RCN Scotland's response to the Scottish Government's Consultation on on the Health and Care (Staffing) (Scotland) Act 2019 Statutory Guidance

https://consult.gov.scot/health-and-social-care/health-and-care-staffing-scotland-act-2019/

September 2023

Question 1(a)
Do you think the guidance is clear and easy to understand?

☒ Yes

☐ No

Question 1(b)
Please detail any specific areas of the guidance that you found unclear or hard to understand. Please tick the relevant section(s) and provide further information in the text box.

☐ section 3

☐ section 4

☐ section 5

☐ section 6

☐ section 7

☐ section 8

☐ section 9

☐ section 10

☐ section 11

☐ section 12

☐ section 13

☐ section 14

☐ section 15

☐ section 16

☐ section 17

☐ section 18

Comment 1
RCN Scotland appreciates that statutory guidance is intended to make clear the requirements of often complex legislation in non-legal language. The Health and Care (Staffing) (Scotland) Act 2019 is complex. We consider that the guidance (pending acceptance of our comments) is as clear as such guidance can be. However, we know that the guidance is not – and is not intended to be - a training manual for front line staff.

The guidance might therefore read most clearly to those who are used to dealing with statutory guidance and who have an appreciation of how complex the underpinning legislation can be, and in this case is.

That being the case, it is imperative that the duties on employers to train staff are complied with in a way that makes sure that more accessible materials are. produced locally for front line staff as needed.

We expect that the support that will be offered by Healthcare Improvement Scotland through its Healthcare Staffing Programme and by the Care Inspectorate through its Safe Staffing Programme will be instrumental in enabling and empowering frontline staff to implement the requirements of the Act.

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?

☒ Yes

☐ No

Question 2(b)

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

Integration Authorities
Comment 2
RCN saw earlier versions of the guidance during the Scottish Government's stakeholder engagement exercise. It took place before the public consultation. In those earlier versions, across all relevant chapters, there was a lot more detail on the responsibilities of Integration Authorities and the way that they, and Health Boards and Local Authorities, needed to account for the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014 when complying with the provisions of the Health and Care (Staffing) (Scotland) Act 2019.

The draft guidance as published does not contain this level of detail. There is a little more detail on the explicit responsibilities of Integration Authorities under the Act. For example, responsibilities under section 3(2) of the Act are covered in chapter 16. But the detail specifically to do with the interaction between the 2014 and 2019 Acts seems to be limited to very brief references in sections 3.3, 4.8, 4.18, 15.31 and 6.16. The third paragraph of section 3.3 is the most relevant to our point:

"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."

Perhaps some of the detail previously provided was found to be unclear or incorrect. If so, it is right that it was removed. But given the potential complexities of the interaction between the two Acts we suggest that a greater level of detail is needed than what is given in the version of the guidance shared through this public consultation.

Even though statutory guidance on one Act would not normally include guidance on another Act, we assume this does not apply where giving information on the latter Act is necessary to give proper guidance on the former Act.

If this level of detail is not provided, there is a significant risk of an inconsistent application of the 2019 Act across Scotland. This inconsistency would not come about through legitimate responses to local health and social care needs. It would come about through a differing understanding at senior management level of the operation of the law, which is what the guidance is intended to prevent.

The guidance should contain more detail on the interaction between the 2014 and 2019 Acts.

Relevant Organisations
Comment 3
In previous versions of the guidance the sections dealing with safe staffing in health care collectively described the organisations subject to the various duties and requirements as “Health Boards." The Act itself typically uses the collective phrase, "Health Board, Special Health Board and the Agency.” In this version of the guidance the collective phrase “relevant organisations” has been used instead of “Health Boards." This is not as clear as using “Health Boards” for two reasons:
1. All the entities referred to collectively as Health Boards in earlier versions of the guidance were (and remain) Health Boards, so to call them that was accurate. It would be accurate to continue to do so. If the guidance needs a term that means “Health Boards and, where relevant, Integration Authorities” we suggest it uses that phrasing.
2. The phrase “relevant organisations” is used elsewhere in the guidance to mean something other than Health Boards. For example, in chapters 2 and 3 it refers to all entities covered by the Act. In chapter 16 it refers specifically to local authorities and Integration Authorities.

