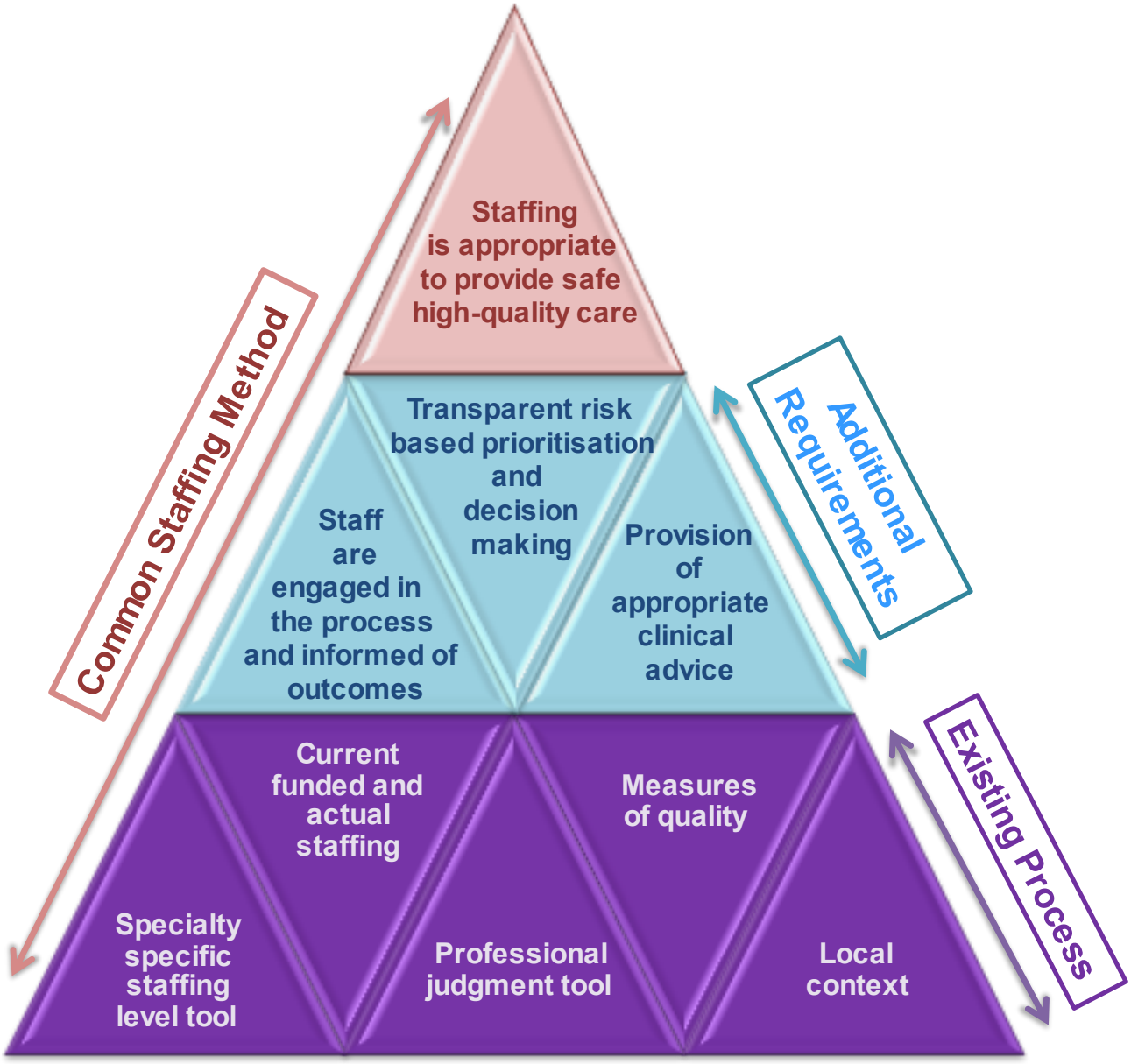
escalation process in line with the section 12ID Duty to have risk escalation process in place.

The use of staffing level and professional judgement tools is a key component of the CSM. The appropriate tools to use and the frequency at which the CSM should be used in relevant areas are defined in Regulations.

12.5 What is the common staffing method?

The CSM is illustrated in figure 1 below:

Figure 1: the common staffing method



The CSM sets out a process, including the use of speciality-specific staffing level and professional judgement tools and a range of other considerations, which must be applied rigorously and consistently. The application of the CSM will support relevant organisations to ensure appropriate staffing for the health, wellbeing and safety of patients and the provision of safe and high-quality care. It will form part of the evidence that relevant organisations submit to demonstrate how they have complied with the Act. Section 12IK lists each type of health care that is covered by the CSM. For each type of health care covered, the Act specifies for which employees and in which locations the CSM must be used.

The CSM is composed of a number of parts that should be used together to make staffing decisions. Staff at all levels should be engaged in the CSM and there should be a culture of decision-making based on a shared understanding of the workload and the need to balance quality of care, staffing, and other resource considerations. As with all parts of the Act, the CSM needs to be applied alongside the guiding principles and the section 12IA Duty to ensure appropriate staffing.

12.6 Do I have to use the common staffing method?

Section 12IK of the Act lays out in table format the types of health care, the locations and the employees for which the CSM must be applied. The CSM should be applied in each setting that falls within the definitions in this table. As explained earlier in this chapter, the CSM can be used in types of health care, locations and employees not listed in the table in section 12IK but this is not mandatory.

12.7 How do I use the common staffing method?

The CSM is a five-part process which needs to be followed when making decisions about staffing in each of the types of health care that are covered by the CSM:

- the relevant speciality-specific staffing level and professional judgement tools need to be used by the relevant organisation and the results taken into account;
- any measures for monitoring and improving care which are published by the Scottish Ministers as standards and outcomes need to be taken into account, so far as relevant;
- the range of factors listed in the Act need to be considered, namely:
    - current staffing levels and vacancies;
    - different skills and levels of experience of employees;
    - role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care;
    - effect that decisions about staffing and the use of resources taken may have on the provision of other types of health care including, in particular, those to which the CSM does not apply;
    - local context;

        - patient needs;
        - appropriate clinical advice;
        - any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides;
        - experience gained from using the real-time assessment arrangements under section 12IC and the risk escalation processes under sections 12ID and 12IE;
        - comments by patients, and individuals who have a personal interest in their health care which relate to the duty imposed by section 12IA; and
        - comments by employees which relate to the duty imposed by section 12IA.
    - risks must be identified and all reasonable steps taken to mitigate against them taken; and
    - the relevant organisation needs to decide what changes, if any, are needed to its "staffing establishment", and the way in which it provides care.

For each type of health care covered, the Act specifies for which employees in which locations the CSM must be used. The CSM must be used in each individual clinical ward or team within that type of health care, for example for Adult Inpatient Provision, in relation to nursing workload, it would be run separately in every adult inpatient ward which has 17 or more occupied beds on average. In a community setting it would be run in each separate team.

12.8 Staffing level and professional judgement tools

The first step of the CSM is the application of the relevant speciality-specific staffing level tool. A staffing level tool requires individuals to input certain information about the location in which it is being used, such as a ward or a community service. The tool then outputs quantitative information about staffing, to assist in determining appropriate staffing levels.

A professional judgement tool requires individuals to assess staffing requirements based on their professional opinion of the current workload and the local context. Again, the tool outputs quantitative information about staffing, to assist in

determining appropriate staffing levels. The outputs of the two types of tools should be compared with each other and any differences considered, along with the other parts of the CSM.

Details of the tools that must be used for the specific type of health care, location, and employees can be found in these Regulations {link will be added to final guidance once Regulations enacted}. These tools have been designed and tested with the specific setting in mind and should not be used outside these designated settings.

Tools should be applied in accordance with the appropriate user guide. Relevant organisations may also have their own procedures which should be followed as appropriate.

12.9 Measures for monitoring and improving the quality of care

Relevant quality measures published as standards and outcomes by the Scottish Ministers under section 10H of the 1978 Act must be considered, such as the Health and Social Care Standards.. This provides an overview of the quality of care being provided, and allows exploration of whether current staffing levels are a factor in this. Alongside these measures, organisations may also have their own internal measures of quality which they may wish to also consider.

Following the use of the speciality-specific staffing level and professional judgement tools and the consideration of quality measures, the Act then goes on to list a number of factors (listed in 12.7 of this chapter) that also need to be taken into account when determining the “staffing establishment” and the way it which it provides health care. These are further considered below.

12.10 Current staffing levels and any vacancies

Current staffing levels in that type of health care and any vacancies that exist need to be taken into account, along with any impact this has on quality of care. Associated risks should be assessed and mitigating actions identified. This may include, but not necessarily be limited to, assessment of rosters/rotas, absence

(including the use of Predicted Absence Allowance – PAA – as applicable), vacancy and supplementary staffing levels.

12.11 Skills and level of experience of employees

Skill mix and the level of knowledge and experience of staff needs to be taken into account, and any impact this has on quality of care needs to be considered; with any associated risks and mitigating factors identified.

12.12 Role and duties of individuals with lead clinical professional responsibility

As part of the CSM process, the role and professional duties of individuals with lead clinical professional responsibility for a type of health care covered by the CSM must be considered when determining staffing levels. More detail is provided about this in chapter 10. Currently, no staffing level or professional judgement tool automatically takes into account the time required for clinical leaders to undertake their leadership role, so it is important that this is factored in.

12.13 Effects of decisions on other areas of health care

The CSM is only required to be used in relation to the types of health care, locations and employees listed in section 12IK of the Act. Nevertheless, it is important to remember that other types of health care, locations and employees still need to be considered, as they may be impacted by decisions made in the types of health care covered by the CSM.

Those services required to use the CSM must consider the effect that decisions taken about staffing in that particular area may have on other areas, particularly those areas who are not required to use the CSM. An example may be where a decision to increase or decrease the nursing establishment having followed the CSM could have a direct impact on staffing requirements in AHP or medical provision in a type of health care not covered by the CSM.

Although not required under the Act it could be beneficial to consider the converse situation, i.e. the effects changes made in other services would have on the service using the CSM. This may require an increase or decrease in staffing dependent on

the situation. Some examples where this may apply are listed below (this is not an exhaustive list):

- changes to allied health profession support in a clinical area;
- changes to support services e.g. administration support or portering services in a clinical area;
- changes to medical support in a clinical area; or
- changes in access to multi-agency support e.g. social workers, child protection services.

12.14 Local context

The local context in which the type of health care is being delivered can also have an impact on staffing requirements and it is therefore important this is considered as part of the CSM. The calculators behind the staffing level and professional judgement tools are based on a range of service delivery models and are flexible enough to be adapted to most situations. Therefore the factors which should be considered are those where there is something distinct in that clinical area that differs from the majority of areas providing a similar service. Examples of situations where the local context will be important include, but are not restricted to:

- very remote and rural areas;
- the clinical environment e.g. single rooms;
- significantly different service models;
- additional clinical activity e.g. clinics in ward environments;
- hub and spoke models of care e.g. satellite units; and
- demographic factors, e.g. areas of deprivation and marginalised groups.

12.15 Patient need

Patient need, beyond what has already been considered as part of the staffing level and professional judgement tools, must also be considered. No two service users are the same and the outcomes that matter to a particular service user will vary. When using the CSM, consideration must be given to the service users themselves, rather than just their needs in isolation. Patient need in this context must include consideration of both current provision and unmet need.

12.16 Appropriate clinical advice

Relevant organisations must also ensure that appropriate clinical advice is sought as part of the CSM. Chapter 9 contains further guidance on this.

12.17 Quality assessments

The CSM requires relevant organisations to take into account any assessment by HIS (Healthcare Improvement Scotland), and any other relevant assessment, of the quality of care being provided in that type of health care. This means that the effect of staffing on the outcome of any HIS assessment of quality, or other relevant internal or external quality measures/assessment should also be considered when determining staffing requirements as part of the CSM. This may include, but is not restricted to, outcomes from any Healthcare Improvement scrutiny, specialty specific national measures of quality or audits.

12.18 Experience gained from real-time staffing assessment and risk escalation

Any trends or issues identified as part of the section 12IC Duty to have real-time staffing assessment in place, section 12ID Duty to have risk escalation process in place and section 12IE Duty to have arrangements to address severe and recurrent risks under the Act should also be considered when determining staffing requirements as part of the CSM. For example, if a particular clinical area has regularly identified a staffing shortfall during real-time assessment, further exploration is required to identify the root cause and to ensure a sustainable solution is sought as part of decisions made following use of the CSM.

12.19 Feedback from service users

Any feedback from patients, service users, their families or carers regarding the provision of safe, high quality health care should be considered. It will be important that processes are in place to ensure that this information is collated consistently across the organisation. In practice this will mean that where comment has been made and investigation has revealed there is a correlation with staffing levels and skills, this must be considered when decisions are made following use of the CSM.

12.20 Staff engagement

Any comments made by staff regarding whether there is appropriate staffing should be taken into account. It is important there are processes in place to ensure this information is collated consistently across the organisation. In practice this will mean that where comment has been made and trends are identified there is a requirement for this to be considered when staffing decisions are made as part of the CSM.

These comments may be made by staff using existing opportunities, such as daily handovers, team huddles, adverse event reporting, or during team or individual meetings with line managers, senior managers or partnership organisations. Relevant organisations may feel it more appropriate for a dedicated forum or procedure to be established for staff to feel psychologically safe to provide comments about staffing levels / workload to inform the CSM. There must also be a mechanism for feedback to be provided to staff about the use of the CSM, and staffing decisions made as a result (see 12.25 of this chapter for further detail).

12.21 Identify and mitigate risks

Once all this information for an individual area has been gathered it is important that each of the factors is considered so that there is a detailed understanding of what the staffing requirement is and how that relates to the current staffing levels. Having gained this understanding the Act then goes on to describe the steps that should be taken using this information.

There is a requirement to identify any risks that exist with the current staffing levels and to put in place all “reasonable steps” to mitigate these risks. It may be that risks have been identified, but they are of an acceptable level or nature that they can be managed locally and no action is required. A risk may also be mitigated in a number of ways, dependent on the level of risk. For example, issues with staffing may be mitigated by proactively reducing clinical activity within an area, but could also be mitigated by providing additional administrative support to clinical staff, or increasing the levels of relevant clinical staff. If after taking mitigating action the level of risk is still not at an acceptable level, then consideration of this risk would be escalated in line with the relevant organisation’s processes under the section 12ID Duty to have

risk escalation process in place and the section 12IE Duty to have arrangements to address severe and recurrent risks.

Relevant organisations should ensure they have a risk assessment process so that across all types of health care covered by the CSM there is a consistent approach to mitigation and escalation of risk. In addition, subsequently there should be a consistent approach to prioritisation of any changes to staffing required across the organisation.

12.22 Decide what changes are needed

Once these steps have been completed, an evaluation is required to consider whether changes to “staffing establishments”, or the way in which that type of health care is provided are required. It is important that the impact on staffing requirements of each aspect of the steps is considered and any differences, for example in output from the speciality-specific staffing level tool, the professional judgement tool and feedback, are investigated to enable a detailed understanding of the staffing requirement and how that relates to current staffing levels. The short-term aim is for risks to be mitigated, and, on the longer term, for relevant organisations to consider service redesign or to staffing, to ensure staffing levels are appropriate and sustainable.

The CSM is required to be followed in each setting in the type of health care to which this Act applies, for example a ward or a community team. It is important that each relevant organisation to which this duty applies has a consistent process to ensure that every setting providing health care of a type covered by the CSM applies the CSM at minimum at the frequency defined in Regulations {a link will be added to the Regulations once they have approved by Parliament}, and that the outputs, including decisions about service redesign, are considered on an organisational basis

Following the use of the CSM in each setting in which it applies, relevant organisations should use existing governance processes to make staffing decisions and implement changes as determined by the use of the CSM.

12.23 Frequency of application of the common staffing method

The Act provides for Regulations {a link will be added to the Regulations will be added once they have been approved by Parliament] to determine the minimum frequency with which the CSM should be used and relevant organisations must adhere to this. This can differ for different types of health care and can be altered over time. Frequency of application will also be determined for any new type of health care covered by the CSM in the future (i.e. those added to the table in section 12IK of the Act). It should be noted that this is a minimum frequency and good practice would dictate that the CSM should be run more frequently in certain circumstances. It should also be noted that regardless of the frequency of the application of the CSM, a real-time staffing assessment, risk escalation process and process to address severe and recurrent risks still needs to exist and be applied on an ongoing basis.

Circumstances in which the CSM could be run more frequently include but are not limited to:

- following service redesign;
- significant policy change in the type of health care;
- reduction in quality of care being provided identified through analysis of quality outcome indicators, including patient and staff feedback;
- where there has been a significant change in client group being cared for in that type of health care;
- where, in the professional judgement of the clinical leader there has been a change to workload impacting on staffing requirements; or
- where a risk has been escalated in an area to which the CSM applies or a severe or recurrent risk has been identified.

In some types of health care and / or locations, workload tools outside those required to be used for the CSM may be used and / or measures of patient acuity/dependency assessed and recorded. This may provide information on staffing requirements, the usual purpose of which is to assess requirements in real-time. This is not sufficient to meet the requirements of the CSM as it does not take all the

information described in the method into account when planning staffing requirements, for example taking into account assessment of quality, comments from employees or the local context in which the service is being delivered. An example of this would be a workload tool which is applied daily and provides information in real-time; in this case the entire CSM including all other aspects, should still be applied at the frequency provided for by the Regulations as a minimum.

Relevant organisations are expected to have a clear timeline for running the CSM in all areas required at the minimum frequency required.

12.24 Who should apply the common staffing method?

Legal responsibility for applying the CSM sits with the relevant organisation. In practice, it is expected that the relevant clinical team leaders will be responsible for applying the CSM in their clinical area. The clinical team leader must then be supported through time and resources to assess the output from the tools and all other data and aspects associated with the CSM. Decisions on staffing establishments will then be made by the appropriate decision-makers in the organisation, having followed the section 12IF Duty to seek clinical advice on staffing prior to making those decisions.

The relevant organisation must ensure that staff involved in the application of the CSM have the necessary and sufficient clinical expertise and knowledge of the process to properly assess and analyse the outcomes in order to identify staffing requirements. For the current types of health care covered by the CSM, which are primarily nursing and midwifery settings, this is likely to be the Senior Charge Nurse/Midwife or a more senior Nurse/Midwife, supported via the organisation's managerial and professional structures.

It is important that the team is fully engaged in the running of the CSM and the output and decisions made as a result are discussed with them.

The CSM will be run across a large number of locations and teams. The information should be collated in a consistent manner across the organisation and taken into consideration, alongside existing governance processes, when staffing decisions are

made at board level. The information should form the basis of staffing decisions at all levels of the organisation, for the types of health care covered by the CSM.

12.25 Training and consultation of staff

Section 12IL of the 1978 Act places an additional responsibility on relevant organisations to encourage and support employees to give views on staffing arrangements, for the types of health care covered by the CSM, and to take account of and use such views. This will enable identification of areas of best practice and areas for improvement in staffing arrangements in areas where the CSM applies. In practice this will mean that a process will need to be in place for staff to provide their views on staffing, for any areas of good practice to be shared across the organisation, any challenges identified, and for this information to feed in to decisions made as a result of applying the CSM. This process should make links to existing governance, professional and partnership structures.

This requirement should be read in conjunction with existing responsibilities on the training and consultation of staff, most significantly the Staff Governance Standard — NHS Scotland Staff Governance. Relevant organisations are already responsible for the implementation of the Staff Governance Standard at a local level. As such this existing requirement requires that staff are well informed, appropriately trained and developed and involved in decisions that affect them.

Staff who are using the CSM must be trained in its use. This training requirement covers all the staff involved in applying the CSM, including those who apply the staffing level and professional judgement tools and individuals who may be providing clinical advice. The training required will be dependent on the level of involvement in the process and current knowledge and understanding.

Staff must also receive adequate time to use the CSM process when determining staffing requirements. Again, this applies to all employees who are involved in its application, including those identifying and mitigating risks and those making staffing decisions. It is likely that the individual running the staffing level and professional judgement tools will require the most time.

User guides are available for application of the staffing level and professional judgement tools at Staffing (workload) tools and methodology. In addition, an educational resource toolkit is provided by Healthcare Improvement Scotland as a training resource for staff at Health and Care Staffing in Scotland | Turas | Learn. Healthcare Staffing Programme staff at Healthcare Improvement Scotland are also available to provide organisations with support and advice on complying with the requirements in the Act.

Relevant organisations will also be required to provide information to staff working in areas where the CSM applies about how the method has been used in the area. This includes the results from using the staffing level and professional judgement tools, the other factors taken into account, and what decisions have been made as a result. As required by the Staff Governance Standard, staff should be engaged and involved in decision-making which affects them. There must be a mechanism for accessible and timely feedback to be provided to staff about the use of the CSM, and staffing decisions made as a result.