The term “Health Boards” should be used instead of “relevant organisations” wherever the reference is to Health Boards only.

Students
Comment 4
The Scottish Government has put information online titled “Health and Care (Staffing) (Scotland) Act 2019 roles in scope.”
https://www.gov.scot/publications/health-and-care-staffing-scotland-act-2019-overview/pages/roles-in-scope-of-the-act/#students

It says:

“Students are referenced in the Act in section 12IK which details the types of health care, locations and employees to which the common staffing method applies. This states that when applying the common staffing method, “employees” does not include students studying to enter the Nursing & Midwifery Council register or the register of medical practitioners maintained by the General Medical Council.

This applies to pre-registration nursing, midwifery and medical students that undertake any defined ‘supernumerary placement’ as part of their learning

programme. Staff undertaking training whilst employed or supported on apprenticeships or other 'earn as you learn' models, should be included in the definition of a 'student' and so 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."

In the guidance chapter on the common staffing method at section 12.3, which deals with staffing in health care, it says:

"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."

The first paragraphs of the online information and the guidance section match. The second two do not. "Students" are property defined in the online information but not in the guidance section. The online information explicitly sets out when apprentices and people in an 'earn and learn' situation should be treated as students and so should not be included in the safe staffing calculation. The guidance specifically includes all those people in the safe staffing calculation and does not make it clear that there are circumstances when they should be excluded. RCN's view is that the online information is correct, and the guidance should be altered to match it.

We understand that the situation in care is different. Students must be excluded from any safe staffing calculation in care but apprentices and people in an 'earn and learn' situation should be included, as per section 11 of the Act. The guidance deals with this in the last but one paragraph of section 15.3. It says:

"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."

This mirrors the language online information. But we are of the view that the justification for exclusion provided in section 12.3 of the guidance is useful and should be added to section 15.3:

"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."

We are also of the view that the justification for exclusion should be added to the last but one paragraph of section 16.3 and the last but one paragraph of section 17.3.

Question 3
Do you have any other comments on the draft guidance?

Section 3
See above on Integration Authorities.

Section 4
Comment 5
The duties in the Act for safe staffing in healthcare are structured deliberately so that they cannot be read in isolation from one another nor reasonably read in isolation from the guiding principles in the Act. We have taken legal advice on the matter, and we have two arguments to make about the applicability of the guiding principles to the duties in the Act before making our final point. We have gone into this level of detail because, during the stakeholder engagement process that preceded the public consultation, feedback from Scottish Government made it clear that it explicitly disagreed with our interpretation of the way the Act works on this point. However, we are confident that our interpretation is correct, and that the guidance needs to be amended.

Argument 1

Section 1 of the Act lists the "guiding principles" that govern "staffing for health care and care services." Under the Act "health and care staffing" is a multifaceted concept involving several activities. For it to have any useful meaning, section 1 must be understood as follows:

All of Section 1(1) comprises guiding principles. The distinction between subsections 1(1)(a) and 1(1)(b) is that the guiding principles that appear in subsection 1(1)(a) consist of the main purposes of staffing for health care and care services, whereas the guiding principles that appear in subsection 1(1)(b) consist of matters that must be particularly accounted for when "staffing for health care and care services is (being) arranged."

Section 1 applies to any concept or activity that can reasonably be defined as "health and care staffing" under the Act. In practice this means virtually all of the Act. As a matter of legislative interpretation, it is not necessary for every single subsequent section of the Act itself, or of those sections of the National Health Service (Scotland) Act 1978 that are inserted by the Act, to expressly state that they are subject to the guiding principles in section 1 for them to be subject to them.

The specific language of section 2 has the effect of reinforcing and clarifying the governing role of the guiding principles in health care. But this language does not limit the application of section 1 to the Act as that application is described above. The fact that in carrying out the duty "imposed by section 12IA… Health Boards and the Common Services Agency must have regard to the guiding principles for health and care staffing" does not mean that when carrying out other duties under the Act the guiding principles can be wholly disregarded. If that was the case, they couldn't really qualify as guiding principles.

Argument 2

The guidance calls the section 12IA duty the "general duty." The wording of section 2 means that it is not possible to comply with the general duty unless, in doing so, one has regard to the guiding principles.

There are then several other duties placed upon Health Boards that can be referred to as the "subsequent duties." These are the duties contained in sections 12IB to 12IF and 12IH to 12IM. We have not included section 12IG in this list because it concerns duties placed upon Scottish Ministers, not upon Health Boards.

It is beyond doubt that sections 12IB to 12IM (including section 12IG) constitute "arrangements" made for staffing for health care and care services in terms of section 1. If they did not constitute such arrangements, then the question would be: "What do they constitute and what they are doing in an Act whose purpose is to require that such arrangements are made?" To consider these sections not to be "arrangements" would render the Act absurd.

The connection between section 12IA and sections 12IB to 12IF and 12IH to 12IM is established by the language of the Act. The language in sections 12IB, 12IH and 12II is especially specific.

This language of 12IB makes it clear that the Act envisages agency workers being utilised in order to comply with the duty in section 12IA. It is hard to envisage a situation where agency workers world be utilised for a different purpose. In that situation section 12IB would clearly comprise an element of section 12IA. Its status as an element of section 12IA means that in carrying out the section 12IB duty Health Boards must have regard to the guiding principles by virtue of subsection 2(1).

The language of sections 12IH and 12II is very explicit. They both use the phrasing "In complying with the duty imposed by section 12IA, every Health Board and the Agency must…" and then explain what a Health Board must do. This makes it clear that these duties are unequivocally elements of the section 12IA duty. It is not possible to comply with the general duty unless these two duties are also complied with. Compliance is not optional, as the word "must" make clear. The guidance recognises this at paragraph 10.11 with respect to section 12IH, but it does not recognise it with respect to section 12II.

The language of sections 12IC to 12IF and 12IJ to 12IM is not quite as explicit, although it varies.

Sections 12IC to 12IE do not include language equivalent to that used in sections 12IH and 12II, although this is not fatal to our argument. It is clear from the language that they do use that the duties they impose are imposed in pursuit of carrying out the duty in section 12IA. Without there being in place a real time staffing assessment, a risk escalation process and arrangements to address severe and recurrent risk, the section 12IA duty simply cannot be said to have been carried out. This means that sections 12IC to 12IE are also elements of the section 12IA duty.

Section 12IF, however, is explicit that the duty it imposes (to seek clinical advice) is imposed in pursuit of carrying out various duties, including the duty in section 12IA. Health Boards must "put and keep in place arrangements for (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL." In other words, Health Boards must seek clinical advice when making arrangements under section 12IA. It is plain that the section 12IA duty simply cannot be said to have been carried out unless clinical advice has been secured and taken into account. Like sections 12IB, 12IH and 12II, this section is therefore an explicit element of section 12IA. This is the case regardless of the fact that the language of section 12IF is not as explicit as the language of sections 12IB, 12IH and 12II.

Section 12IJ provides that in relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2) of 12IJ. Section 12IK sets out the types of health care. Section 12IL sets out the absolute obligation on every Health Board and the Agency in respect of training and consultation when complying with, and in order to comply with, the section 121IJ duty.

In common with each of sections 12IC to 12IF section 12IJ creates and imposes a new specific duty which is ancillary to, but which supports compliance with, the section 12IA duty. Section 12IK makes the requirements of section 12IJ clearer. Section 12IL imposes a duty that must be carried out in order to comply with the section 12IJ duty. Sections 12IK and 12II are therefore elements of the section 12IJ duty.