In practice, relevant organisations need to ensure that they have governance processes in place which follow the Staff Governance Standard and which therefore will contribute to:

- application of the CSM in all areas where it applies at the minimum frequency determined in Regulations;
- provision of appropriate clinical advice at all levels of decision-making (this will include at board level);
- identification, mitigation and escalation of risk on an organisation-wide basis;
- identification of redesign opportunities;
- internal reporting and risk assessment processes; and
- appropriate staff engagement, training and communication.

12.26 How does a relevant organisation evidence compliance?

Like the other duties contained in this Act, the provisions of the CSM are about ensuring safe and high-quality care. While ensuring the right processes are in place

is important, the main purpose of these processes is to ensure appropriate staffing and that should be the focus.

In meeting the CSM, the relevant organisation needs to set out:

- the arrangements it has for ensuring the CSM is used in all clinical areas (individual wards or teams) to which it applies;
- the governance arrangements it has for deciding on staffing levels required as a result of applying the CSM, including provision of appropriate clinical advice;
- the arrangements it has in place for the identification and reporting of risk, mitigation, and escalation relating to staffing requirements as a result of applying the CSM;
- the arrangements it has in place for seeking staff views and feeding back to staff about decisions made as a result of applying the CSM; and
- the arrangements for ensuring staff have appropriate time and training to apply the CSM.

12.27 Other relevant guidance and legislation

Carers (Scotland) Act 2016 (legislation.gov.uk)
Staff Governance Standard — NHS Scotland Staff Governance
Healthcare quality strategy for NHSScotland - gov.scot (www.gov.scot)
Clinical and care governance framework: guidance - gov.scot (www.gov.scot)
Excellence in Care (healthcareimprovementscotland.org)
Standards - The Nursing and Midwifery Council (nmc.org.uk)
Ethical guidance - GMC (gmc-uk.org)
Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project - gov.scot (www.gov.scot)
Quality improvement | NHS Education for Scotland
CEL 32 (2011) - Revised workforce planning guidance 2011 (scot.nhs.uk)

13. Reporting in Health

13.1 Which sections of the Act is this chapter about?

This chapter provides further detail on:

- section 2 of the Act: Guiding principles etc. in health care staffing and planning; and
- section 12IM of the 1978 Act (as inserted by section 4 of the 2019 Act): Reporting on staffing.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

Section 12IB, Duty to ensure appropriate staffing: agency workers, requires quarterly reporting on high-cost use of agency workers. These quarterly reports are not covered under this chapter; guidance for these reports can be found in chapter 7.

Section 12IF, Duty to seek clinical advice on staffing, requires those with lead clinical professional responsibility for a particular type of health care to report at least quarterly to members of the Board of their relevant organisation. These reports are not covered under this chapter; guidance for these reports can be found in chapter 9.

13.2 Who does this chapter apply to?

The following organisations must comply with the requirements contained in this chapter:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

13.3 In what settings and to which staff does this chapter apply?

Reporting requirements contained in these sections apply to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act), with the exception of reporting related to sections 12IJ and 12IL in relation to the common staffing method. These only apply to the types of health care, locations and employees listed in section 12IK of the Act.

Accountability for all the requirements covered in this chapter remains with the relevant organisation and not with individuals who may be charged with carrying out certain actions.

13.4 What is this chapter about?

Section 12IM of the 1978 Act requires relevant organisations to publish and submit an annual report to the Scottish Ministers detailing how it has carried out its duties under the following sections of the 1978 Act:

- 12IA Duty to ensure appropriate staffing (including how the relevant organisation has had regard to the guiding principles in section 2 of the Act);
- 12IC Duty to have real-time staffing assessment in place;
- 12ID Duty to have risk escalation process in place;
- 12IE Duty to have arrangements to address severe and recurrent risks;
- 12IF Duty to seek clinical advice on staffing;
- 12IH Duty to ensure adequate time given to clinical leaders;
- 12II Duty to ensure appropriate staffing: training of staff; and
- 12IJ and 12IL Duty to follow the common staffing method, including training and consultation of staff.

This annual report also includes details of any challenges or risk that relevant organisations have faced in carrying out certain duties under the Act and the steps they are taking / will take in addressing these.

Section 2(1) of the Act requires a relevant organisation to have regard to the guiding principles for health and care staffing when carrying out its duty under section 12IA of the 1978 Act (Duty to ensure appropriate staffing). Section 2(3) of the Act requires Health Boards / NHS National Services Scotland to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this requirement.

Section 2(2) of the Act requires Health Boards / NHS National Services Scotland, when planning or securing health care from a third party under the 1978 Act to consider both the guiding principles in section 1 of the Act and the need for the third party to have appropriate staffing arrangements in place (see chapter 5 for more detail on planning or securing health care from a third party). Section 2(3) of the Act requires Health Boards / NHS National Services Scotland to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this requirement.

Under section 2(5) of the Act, the Scottish Ministers are required to collate information received in these reports about the planning and securing health care from third parties into a combined report and lay this before Parliament. This combined report must include information as to how relevant organisations have complied with the requirements regarding planning and securing health care from third parties, along with the steps the Scottish Ministers will take in response regarding staffing of the health service.

All of the annual reporting requirements of relevant organisations under the Act will be incorporated within one report (referred to here as the “annual reporting requirement”).

The purpose of the annual reporting requirement is to:

- enable monitoring of the impact of the legislation on quality of care and staff wellbeing;
- identify areas of good practice that can be shared;

- Identify challenges relevant organisations are facing in meeting requirements in the Act and what steps they have taken / are taking to address these;
- identify any improvement support required; and
- inform Scottish Government policy on workforce planning and staffing in the health service, alongside other sources of information and data.

Following receipt of these annual reports from relevant organisations, under both section 2 of the Act and section 12IM of the 1978 Act, there are various requirements placed on Scottish Ministers regarding laying these reports before Parliament, along with certain other information.

13.5 What will the format of the report be?

To promote consistent reporting across relevant organisations, the Scottish Government will provide a report template. This template will contain guidance on completion and details of how to submit.

13.6 What are the timescales for reporting?

The annual report will cover the financial year, i.e. the period from 01 April to 31 March. The report must be published and submitted to the Scottish Ministers by the 30 April following the end of the financial year.

13.7 Who should be included in the report?

Each relevant organisation should submit one annual report to cover all NHS functions that it exercises and professional disciplines involved.

13.8 Where does the report have to be published?

The Act states that the annual report required by section 12IM must be published as well as being submitted to the Scottish Ministers. The most appropriate means to achieve this should be decided by the relevant organisation but it is envisaged this would comprise using existing methods used to publish other reports.

14. Role Of Healthcare Improvement Scotland (HIS)

14.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections of the 1978 Act, each of which is inserted by section 6 of the Act:

- section 12IP: HIS: monitoring compliance with staffing duties (referred to here as the "section 12IP duty");
- section 12IQ: HIS: monitoring and review of common staffing method (referred to here as the "section 12IQ duty");
- section 12IR: HIS: monitoring and development of staffing tools (referred to here as the "section 12IR duty");
- section 12IS: HIS: duty to consider multi-disciplinary staffing tools (referred to here as the "section 12IS duty");
- section 12IT: HIS: duty on Health Boards to assist staffing functions (referred to here as the "section 12IT duty");
- section 12IU: HIS: power to require information; and
- section 12IV: HIS: ministerial guidance on staffing functions.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

14.2 Who does this chapter apply to?

Sections 12IP, 12IQ, 12IR, 12IS and 12IU apply to HIS.

Sections 12IT and 12IU place requirements on the following organisations:

- All geographical Health Boards;
- NHS National Services Scotland (referred to in the Act as the 'Agency'); and
- Special Health Boards who deliver direct patient care, i.e., NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board.

These are referred to as "relevant organisations" in this chapter.

14.3 In what settings and to which staff does this chapter apply?

Reporting duties contained in these sections apply to all NHS functions provided by all professional disciplines (chapter 3, introduction provides more details on professional disciplines covered by the Act). They are not limited to the types of health care listed in the Act in relation to section 12IJ Duty to follow the common staffing method.

Accountability for all the duties and requirements covered in this chapter remains with HIS and, where appropriate, the relevant organisations and not with individuals who may be charged with carrying out certain actions.

14.4 What is this chapter about?

The purpose of HIS's function in relation to the Act is to provide assurance to the Scottish Ministers that relevant organisations are complying with the duties required by the Act. This will enable areas of good practice and constructive areas of learning from events to be identified and shared, and for appropriate improvement support to be provided.

In addition to this assurance function, HIS also has requirements under the Act to monitor and review the common staffing method and monitor and develop staffing level and professional judgement tools, including considering whether these tools should be multi-disciplinary. This is to ensure that such a method and tools remain contemporary and fit for practice.

The intention of the duty on relevant organisations to assist HIS in its staffing functions (section 12IT) and the power for HIS to require information from relevant organisations (section 12IU) are to ensure that HIS has appropriate information in order to fulfil its requirements under the Act.

14.5 12IP HIS: monitoring compliance with staffing duties

HIS is required to monitor how relevant organisations have discharged staffing duties required of them under the 1978 Act. These are:

- section 12IA Duty to ensure appropriate staffing, including related duties under section 2 guiding principles;
- section 12IC Duty to have real-time staffing assessment in place;
- section 12ID Duty to have risk escalation process in place;
- section 12IE Duty to have arrangements to address severe and recurrent risks;
- section 12IF Duty to seek clinical advice on staffing;
- section 12IH Duty to ensure adequate time given to clinical leaders;
- section 12II Duty to ensure appropriate staffing: training of staff;
- section 12IJ Duty to follow the common staffing method;
- section 12IL Training and consultation of staff;
- section 12IM Reporting on staffing; and
- section 12IN Ministerial guidance on staffing.

By monitoring relevant organisations' compliance with the Act, HIS will identify areas of good practice, shared learning and improvement support.

The approach to monitoring compliance will be consistent with HIS's organisational approach to quality assurance but must include all aspects of the Act described above and HIS must take into account aspects of this statutory guidance relating to the operation of sections 12IP to 12IU.

In order to monitor compliance by relevant organisations, HIS will need to consider the extent to which these organisations have taken into account relevant measures for monitoring and improving quality of health care. These measures are those published as standards and outcomes by Scottish Ministers (including any measures developed as part of a national care assurance framework).

It is intended that review by HIS of relevant organisations' compliance with the Act, as part of their scrutiny function, will provide additional information to that provided by the organisations in their annual reports. This additional information may inform decisions by Scottish Ministers regarding any intervention required or any decisions relating to policy in health care staffing. It may also provide intelligence that will be useful for HIS in deciding if it may be necessary to review existing, or develop new, staffing level tools, amend the professional judgement tool or the common staffing method.