Using the CSM for the types of health care listed in section 12IK is mandatory. It is not possible to discharge the duty in section 12IA without using the CSM to arrange staffing for those types of health care. That plainly means that the requirements of sections 12IJ are elements of the section 12IA duty. Because sections 12IK and 12Il are elements of the section 12IJ duty they too are elements of the section 12IA duty.

Section 12IM does not use the specific language of duty with respect to itself but since Health Boards 'must' report on section 12IA as described and have no discretion in the matter, this requirement qualifies as a duty. A core purpose of producing reports on staffing is to inform Scottish Government policy on staffing (see specifically section 12IM (5)). If the process of producing those reports is not an arrangement for health and care staffing in terms of the Act it is unclear what it is.

Final point

The impossibility of separating the subsequent duties from the general duty means that if the carrying out of the general duty "must have regard to the guiding principles" then the carrying out of the subsequent duties also "must have regard to the guiding principles." This is true of all of them, whether this can be clearly understood from explicit language (as in, for example, sections 12IH and 12II) or by the process of reasoning, based on language of the Act, that we have set out.

This indivisibility of the subsequent duties from the general duty, is actually made in the guidance as it stands but only obliquely and not as a stand-alone point in the way that we consider it should be made. For example:

Section 4.17 notes 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.” But it does not make clear that the subsequent duties count as arrangements.

Section 6.4 notes that “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.” Section 6 is described at section 5.4 as “guidance on what constitutes appropriate staffing arrangements.” This coverage of the duties and requirements of section 4 of the Act supports our argument that they are “arrangements” under section 1.

There are also duties placed upon Health Improvement Scotland to have regard to the guiding principles when monitoring and reviewing the common staffing method (section 12IQ(3)(b)) and when collaborating to monitor and develop of staffing tools (section 12IR(4)(b)). In terms of the purposes of the Act, it would be inconsistent for the guiding principles to apply to these matters of monitoring, development and review, but not to apply to the matter of the operation and use of, and training in, the common staffing method and the staffing tools, as set out at sections 12IJ to 12IL.

Paragraph 86 of policy memorandum to the Bill states that the Bill contains “guiding principles which Health Boards and care service providers must have regard to when carrying out their duties to ensure appropriate staffing.” The use of the plural “duties” means that applicability of the guiding principles cannot be taken to be confined to the general duty in section 12IA or to exclude the subsequent duties.

At various points, the guidance makes it clear that having regard to the guiding principles is applicable to the general duty, but it does not explain that having regard to the guiding principles is applicable to the subsequent duties as well. It must be amended to do this.

We appreciate that this is a rather technical point, but we cannot overstate its importance. For example; one of the guiding principles is to be “open with staff and service users about decisions on staffing.” That would be very relevant when designing a system for real time staffing assessment, which is one of the subsequent duties.

A simple explanation of this point in Chapter 4 may be enough to make this relationship clear, but our members have suggested that the guidance may also benefit from a diagram showing it.

Comment 6
In section 4.8 there is a typo. ‘The factors principles to be met are’ should read ‘The principles to be met are’ (or perhaps ‘The principles that must be abided by are’).

<u>Section 5</u>
We are content with this chapter.

<u>Section 6</u>

We are content with this chapter.

Section 7
Comment 7
Our members were keen that any template produced under section 7 should provide more detail on what costs should be used to calculate "the total amount paid to secure that (agency) worker for the shift" (as noted in the last paragraph of section 7.6 of the guidance).

Comment 8
Section 7.9 refers to a template for agency reporting. In the absence of a template, we cannot comment on its content. But we would urge the Scottish Government to create a template that shows, and differentiates between, different professional groups. This would allow transparency on whether the 150% ceiling was being exceeded for certain professional groups as opposed to others. That would be helpful to know for safe staffing and workforce planning purposes, even if the total agency spend on all professional groups during the quarterly reporting period did not exceed the 150% ceiling. The current published annual data on nursing and midwifery bank and agency spend is useful but does not go into as much granular detail as we are advocating. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-june-2022-workforce/dashboards/nhsscotland-workforce/?pageid=6963

Section 8
Comment 9
There is a typo in the last but one paragraph of section 8.4; "on at last a quarterly basis" should read "on at least a quarterly basis."