14.6 12IQ HIS: monitoring and review of common staffing method

HIS is required to monitor, in respect of each type of health care listed in section 12IK, the effectiveness of the common staffing method process described in section 12IJ(2) of the Act and the way in which relevant organisations are using it.

Scottish Ministers can direct HIS to carry out a review of the common staffing method, however in practice it is anticipated that HIS will decide the frequency by which it undertakes a review. The requirement for a review will be considered by assessing the way in which relevant organisations apply the common staffing method; the appropriateness of application of the method for the specified areas of health care, location and employees; and analysing intelligence about decisions being made as a result of application of the method.

When undertaking a review of the common staffing method, HIS must work together with:

- Scottish Ministers;
- Social Care and Social Work Improvement Scotland (the Care Inspectorate);
- every Health Board;
- every relevant Special Health Board;
- every Integration Authority;
- NHS National Services Scotland;
- trade unions and professional bodies that HIS considers to be representative of employees of Health Boards, Special Health Boards, Integration Authorities and NHS National Services Scotland;

- professional regulatory bodies for employees of Health Boards, Special Health Boards, Integration Authorities and NHS NSS that HIS considers appropriate;
- any other providers of health care as HIS considers to have relevant experience of using staffing level and professional judgement tools; and
- any other group or person HIS considers appropriate.

The intention of stakeholder consultation and feedback is to ensure the common staffing method remains contemporary and that it can work in practice across diverse practice settings and staff groups.

In undertaking a review of the common staffing method, HIS must have regard to how the method aligns with the guiding principles for health and care staffing set out in section 1 of the Act. The intention of this is to ensure that the common staffing method supports relevant organisations to fulfil their requirements to ensure appropriate staffing as defined in the Act. In recommending changes, HIS may take into account the revision of existing, or development of new, staffing level or professional judgement tools.

Having completed a review of the common staffing method, HIS may recommend changes to the common staffing method to Scottish Ministers. To do this it must submit a report to Scottish Ministers which includes a summary of the review it has carried out, recommendations for changes, and reasons for these.

Having submitted this report to Scottish Ministers, HIS must then publish it. The purpose of this process is to ensure any review of the common staffing method is comprehensive, inclusive, and transparent, and to assure Scottish Ministers that the common staffing method is contemporary and fit for purpose.

14.7 12IR HIS: monitoring and development of staffing tools

HIS is required to monitor the effectiveness of any staffing level and professional judgement tools prescribed by the Scottish Ministers. Where it is considered that any staffing level or professional judgement tool is no longer effective, HIS must recommend the revocation or replacement of the tool. The purpose of this is to ensure that tools remain contemporary and can reliably inform staffing requirements across diverse practice settings and staff groups.

The frequency of monitoring effectiveness of the tools will be determined by HIS, using intelligence from relevant organisations' experience of using the tools, analysis of tool outputs, and significant policy or practice change in the specialty to which the tool applies. In practice, HIS will routinely review and refresh staffing level and professional judgement tools on a cyclical basis to ensure they remain contemporary and function effectively.

HIS may also develop and recommend to Scottish Ministers new or revised staffing level tools or professional judgement tools for use in relation to any kind of health care provision.

When developing new, or revising existing tools, HIS must work together with:

- Scottish Ministers;
- Social Care and Social Work Improvement Scotland (the Care Inspectorate);
- every Health Board;
- every relevant Special Health Board;
- every Integration Authority;
- NHS National Services Scotland;
- relevant trade unions and professional bodies that HIS considers to be representative of employees of Health Boards, Special Health Boards, Integration Authorities and NHS National Services Scotland;
- Such professional regulatory bodies for employees of Health Boards, Special Health Boards, Integration Authorities and NHS National Services Scotland as HIS considers appropriate;

- any other providers of health care as HIS considers to have relevant experience of using staffing level and professional judgement tools; and
- any other group or person HIS considers appropriate.

The intention of this requirement is to ensure there is appropriate stakeholder engagement, across the relevant sectors, which will in turn ensure tools are contemporary and work across diverse practice settings and staff groups.

In undertaking the collaboration described above, HIS must have regard to such guidance as HIS considers appropriate, published by relevant professional bodies or other relevant bodies, relevant clinical evidence and research, and the guiding principles for health and care staffing set out in section 1 of the Act. The intention of this is to ensure that staffing level and professional judgement tools remain contemporary and appropriate for professional practice, and that they also support relevant organisations to fulfil their requirements to ensure appropriate staffing under the Act.

Scottish Ministers can also direct HIS to develop a new, or to revise an existing, staffing level tool or professional judgement tool. In this case the same process of collaboration described above must be followed. The purpose of this is to ensure that Ministers can prioritise development in line with Scottish Government requirements.

Scottish Ministers may also require that assumptions on certain matters must be made by HIS in making recommendations about the development of new, or revision of existing, tools. The purpose of this is to ensure that such tools take account of staff national policy. An example of such an assumption may be to apply particular predictable absence rates or average bed occupancy levels.

14.8 12IS HIS: duty to consider multi-disciplinary staffing tools

When developing a new or revised staffing level or professional judgment tool, HIS is required to consider whether the tool should apply to more than one professional discipline. The intention of this being to ensure that, where appropriate, the workload of all staff groups providing care in a specialty area is considered for inclusion in the review of existing, or development of new, tools.

Having considered inclusion of additional staff groups in the review of existing, or development of new, tools, HIS can recommend to Scottish Ministers that a staffing level or professional judgement tool should apply to more than one professional discipline. The intention is to ensure that, where appropriate, future tools will be multi-disciplinary in nature. In cases where staffing groups are not included in revision or development of tools, there should be a clearly stated rationale for this.

14.9 12IT HIS: duty on Health Boards to assist staffing functions

Every Health Board, relevant Special Health Board, and NHS National Services Scotland must give such assistance to HIS as it requires to perform its functions under sections 12IP to 12IS the 1978 Act.

14.10 12IU HIS: power to require information

HIS may serve a notice on a relevant organisation to provide information to enable it to carry out its functions under sections 12IP to 12IS of the 1978 Act. This notice will be a written request and must explain why the information is required and for what function and state a date by which it must be provided. The relevant organisation must comply with any notice served on it.

The purpose of this is to ensure that HIS has all the necessary information available to fulfil its functions in sections 12IP to 12IS of the Act effectively, whilst ensuring the information requested is proportionate and relates specifically to fulfilment of HIS's staffing functions in the Act.

14.11 Other relevant guidance and legislation

Inspection and regulation of healthcare services (healthcareimprovementscotland.org)

15. Duty to Ensure Appropriate Staffing and Guiding Principles in Care Services

15.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections of the Act:

- section 1: Guiding principles for health and care staffing as these principles apply to staffing for care services);
- section 3: Guiding principles etc. in care service staffing and planning;
- section 7: Duty on care service providers to ensure appropriate staffing; and
- Part 3, section 8: Training of staff

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

Note that the duty under regulation 15 (staffing) of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 has now been repealed and replaced with the requirements of the Health and Care (Staffing) (Scotland) Act 2019 **{this will be done at the point the Act comes into force and this guidance is published}**. Whilst the requirements of regulation 15 and the Act are similar, they are not identical and, therefore, care service providers should make themselves aware of the requirements of the Act.

15.2 Who does this chapter apply to?

All those providing a care service listed in section 47(1) of the Public Services Reform (Scotland) Act 2010, (collectively referred to as “care service providers” in this guidance) must comply with the requirements contained in this chapter.

This chapter is also applicable to local authorities and integration authorities when planning or securing the provision of a care service from a third party.

15.3 In what settings and to which staff does this chapter apply?

Requirements contained in these sections apply to all functions provided by all individuals working in a care service (chapter 3, introduction provides more details on the types of individuals covered by the Act). Note that the definition of those working in a care service (which is found in section 11 of the Act) includes those working for payment or as a volunteer, and working under a contract of service, an apprenticeship, a contract for services or otherwise than under a contract. This is wide-ranging and would include, for example:

- employees of the care service;
- agency and other temporary / contract workers;
- self-employed workers;
- those on apprenticeship schemes and other 'earn as you learn' schemes who are employed by the care service; and
- all volunteers.

Any reference to "staff", "staffing" or "working in a care service" within this chapter includes all these groups of people.

Students should not be considered as "staff" and should be treated as supernumerary when they are participating in a supernumerary placement or are undertaking protected learning time as detailed within the relevant course outline or conditions of employment.

Accountability for all the requirements covered in this chapter remains with the care service provider and not with individuals who may be charged with carrying out certain actions.

15.4 What is this chapter about?

The section 7 duty on care service providers to ensure appropriate staffing is one of the two 'general' duties created by the Act. The other is the section 12IA duty to ensure appropriate staffing in health care. The section 7 duty to ensure appropriate staffing is to enable the provision of safe and high-quality services which meet the needs of people who use them, through having appropriate staffing, with the right person, with the right skills, available in the right place, at the right time to provide

care. The ‘general’ duty to ensure appropriate staffing must be carried out having regard to the guiding principles of the Act.

The guiding principles, alongside the duty to ensure appropriate staffing, underpin the outcomes that the Act is seeking to deliver. They explain what people using care services and those who work in them can expect; the requirements on care service providers; and actions required of those who are involved in making decisions about staffing. The guiding principles have been developed to ensure that decisions made in relation to staffing are aligned with wider health and social care policy.

The other requirement considered in this chapter is section 8 which covers the training of staff, comprising all individuals working in the care service.

15.5 What are the guiding principles in section 1 of the Act?

The Act states that the main purposes of staffing for health care and care services are:

- to provide safe and high-quality services; and
- to ensure the best health care or (as the case may be) care outcomes for people using services.

The Act then lists principles to be met, in so far as they are consistent with these main purposes, when care service providers are arranging appropriate staffing.

15.6 What is meant by “safe”?

When judging whether or not a service is “safe”, safe does not mean “no-risk”. Depending on the service, safe may not even mean low risk; risks are an inevitable part of all care services. Risk must be managed whilst still ensuring safety. In many services, for example where an enablement approach is taken, a level of risk is required and needs to be managed by both people using the service and staff to support people to achieve outcomes. Positive risks, as defined in the Health and Social Care Standards (paragraphs 2.24 and 2.25), mean making balanced decisions about risks and benefits, recognising that risks to safety are inevitable and can sometimes result in benefits.

However, the Act requires relevant organisations to have appropriate staffing in place to enable provision of safe and high-quality services, and so reduce risk to people using services. People using services should not be put at unnecessary risk as a result of staffing which fails to provide high-quality care services.

It is important to note that while the guiding principles are focused on outcomes for people experiencing care and the reference to “safe” is drafted with those individuals in mind, this cannot be separated from the wellbeing of staff themselves. An unsafe staffing environment can create unsafe services. Conversely, improving the wellbeing of staff can improve the safety, quality of care and experience of people who use services and so the two are inextricably linked. See also 15.13 below about the wellbeing of staff.

15.7 What is meant by “high-quality”?

The provision of high-quality care that is right for the individual experiencing care is one of the headline outcomes of the Health and Social Care Standards and as such the guiding principles should be read alongside these. As these standards make clear, care can only be “high-quality” if it provides support or services that are right for the individual, taking into account their own particular characteristics.

High-quality care, as detailed in the Health and Social Care Standards should include

- consideration of the dignity and respect of people using services, and their carers and representatives where appropriate;
- respect and promotion for their human rights;
- compassionate care and support;
- empowering and enabling individuals experiencing care to be fully involved in all decisions about their care and support;
- responsive care which adapts to the needs of the individual; and
- care which improves wellbeing.

15.8 What principles need to be met in arranging staffing?

The principles to be met are:

- improving standards and outcomes for people using services;
- taking account of the particular needs, abilities, characteristics and circumstances of different people using services;
- respecting the dignity and rights of people using services;
- taking account of the views of staff and people using services;
- ensuring the wellbeing of staff;
- being open with staff and people using services about decisions on staffing;
- allocating staff efficiently and effectively; and
- promoting multi-disciplinary services as appropriate.

All of these principles need to be read in the context of achieving the overarching outcome of safe and high-quality services and ensuring the best care outcomes for people using services. The focus of the guiding principles should always be to look at how these impact on people using services. No one factor is more important than another and they should all be considered together when determining staffing.

15.9 Improving standards and outcomes for people using services

Outcome measures of the quality of services being provided, such as those detailed in the Health and Social Care Standards should be considered; identifying trends, and exploring whether staffing has had an impact. The emphasis should be on identifying how standards and outcomes for people using services could be improved.

15.10 Taking account of the particular needs, abilities, characteristics and circumstances of different people using services

No two individuals using services are the same and the outcomes that matter to a particular person will vary. Care service providers need to ensure a holistic person-centred approach which involves people using services, and / or their representatives (such as those with Power of Attorney) as appropriate, in decision making about meeting their individual needs. This could reflect the range of support

the individual has through paid or unpaid care and would be relevant, for example, in ensuring carer involvement in the discharge of cared-for persons from hospital under the Carers (Scotland) Act 2016. Staffing decisions also need to reflect the ability of people using services, for example the extent to which they can participate in their own care needs.

This is in line with the Health and Social Care Standards, examples of which include:

- 2.9 I receive and understand information and advice in a format or language that is right for me;
- 2.11 My views will always be sought and my choices respected, including when I have reduced capacity to fully make my own decisions;
- 2.27 As a child, I can direct my own play and activities in a way that I choose, and freely access a wide range of experiences and resources for my age and stage, which stimulate my natural curiosity, learning and creativity; and
- 5.27 As a child or young person living in a care home, I might need or want to share my bedroom with someone else and I am involved in this decision.

The principles of Getting it right for every child (GIRFEC) would also be applicable here.

15.11 Respecting the dignity and rights of people who use services

People can expect to experience care services which are underpinned by a Human Rights Based approach in which their rights are respected, protected and fulfilled; they are involved in decisions that affect them; informed of their rights and entitlements; and provided with a form of redress if they believe their rights are being denied. People must be treated with dignity and, as far as possible, be in control and able to express themselves about their requirements. This would include involvement of their representatives as appropriate.

For example, the Health and Social Care Standards, state in paragraph 4.1 ‘My human rights are central to the organisations that support and care for me’. Other publications relevant to an individual could include Adults with Incapacity (Scotland)

Act 2000, Children and Young People (Scotland) Act 2014, and the guidance related to the Self-directed Support (Scotland) Act 2013

15.12 Taking account of the views of staff and people using care services

The views of those who work in care services and people who use these services are crucial to ensuring individuals' dignity and rights are respected and standards and outcomes are improved. Care service providers must be able to demonstrate how the views of people who use their service and those working in their service have been gathered and how they have informed decision making.

This reflects existing guidance such as the Codes of Practice for Social Service Workers and Employers - Scottish Social Services Council. This states in paragraph 2.3 that employers will have systems in place to listen to and consider feedback from people who use services, carers and other relevant people, to shape and improve services and the performance of social service workers and in paragraph 2.4 that employers will have systems in place for social service workers to report inadequate resources or difficulties which might have a negative effect on the delivery of care.

15.13 Ensuring the wellbeing of staff

There is a link between the safety of people who use services and the wellbeing of individuals delivering the service. Increased wellbeing of individuals working in care services can reduce sickness absence, burnout and work-related stress, meaning that they are available to care for people using services. Healthy, engaged and well supported people working in care services are also better able to provide safe and high-quality services. In some situations, people working in care services will be working in challenging environments or as lone workers, which can increase risks to their wellbeing. In order to provide safe and high-quality services, appropriate measures and checks need to be in place to achieve and maintain the wellbeing of individuals working in the service.

An environment where people working in care services feel able to raise issues about the safety of people using services, mistakes or areas of concern is vital to their wellbeing. This involves creating a culture of transparency, continuous improvement and open communication and an environment where it is clear to

individuals working in the care service that the relevant care service provider(s) have a culture of system improvement rather than blaming individuals. Individuals working in care services need to feel safe to raise concerns at all times regarding any risks resulting from staffing.

15.14 Being open with staff and people using care services about decisions on staffing

As well as taking into account the views of those working in and using care services, care service providers must be open with those individuals about decisions on staffing. Care service providers should foster the development of an open culture which allows and encourages those who work in the service to raise issues and be supported in finding new ways to overcome risks without fear of adverse consequences.

15.15 Allocating staff efficiently and effectively

Staffing arrangements should allocate individuals who work in a care service so they have the greatest impact on providing safe and high-quality services that result in the best outcomes for people using them. This could include effective rostering and allocation systems which ensure people with the right knowledge and skills are in the right place at the right time to meet the needs of people using the service. It could also include matching the abilities and skills of individuals working in the service to the needs and choices of individuals using the service.

15.16 Promoting multi-disciplinary services as appropriate

Staffing arrangements should promote a multi-disciplinary approach where this is appropriate to meet the needs of people using the service. This may involve multi-disciplinary teams working within the service, or coordination with others out with the service, such as district nursing teams, GP's or Allied Health Professionals (AHP's). The definition of multi-disciplinary services provided in this section of the Act makes it clear that this refers to care services delivered together by individuals from different professional disciplines. This may, or may not, be in close proximity, but always in collaboration.

This principle should not be interpreted as requiring care service providers to prioritise multi-disciplinary services over and above other services, or where this is not deemed appropriate. This principle must be consistent with the main purposes of the guiding principles, namely the provision of safe, high-quality services and to ensure the best care outcomes for people using those services. Care service providers should consider multi-disciplinary service models as well as profession-specific models in terms of opportunities / benefits when deciding what is suited to the needs of the person receiving care. Again this aligns with the Health and Social Care Standards, which state in, for example in 1.13 'I am assessed by a qualified person, who involves other people and professionals as required' and 2.26 'I know how different organisations can support my health and wellbeing and I am helped to contact them if I wish'.

The unique role of each profession in the multi-disciplinary service should continue to be recognised and promoted within the context of ensuring the highest quality of care is provided to people using the service. This consideration is central to determining whether or not the involvement of another discipline from the multi-disciplinary team is "appropriate" or not. Where it is not deemed appropriate, best practice would be to provide clear rationale for the decision-making.

15.17 How are the guiding principles applied in care services (section 3 of the Act)?

Section 7 of the Act imposes a general duty on care service providers to ensure appropriate staffing. Section 3 states that in carrying out this duty every provider must have regard to the guiding principles. This means that whenever care service providers are putting in place staffing arrangements to comply with the duty to ensure appropriate staffing, they must take into account the guiding principles.

Section 3 also makes provision in relation to the planning or securing of care services by local authorities and integration authorities. In planning or securing care services from another person under a contract, agreement or other arrangements, these organisations must have regard to:

- the guiding principles in the Act;

- the duty of care service providers to have regard to the guiding principles in ensuring appropriate staffing;
- the duty of care service providers to ensure appropriate staffing;
- the requirements on care service providers relating to training of staff;
- the requirement that care service providers have regard to guidance issued by the Scottish Ministers;
- the duties on care service providers under Chapter 3 of Part 5 of the Public Services Reform (Scotland) Act 2010, for example with regard to registration of care services; and
- the duties on care service providers under Chapter 3A of Part 5 of the Public Services Reform (Scotland) Act 2010, for example with regard to the use of any prescribed staffing methods or staffing tools. Note that the Health and Care (Staffing) (Scotland) Act inserted chapter 3A into the Public Services Reform (Scotland) Act.

Local authorities and integration authorities must publish an annual report on how they have carried out the requirements regarding planning and securing care services from another person. Further detail about this and these reports can be found in chapter 16.

15.18 Section 7 – duty on care service providers to ensure appropriate staffing

This section places a duty on care service providers to ensure appropriate staffing for the health, wellbeing and safety of people using the service, the provision of safe and high-quality care and, in so far as it affects either of those matters, the wellbeing of staff.

What follows is more detailed guidance on the meaning of the language in the Act, which will support its effective application in practice by care service providers.

15.19 What is meant by “at all times”?

Care can be a 24/7 service, so ‘at all times’ should be taken as having its normal, everyday meaning. The changing needs of people who use services over any time

period (e.g. a day, a week, a year) do not affect the requirement to comply with the duty. Care service providers must demonstrate that they have made every effort to adjust staffing accordingly.

15.20 What is meant by "suitably qualified and competent individuals are working in such numbers as are appropriate for…"?

This provision is intended to ensure there are sufficient staff providing care, with the appropriate knowledge, skills and competence to meet the needs of people experiencing care.

Care service providers should be able to demonstrate clearly that they have considered the levels of practice, training, education, experience and professional regulatory responsibilities of all of the staff within a team providing care.

In ensuring these requirements are fulfilled, it would normally be expected that the unique knowledge, skills, competence and capability of each member of staff are respected and that each member of staff is equipped, enabled and has the support to work to the top of the skill level for the role they are employed to do.