Comment 10
The same paragraph should clarify that the reporting required under section 12IF includes reporting on section 12IF itself as well as on the other sections referenced. The Act is clear on this point, at section 12IF (2)(b)(i) and (c)(i).

Comment 11
Section 8.5 covers the arrangements to be made for the real time assessment and mitigation of risk. A line has been removed from an earlier version of the guidance in what is now the bulleted list in the last but one paragraph of the section. It required an arrangement to be put in place for "Assessing the impact of mitigation (including how staff, both clinical and non-clinical, should proceed where mitigation is not successful)." This line should be put back. That is because an assessment of the impact of mitigation is necessary to determine whether there is a need to escalate further, as outlined in section 12ID(2)(d) of the Act.

Comment 12
Section 8.13 deals with what is to happen when staff disagree with a decision on which clinical advice has been sought. Staff "must be notified of every decision made and the reasons for it." This reflects the requirements of section 12IF (2) (iii).

In keeping with the Act's guiding principles and acknowledging the requirements of the regulatory regimes governing nursing and other health and care professions, RCN's position is that this notification should be in written form. The guidance

should say that. This will provide assurance to, and an accurate record for, staff. The notification need not be in the form of a formal, physical letter, it could be an electronic record, but it needs to exist beyond a verbal update with no record.

Written notification to the individual cannot be assumed to be the result of the operation of the other provisions in section 12IF for the recording of decisions. We understand that the Safe Care staffing software could be used for this purpose. For those Health Boards that have Safe Care we agree with using it. For those that don't, equivalent measures must be put in place so that every Health Board has a system of written notification and is using it to fully comply with the provisions of the Act.

Comment 13
Section 8.15 deals with the factors that should be considered in the risk mitigation process. of that section begins "

RCN Scotland strongly disagrees with the way the last paragraph of this section reads (beginning "Long term (in excess of one month)." Our members' views have strengthened our position. We accept that mitigation is required by the Act. But some of the examples, including reviewing staffing establishment and service delivery models or patient pathways, are problematic. The current wording appears to allow relevant organisations, when faced with staffing shortages, to simply cut services or reduce staffing establishments to appear to be avoiding staffing risk, even in the absence of a change in patient need. So, for example, faced with nursing staff vacancies, relevant organisations could, as a mitigation, simply reduce the number of staff that they deem required to run the service.

This would be the opposite of the policy intention behind the Act. This may not be the intention of the guidance but if we can read it that way, so can others. We would suggest either removing this entire section or, at the very least, making it much clearer that mitigations cannot be made in breach of the general duty to ensure appropriate staffing and expressly ruling out the above interpretation of that section.

Comment 14
Section 8.16 asks 'What is a severe or recurrent risk?' It notes that these words are not defined in the Act and opts not to define them. But the guidance has sought to provide further detail in other areas where the Act does not include a definition (for example in the section on Agency Spending). We feel that providing a definition of severe and recurrent risks would beneficial as this is a key part of the Act. Using the ordinary meaning of recurrent would suggest that a recurrent risk has an element of repetition. The ordinary meaning of severe would suggest that a severe risk is something which significantly impacts on patient care. There is concern among our members that staffing risks of all kinds are arising so often in some areas that instances of severe risk are common but are being informally downgraded and therefore normalised instead of being accorded the level of severity that they warrant. "Corridor care" is one example. Just because instances of severe risk happen regularly does not make them any less severe. If this downgrading were to continue, the legislation may not have its intended effect.

Some members suggested that “severe or recurrent” might usefully be defined by reference to the current risk matrix used by Health Boards. (Please note that Citizen Space would not accept a diagram of this matrix).