This should also include required qualifications and/or competencies, including those produced by regulatory bodies, professional organisations, Scottish Government and other relevant programmes and initiatives that may, from time to time, be applicable to the function of the role.

15.21 What is meant by "the health, wellbeing and safety of service users"?

Staffing should always be available, both in terms of numbers and skills mix, to ensure that people experiencing care achieve their best possible health and wellbeing outcomes. This should be read in the context of the national health and wellbeing outcomes framework and the Health and Social Care Standards, along with other standards published by the Scottish Ministers under the Public Services Reform (Scotland) Act 2010.

The duty to ensure the safety of people experiencing care is not intended to imply that care service providers are under a duty to remove all risks; risk enablement is

important. The section 7 duty however requires care service providers to have appropriate staffing levels in place to enable provision of safe and high-quality services and so reduce risk to people experiencing care.

15.22 What is meant by "the provision of safe and high-quality care"?

When judging whether or not a service is "safe", safe does not mean "no-risk". Depending on the service, safe may not even mean low risk. Risk enablement is important and risks are an inevitable part of most care services. Positive risks, as defined in the Health and Social Care Standards sections 2.24 and 2.25 means making balanced decisions about risks and risk management and recognising that risks to safety are inevitable and can sometimes result in benefits. However, people experiencing care should not be put at unnecessary risk as a result of staffing which fails to provide high-quality care services.

Provision of high-quality care requires the right people, in the right place, with the right skills at the right time, with the appropriate amount of time available, reflecting individual care needs, to ensure the best care outcomes for those experiencing care.

The provision of high-quality care that is right for the individual using the service is also one of the headline outcomes under the Health and Social Care Standards and, as such, the duty to ensure appropriate staffing should be read alongside these. As those standards make clear, care can only be "high-quality" if it provides support or services that are right for the person experiencing care, taking into account their own particular characteristics. High quality care should include consideration of the dignity and respect of the person experiencing care, including respect and promotion for their human rights; compassionate care and support; inclusion in care of those using the service, along with their carers and representatives as appropriate; responsive care which adapts to the needs of the person; and care which improves wellbeing.

15.23 What is meant by “in so far as it affects either of those matters, the wellbeing of staff”?

The duty requires that the wellbeing of staff is considered **in so far as it affects** staffing for the health, wellbeing and safety of those experiencing care and the provision of safe and high-quality care. In practice, this has wide-ranging effects.

There is a link between the safety of people experiencing care and the wellbeing of staff delivering the service. Increased staff wellbeing can reduce sickness absence, burnout and work-related stress, meaning that staff are available to care for people. Healthy, engaged staff are also better able to provide safe and high-quality services. In some situations, staff will be working in challenging environments or working as lone workers. In order to provide safe and high-quality services, checks need to be in place to maintain staff wellbeing.

An environment where staff feel able to raise issues with the safety of those experiencing care, mistakes, or areas of concern is vital to the wellbeing of staff. This involves creating a culture of transparency, continuous improvement and open communication and an environment where it is clear to staff that care providers have a culture of system improvement rather than blaming individuals. Care service providers should ensure that staff feel safe to raise concerns about the risks resulting from staffing at all times.

As noted above, the duty to ensure appropriate staffing sits in the context of the guiding principles. However, care service providers must also consider how it also sits alongside existing requirements in relation to the health, wellbeing and safety of staff (e.g. health and safety law, a contract of employment, or a local agreement between staff and an employer).

15.24 What do care service providers have to have regard to when determining what constitutes appropriate staffing?

Section 7(2) sets out what, at a minimum, care service providers should take into account when assessing staffing levels so that they comply with the duty to ensure appropriate staffing. These factors comprise:

- the nature of the care service;
- the size of the care service;
- the aims and objectives of the care service;
- the number of service users; and
- the needs of service users.

15.25 What is meant by "the nature of the care service"?

Care services covered by the Act are those listed in section 47(1) of the Public Services Reform (Scotland) Act 2010. This comprises a wide variety of service types. Clearly the provision of appropriate staffing will differ and will need to be tailored to the specific nature of the care service being provided

15.26 What is meant by "the size of the care service"?

In determining staffing requirements, it is important to ensure that the local context in which the service is being delivered and any impact of this on staffing requirements is considered. An example of this may be that a small service may only require one person on duty at any one time in terms of workload, but for health and safety reasons or as a condition of registration, there requires to be two staff on duty at all times.

Another may be that the service is delivered over a large geographical area and therefore travel time between people experiencing care is longer, which would have an impact on staffing. The layout of the building, for example care delivered across multiple floors, may also impact on staffing requirements and would need to be considered.

There are many other examples where size and local context may have an impact on staffing requirements but relevant care service providers should be able to demonstrate how local context has been taken into account in determining staffing, alongside non-staffing solutions to logistics and communication.

15.27 “the aims and objectives of the care service”

Staffing within the care service should be sufficient to ensure the objectives and outcomes for individuals using the service can be met. Currently, to register with the Care Inspectorate, care services are required to have aims and objectives agreed. These would include the type of care and support they are registered to provide e.g. short breaks, care for people living with dementia etc.

15.28 “the number of service users”

Care service providers are expected to be able to demonstrate that they have undertaken the necessary assessment of care provision for individual people within the care service, and analysis of met and unmet need in determining the number of people requiring provision of any service.

15.29 "the needs of service users”

No two people are the same and the outcomes that matter to an individual will vary. A holistic person-centred approach should be taken which involves people experiencing care in making decisions about their care and support. For example, it is expected that the range of paid and unpaid care an individual has is supported and that known risks and the preferences of the person receiving care are incorporated. Decisions about staffing levels, skill mix and deployment also need to reflect an asset-based approach which includes the ability of people using the service, for example the extent to which they can participate in their own health or care needs. An asset-based approach aims to nurture, sustain, protect and build the assets in every individual, in order to improve people’s life chances and enhance positive health and wellbeing.

15.30 Section 8 – training of staff

Care service providers must ensure that individuals working in the care service receive appropriate training for the work they are to perform and suitable assistance, including time off work, to obtain further qualifications appropriate to their work.

15.31 Other relevant guidance and legislation

The Health and Social Care Standards, the principles set out in section 4 of the Public Bodies (Joint Working) (Scotland) Act 2014, the Public Services Reform (Scotland) Act 2010 and the Care Inspectorate Quality Framework all continue to apply.

Scottish Government published the Health and Social Care Standards in June 2017, which set out what people should expect when using health, social care or social work services in Scotland. The standards seek to provide better outcomes for everyone, to ensure that individuals are treated with respect and dignity, and that the basic human rights we are all entitled to are upheld. The objectives of the standards are to promote improvement, encourage flexibility and enable innovation in how people are cared for and supported. All services and support organisations, whether registered or not, should use the standards as a guideline for how to achieve high quality care. From 1 April 2018, the standards have been taken into account by the Care Inspectorate, Health Improvement Scotland and other scrutiny bodies in relation to inspections and registration of care services.

The Care Inspectorate has published guidance on staffing, see Safe Staffing Project | Care Inspectorate Hub for further details.

16. Planning or Securing the Provision of Care Services from Others

16.1 Which sections of the Act is this chapter about?

This chapter provides further detail on section 3(2) and (6) of the Act.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

16.2 Who does this chapter apply to?

The following organisations must comply with the duties contained in this chapter:

- All local authorities, and
- All integration authorities within the meaning of section 59 of the Public Bodies (Joint Working) (Scotland) Act 2014

These are referred to as “relevant organisations” in this chapter.

Health Boards, relevant Special Health Boards and NHS National Services Scotland must comply with a similar duty (found in section 2 of the Act) when planning or securing the provision of health care from others. Further information about this can be found in chapter 5.

16.3 In what settings and to which staff does this chapter apply?

Section 3(2) applies where a relevant organisation is planning or securing the provision of a care service from a third party. Care services are those listed under section 47(1) of the Public Services Reform (Scotland) Act 2010.

The requirement applies to all functions provided by all staff working in a care service (chapter 3, introduction provides more details on the types of individuals covered by the Act). Note that the definition of “working in a care service”, which is found in section 11 of the Act, includes working for payment or as a volunteer, and working under a contract of service or apprenticeship, a contract for services or

otherwise than under a contract. This is wide-ranging and would include, for example:

- employees of the care service;
- agency and other temporary / contract workers;
- self-employed workers;
- those on apprenticeship schemes and other ‘earn as you learn’ schemes who are employed by the care service; and
- all volunteers.

Any reference to “staff”, “staffing” or “working in a care service” within this chapter includes all these groups of people.

Students should not be considered as “staff” and should be treated as supernumerary when they are participating in a supernumerary placement or are undertaking protected learning time as detailed within the relevant course outline or conditions of employment.

Accountability for all the requirements covered in this chapter remains with the care service provider and not with individuals who may be charged with carrying out certain actions.

16.4 What is this chapter about?

Section 3(2) of the Act places a requirement on relevant organisations when planning or securing the provision of a care service from third parties to have regard to a number of matters. This means that the new legal framework becomes a relevant part of the planning of such services, as well as their delivery. Section 3(6) of the Act requires relevant organisations to report on how they have complied with this requirement.

16.5 Planning or securing the provision of care services

When relevant organisations plan or secure the provision of a care service from a third party provider, they must have regard to the following:

- the guiding principles in the Act (section 1 of the Act);

- the requirement on care service providers to have regard to the guiding principles (section 3(1) of the Act);
- the duty on care service providers to ensure appropriate staffing (section 7 of the Act);
- the requirement on care service providers with regard to training of staff (section 8 of the Act);
- the requirement on care service providers to have regard to guidance issued by the Scottish Ministers (section 10 of the Act);
- the requirements on care service providers under Chapter 3 of Part 5 of the Public Services Reform (Scotland) Act 2010, for example with regard to registration of care services; and
- the duties on care service providers under Chapter 3A of Part 5 of the Public Services Reform (Scotland) Act 2010, for example with regard to the use of any prescribed staffing methods or staffing tools (chapter 3A is new and was added to the Public Services Reform (Scotland) Act 2010 using the Health and Care (Staffing) (Scotland) Act).

Care service providers already had obligations under Chapter 3 of Part 5 of the Public Services Reform (Scotland) Act 2010. The 2019 Act means these and the new requirements (both in the 2019 Act and inserted into the 2010 Act by the 2019 Act) are a relevant part of the planning of care services, decision-making and selecting and contracting with care service providers. The section 3(2) requirement is deliberately general and flexible to allow for the wide variety of contractual arrangements which it covers.

Guidance on the guiding principles in care service staffing, and the duties of care service providers to ensure appropriate staffing and training can be found in chapter 15.

Requirements of the Act are only one part of a larger commissioning cycle and the many factors that will need to be considered when planning or securing the provision of any particular service. For this reason, this chapter should be read alongside

existing guidance on commissioning health and social care services (Strategic Commissioning Plans Guidance).

In practice, relevant organisations will have existing procurement and commissioning strategies in place and it is anticipated that consideration of the above would form part of this existing process.

Examples of evidence relevant organisations might consider when planning or securing services in order to comply with the duty placed upon them include, but are not limited to:

- Care Inspectorate inspection reports for care service providers;
- Care Inspectorate joint inspection reports;
- Care Inspectorate Datastore;
- previous experience of commissioning, or working with, the provider;
- any previous enforcement action;
- evidence of processes in place for the provider to implement the requirements of the Health and Care (Staffing) (Scotland) Act 2019, and
- other relevant inspections and audits.

Such matters should be used in a manner which is compliant with applicable procurement rules.

16.6 Reporting

Section 3(6) of the Act states that relevant organisations must publish information annually on the steps they have taken to comply with the requirement in section 3(2) regarding the planning and securing of care services and any ongoing risks that may affect their ability to comply with this requirement.

In order to promote consistency across all relevant organisations, the Scottish Government will provide a report template for organisations to complete when publishing information under section 3(2).

Information published by relevant organisations under section 3(6) will cover the financial year, i.e. the period from 01 April to 31 March. It must be published as soon

as is reasonably practicable after the end of each financial year. No deadline is included in the Act but the Scottish Government has the view that this should be completed by 30 April each year. The most appropriate means to publish the information should be decided by the relevant organisation but it is envisaged this would follow methods used to publish other reports.

16.7 Existing relevant policy, legislation and guidance

The duty to have regard to the Act when planning or securing the provision of care services from a third party sits alongside existing governance requirements. The contents of existing contracts will continue to apply, as will any guidance around these. Whilst this section of the Act does not require commissioners of services to add additional clauses to any standard contracts they use, relevant organisations will need to consider how they stipulate and obtain evidence of appropriate staffing when planning and securing services.

17. Role of Social Care And Social Work Improvement Scotland (the Care Inspectorate)

17.1 Which sections of the Act is this chapter about?

This chapter provides further detail on the following sections of the Public Services Reform (Scotland) Act 2010 (the "2010 Act"), all of which are inserted by section 12 of the Act:

- section 82A: Development of staffing methods;
- section 82B: Regulations: requirement to use staffing methods;
- section 82C: Review and redevelopment of staffing methods;
- section 82D: Review of duty on care service providers to ensure appropriate staffing;
- section 82E: Duty to consider multi-disciplinary staffing tools; and
- section 82F: Interpretation of Chapter.

A link to the Act can be found here. There are other links to useful information, including to other chapters of the guidance, embedded in this chapter; these are denoted in blue text.

17.2 Who does this chapter apply to?

All sections apply to the Care Inspectorate.

Section 82B of the 2010 Act will become applicable to care service providers where the Scottish Ministers make regulations to require the use of a staffing method by those persons. Care service providers are those who provide a care service listed in section 47(1) of 2010 Act.

17.3 In what settings and to which staff does this chapter apply?

Obligations contained in these sections apply either to all care services or only to particular types of care services. For example, section 82A of the 2010 Act currently applies to care home services for adults but in the future could apply to other care services if Scottish Ministers decide to specify other care services in law.

Section 82F of the 2010 Act states that care services referred to in sections 82A to 82E excludes those services provided by individuals who do not employ, or have not otherwise made arrangements with, other persons to assist with the provision of that service. This means that where a care service is provided by just one individual, for example an individual childminder who does not have any other person working with or for them, they are not required to use staffing methods or staffing level tools. It is important to note however, that these care services are still required to follow all other relevant provisions of the Act, e.g. relating to ensuring appropriate staffing and training of staff.

Where an obligation applies to a care service, it applies to all functions provided by all relevant staff working in that care service chapter 3, introduction provides more details on the types of individuals covered by the Act). Note that the definition of those working in a care service includes working for payment or as a volunteer, and working under a contract of service, an apprenticeship, a contract for services or otherwise than under a contract. This is wide-ranging and would include, for example:

- employees of the care service;
- agency and other temporary / contract workers;
- self-employed workers;
- those on apprenticeship schemes and other ‘earn as you learn’ schemes who are employed by the care service; and
- all volunteers.

Any reference to “staff”, “staffing” or “working in a care service” within this chapter includes all these groups of people.

Students should not be considered as “staff” and should be treated as supernumerary when they are participating in a supernumerary placement or are undertaking protected learning time as detailed within the relevant course outline or conditions of employment.

Accountability for all the duties covered in this chapter remains with the Care Inspectorate and care service providers as appropriate and not with individuals who may be charged with carrying out certain actions.

17.4 What is this chapter about?

This chapter provides guidance on the functions of the Care Inspectorate inserted into the 2010 Act introduced by the Act. These encompass the development, review and redevelopment of staffing methods, including staffing level tools, along with the ability to carry out reviews of the effectiveness of the operation of the duty on care service providers to ensure appropriate staffing.

There is also provision should the Care Inspectorate develop and recommend a staffing method, for the Scottish Ministers to make regulations to require specific types of care services to use that method.

Throughout any process of development, review or redevelopment of such staffing methods and staffing level tools, there is a requirement for the Care Inspectorate to work collaboratively with stakeholders across the health and care sector. This will be essential to provide reassurance that any and all methods or tools developed for the care sector will be designed for the specific type of care service to reflect the unique demands and pressures. The development and validation of any methods or tools will be done in collaboration with professionals in that setting.

17.5 Section 82A Development of staffing methods

Section 82A makes provision for the Care Inspectorate to develop a staffing method for use by those who provide care home services for adults (adults being individuals who are aged 18 years or over). Following development and testing, the Care Inspectorate may then recommend the use of such a staffing method to the Scottish Ministers. In practice, these recommendations would be made through the current sponsorship arrangements between the Care Inspectorate and Scottish Government.

A staffing method sets out a framework or process to be followed by a care service provider to determine what appropriate staffing is in any particular care service and setting. This includes the use of staffing level tools and a range of other considerations such as where and how the service is being provided. The following paragraphs provide details on what a staffing level tool is and what other factors may be taken into account as part of a staffing method when determining appropriate staffing.

The Act also allows Scottish Ministers to make regulations to allow the Care Inspectorate to develop, test and recommend staffing methods for other types of care services. The purpose of this is to ensure that Ministers can prioritise development in line with Scottish Government requirements intended to meet the current and future needs of people experiencing care.

In developing such staffing methods it is essential that a collaborative approach is taken to ensure methods can be implemented in practice across diverse settings and staff groups and provide reliable and relevant information. To this end, the Act lists persons and organisations that the Care Inspectorate must collaborate with:

- Scottish Ministers;
- Healthcare Improvement Scotland;
- Scottish Social Services Council;
- every Health Board;
- every local authority;
- every integration authority;
- representatives of care service providers and people who use care services;
- trade unions and professional bodies representative of those working in those care services; and
- any other persons the Care Inspectorate considers appropriate.

In undertaking collaboration, the Care Inspectorate and persons / organisations they collaborate with must have regard to the guiding principles of the Act, along with aspects of this guidance relating to the operation of section 82A.

The Act requires that any staffing method must include the use of staffing level tools designed to provide:

- quantitative information relating to workload, based on the needs of people using the services of the care service provider. For example, the care service provider will input information on the numbers and needs of the people using its services at the particular point in time and the tool will provide outputs such as numbers and types of staff required; and
- quantitative and qualitative information relating to professional judgement. This requires individuals to assess staffing requirements based on their professional opinion of the current workload and the local context.

The outputs from the use of a tool or tools are then used to assist in determining appropriate staffing for the care service. It is important to remember that the use of such staffing level tools form only one part of the larger staffing method and any outputs must be considered alongside the other components.

Any staffing method that is developed and recommended by the Care Inspectorate may include requiring care service providers to put and keep in place risk management procedures. Any such risk management procedure would need to be appropriate to the particular type of care service, the needs of people who use the service and recognise positive risks, as defined in the Health and Social Care Standards paragraphs 2.24 and 2.25.

Any staffing method that is developed and recommended by the Care Inspectorate may include requiring care service providers to take account of the following factors:

- the current staffing levels and any vacancies;
- the local context in which the care service is provided. Local context could include a variety of considerations about where and how the care will be delivered. For example, location of the care service, e.g. remote and rural area; the type of care service; aims and objectives of the care service; and demographic factors;
- the physical environment in which a care service is provided. For example, this would include the layout of the building;

- any assessment of the quality of a care service;
- the needs of the people who use the care service;
- comments and feedback from people experiencing care, along with individuals who have a personal interest in their care. These could include family members and carers;
- comments and feedback from people working in the care service;
- recommendations from senior care or health care professionals with qualifications and experience that are appropriate to the care service;
- care services standards and outcomes published by the Scottish Ministers, such as the Health and Social Care Standards;
- indicators or measures of the quality of care;
- any relevant published guidance; and
- any appropriate clinical evidence and research.

17.6 Section 82B Regulations: requirement to use staffing methods

Following the development / redevelopment of a staffing method by the Care Inspectorate and its recommendation to the Scottish Ministers, the Ministers can then make regulations that require care service providers to use that method.

These regulations provide for:

- the types of care service and types of individuals working in the care service that are included in requirements to use the staffing method;
- the minimum frequency at which the staffing method must be applied; and
- the staffing level tools that must be used as part of the staffing method.

17.7 Section 82C Review and redevelopment of staffing methods

Any staffing method that is contained within regulations as per section 82B, i.e. a staffing method that care service providers are required to use may be subject to review and redevelopment as appropriate. This is important as any staffing method needs to remain contemporary and fit for purpose in order to provide reliable information to inform staffing requirements across diverse practice settings and staff groups.

This section of the Act makes provision for the Care Inspectorate to carry out such a review to consider whether any particular staffing method is still effective. In practice, intelligence from care service provider experience of using the method, analysis of output of the method (including staffing level tools) and / or significant policy or practice change will inform the timing of such a review.

Where a staffing method is no longer considered effective, the Care Inspectorate can recommend revocation or replacement to the Scottish Ministers.

The Care Inspectorate may develop a revised staffing method and recommend this to the Scottish Ministers. Where any method is redeveloped / revised, the Care Inspectorate must meet the same requirements as for developing a new method in section 82A, including collaboration with listed stakeholders, inclusion of staffing level tools and consideration of the same range of factors. This is to ensure that any revisions of staffing methods go through at least as rigorous development as any new method.

In addition to the Care Inspectorate developing revised staffing methods, the Scottish Ministers may also direct the Care Inspectorate to carry this out. The purpose of this is to ensure that Ministers can prioritise development in line with Scottish Government requirements intended to meet the current and future needs of people experiencing care.

17.8 Section 82D Review of duty on care service providers to ensure appropriate staffing

This section enables the Care Inspectorate to carry out reviews of the effectiveness of the operation of section 7 of the Act: the duty on care service providers to ensure appropriate staffing for the health, wellbeing and safety of people using their services; the provision of safe and high-quality care; and, in so far as it affects either of those matters, the wellbeing of staff. No frequency of such reviews is prescribed in the Act; instead it is left to the decision of the Care Inspectorate as to when such a review would be appropriate.

Once such a review has been completed, a report may be published by the Care Inspectorate to the Scottish Ministers and more widely as it deems appropriate. Again, this section enables the Care Inspectorate to make a decision about the most appropriate timing of carrying out reviews and the most appropriate means of publishing reports.

17.9 Section 82E Duty to consider multi-disciplinary staffing tools

When developing a staffing level tool as part of a new or revised staffing method, the Care Inspectorate must consider if the tool should be multi-disciplinary i.e. apply to more than one professional discipline. The intention of this is to ensure that, where appropriate, the workload of all the different groups of people working in the particular care service is considered for inclusion in the development of staffing level tools. This is to ensure that, in future, staffing level tools will be appropriate for use in multi-disciplinary settings and fit for purpose in contemporary service delivery models.

Having considered whether a tool should apply to more than one professional discipline, the Care Inspectorate can recommend to Scottish Ministers that a staffing level tool that is part of a staffing method should apply to more than one professional discipline.

18. Glossary

Agency worker: the Act defines an agency worker as being "within the meaning of the Agency Workers Regulations 2010". Any staff directly employed by the relevant organisation are not included within this meaning.

Care Inspectorate: the Care Inspectorate is the independent national scrutiny and assurance body responsible for the registration and regulation of care services in Scotland. It scrutinises and inspects services to ensure they meet high standards. Where the need for improvement is identified, they support services to make positive changes. The Care Inspectorate is referred to in the Act as "Social Care and Social Work Improvement Scotland".

Care Inspectorate Data Store: information collated and published by the Care Inspectorate relating to registered care services.

Care service providers: those providing a care service listed in section 47(1) of the Public Services Reform (Scotland) Act 2010.

Common Services Agency for the Scottish Health Service (NHS National Services Scotland (NSS)): NSS provides national strategic support services and expert advice to NHS Scotland and is involved in the delivery of effective health care to patients and the public.

Common Staffing Method (CSM): the CSM sets out a process for determining staffing, involving the use of speciality-specific staffing level and professional judgement tools, consideration of quality measures, and a range of other factors such as the local context, patient needs and appropriate clinical advice. From this, risks are identified and steps taken to mitigate them and the organisation determines whether it needs to make any changes to the "staffing establishment".

Earn and Learn model: a model of employment where individuals are able to combine work and study.

Geographical Health Board: a Health Board constituted under section 2(1)(a) of the National Health Service (Scotland) Act 1978.

General Medical Council (GMC): The independent regulator for doctors in the UK.

Getting it right for every child (GIRFEC): the Scottish Government's commitment to provide all children, young people and their families with the right support at the right time – so that every child and young person in Scotland can reach their full potential.

Health and Social Care Standards: standards setting out what people should expect when using health, social care or social work services in Scotland.

Healthcare Improvement Scotland (HIS): HIS is the health body for the provision of evidenced-based guidance and standards for health and care professionals to provide safer, more effective care. HIS enables the people of Scotland to experience the best quality of health and social care, through measures such as helping health and social care organisations to redesign and continuously improve services, providing evidence and sharing knowledge and providing quality assurance.

Healthcare Staffing Programme: managed by HIS, this programme works with NHS Boards to improve workload and workforce planning to meet the obligations of the Act, through education and training; staffing level tools and methodology development; and tailored support and guidance.

Hub and spoke model of care: a model that arranges service delivery assets into a network consisting of an anchor establishment (hub) which offers a full array of services and is complemented by secondary establishments (spokes) which offer more limited services.

Integration Authority: an authority within the meaning of section 59 of the Public Bodies (Joint Working) (Scotland) Act 2014.

Multi-agency: health care or care involving more than one agency / organisation, for example a hospital, GP, community nursing and social services.

Multi-disciplinary services: the Act defines these as “health care or care services delivered together by individuals from a range of professional disciplines as necessary in order to meet the needs of, and improve standards and outcomes for, service users”.

National health and wellbeing outcomes framework: The National Health and Wellbeing Outcomes provide a strategic framework for the planning and delivery of health and social care services. The outcomes focus on improving how services are provided, and enable people using services and carers to have a clear understanding of what they can expect in terms of improvements in their health and wellbeing.

NHS Education for Scotland (NES): a Special Health Board which is responsible for developing and delivering health care education and training for the NHS, health and social care sector and other public bodies across Scotland.

Patient acuity / dependency: a measure of a patient’s severity of illness or medical condition(s). It is used to assess the intensity of care needed by a patient.

Power of Attorney: a legal document that gives another person the authority to deal with aspects of your affairs.

Predicted Absence Allowance (PAA): an approach used by some professional groups of staff when carrying out planning / assessment of staffing levels for the predicted workload. It involves applying a set figure to allow for the absence of staff due to annual leave, sickness, maternity leave and other reasons.

Professional disciplines: the different types of health care / care professions, for example nursing, psychology, dentistry, physiotherapy etc.

Professional Judgement Tool: a professional judgement tool is designed to provide quantitative information relating to professional judgement in order to assist in determining the appropriate staffing levels for a particular kind of health care provision. It requires individuals to assess staffing requirements based on their professional opinion of the current workload and the local context.

Psychologically safe: the belief that it is okay to take risks, express ideas and concerns, ask questions and admit mistakes, without the fear of negative consequences.

Registered medical practitioner / doctor: a medical practitioner / doctor included on the register of medical practitioners maintained by the General Medical Council under section 2 of the Medical Act 1983.

Registered midwife: a midwife included on the register of members maintained by the Nursing and Midwifery Council under section 60 of the Health Act 1999.

Registered nurse: a nurse included on the register of members maintained by the Nursing and Midwifery Council under section 60 of the Health Act 1999.

Regulations: see “secondary legislation”.

Satellite unit: a small unit in an organisation that is managed or controlled by a larger, central unit. For example, a small health care premises that is operated by a larger hospital.

Scottish Social Services Council: The national regulator for the social work, social care and children and young people workforce, and lead for workforce development and planning for social services in Scotland, with responsibility for: publishing national codes of practice for those working in social services and their employers; registering those working in social services and ensuring they adhere to the codes of practice; promotion and regulation of the learning and development of the social service workforce; and providing official statistics for the sector

Secondary legislation: secondary legislation is a term for law made under an Act of Parliament or Act of the Scottish Parliament (primary legislation), for example regulations or an order. Secondary legislation can be used to implement the detailed policy behind primary legislation. Secondary legislation could also be referred to as subordinate legislation, Statutory Instruments (SIs) Scottish Statutory Instruments (SSIs) or delegated legislation.

Service delivery models: a model used to deliver a health care or care service; the way in which a health care or care service is delivered.

Service redesign: changing or redesigning a health or care service to deliver it in another way.

Social Care and Social Work Improvement Scotland: see "Care Inspectorate"

Special Health Boards: Special Health Boards operate nationally, rather than geographically; examples include NHS24, the Scottish Ambulance Service Board, the State Hospitals Board, the National Waiting Times Centre and NHS Education for Scotland.

Staffing establishment: "staffing establishment", as referred to in the Act, is used in calculating NHSScotland vacancy information to describe total filled and vacant posts by occupation. Establishment is calculated by adding the number of staff employed to the number of vacant posts.

Staffing levels: the number of staff.

Staffing level tool: A staffing level tool is designed to provide quantitative information relating to workload, based on patient needs, in order to assist in determining the appropriate staffing levels for a particular kind of health care provision. A staffing level tool requires individuals to input certain information about the location in which it is being used, such as a ward or a community service. The tool then outputs quantitative information about staffing, to assist in determining appropriate staffing levels.

Staff Governance Standard: Staff Governance focuses on how NHSScotland staff are managed, and feel they are managed, and forms part of the governance framework within which NHS Boards must operate. The Staff Governance Standard Framework is the key policy document to support the legislation which aims to improve how NHSScotland's diverse workforce is treated at work. See Staff Governance Standard — NHS Scotland Staff Governance

Staff redeployment: when staff are moved from one job role / location to another.

Supernumerary: Staff that are not counted as a part of the staffing required for safe and effective care in that setting, often because they are students.

Supplementary staffing: temporary staff, for example those from the NHS Staff Bank or agencies, who work in NHS services.

Uni-professional model: a model of care delivered by one professional discipline (as opposed to a multi-professional model which is delivered by a range of professional disciplines).

19. Consultation Questions

Question 1(a)

Do you think the guidance is clear and easy to understand?

Question 1(b)

Please detail any specific areas of the guidance that you found unclear or hard to understand.

Question 2(a)

Do you think the guidance is comprehensive, in that it contains sufficient detail to be able to support organisations in meeting obligations placed on them by the Act?

Question 2(b)

Please detail any specific areas where you felt information was missing or incomplete.

Question 3

Do you have any other comments on the draft guidance?

20. Responding to this Consultation

We are inviting responses to this consultation by 19 September 2023.

Please respond to this consultation using the Scottish Government's consultation hub, Citizen Space (http://consult.gov.scot). Access and respond to this consultation online. You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of 19 September 2023.

If you are unable to respond using our consultation hub, please complete the Respondent Information Form to:

Health and Care (Staffing) (Scotland) Act 2019 Implementation Team
Scottish Government
Chief Nursing Officer Directorate
St Andrews House
Regent Road
Edinburgh
EH1 3DG

Handling your response

If you respond using the consultation hub, you will be directed to the About You page before submitting your response. Please indicate how you wish your response to be handled and, in particular, whether you are content for your response to published. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form included in this document.

To find out how we handle your personal data, please see our privacy policy: https://www.gov.scot/privacy/

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.gov.scot. If you use the consultation hub to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so. An analysis report will also be made available.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to the contact address above or at hcsa@gov.scot.

Scottish Government consultation process

Consultation is an essential part of the policymaking process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.gov.scot. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review

- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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