Likelihood	Consequences/Impact				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The guidance should also note that this section of the Act clearly separates recurrent risks, severe risk and risks that are simultaneously recurrent and severe. So, for example, a risk that is not severe, but which is recurrent, is in scope.

Section 9

Comment 15

In the last paragraph of section 9.10 beginning “Relevant organisations” the following text was in the draft version of the guidance but has been removed.

"The guidance chapter on 12IM reporting on staffing sets out expectations on relevant organisations in relation to their annual report to the Scottish Ministers. It would be good practice for the quarterly report to include any indicators included in the annual report, to support relevant organisations to provide ongoing monitoring and improvement."

“Quarterly report” refers to the report required by section 12IF(2)(b). This report goes from clinical leaders to the Health Board setting out those leaders’ views on how the Health Board has complied with multiple duties under the Act. This text was helpful and should be reinstated before section 9.11. This is because we agree that matching the indicators between the quarterly and annual reports will act as a support in the way described and believe that it will make for more coherent and understandable monitoring reports. Our members expressed concerns that the reporting could become chaotic if the indicators were not aligned.

Comment 16

The Act says that clinical leaders must be given “adequate time and resource” to lead. The first paragraph of section 9.13 of the guidance deals with what amounts to “adequate time and resource.” It includes some examples of clinical leaders (pharmacists and AHPs). The Scottish Government told us in its previous feedback during the stakeholder engagement exercise that the guidance “cannot list all the other staff that would be required for “adequate time and resource” in this paragraph.” But we remain of the view that the absolute centrality of nursing to the successful implementation of the Act means that Senior Charge Nurses should be an example too, as follows:

"Time for senior charge nurses (SCNs) to supervise the meeting of the clinical needs of the patients in their care, to manage, and support the development of the staff for whom they are responsible, and to lead the delivery of safe, high-quality and person-centred health care and additionally to seek and report views from their teams would be a legitimate resource need for the Nurse Director and would be in keeping with the intended role of SCNs as set out in Leading Better Care https://www.gov.scot/publications/leading-better-care-report-senior-charge-nurse-review-clinical-quality-indicators-project"

The RCN members that we consulted to inform this response strongly agreed with us on this point. They were surprised that the SCN example was not used, given how many of the clinical leaders affected by the Act will be SCNs, the number of staff and patients many SCN's have responsibility for, and that previous enquires into failures of care in the UK have recommended that the critical role of SCN's is acknowledged and resourced. Members were also of the view that it would be helpful to explain that what is calculated as adequate time & resource must be proportionate to the extent to which any given role is typically taken up with the delivery of the tasks set out in section 12IIH.

Section 10
We are content with this chapter.

Section 11
Comment 17
In the fourth paragraph of section 11.3 there is a typo. "Section 12ID(2)(d) requires the arrangements" should read "Section 12ID (2) (h) requires the arrangements."

Comment 18
The seventh paragraph of section 11.3 refers to the section 12IO definition of "employee" but does not explain it further. The explanatory notes to the Act make it clear that this definition excludes staff from third party agencies. The notes do not deal with the status of bank staff. Our view is that bank staff come under the Act's definition of "employee" because a bank is part of a Health Board, not a third party (like an agency is). That means that anyone contracted through the bank has a contract of service with the Health Board. This would include people working for a Health Board bank even if their "day job" was with a different Health Board (for example, an NHS Lothian nurse working on the NHS Borders bank).

Whether or not bank staff are employees matters because some of the duties that a Health Board has towards staff only apply to employees (for example, the duty to ensure appropriate training (section 12II)). This contrasts with the duties that the Health Board has towards staff as "individuals." The term "individual" is wider than "employee" and would cover all staff, regardless of their specific employment status. For example, the duty to ensure adequate time is given to clinical leaders to lead (section 12IH) applies to "individuals."

The guidance should make the status of Health Board bank staff clear by stating that they count as employees under the Act.

Section 12
We are content with this chapter.

Section 13
Comment 19
When engaging with Scottish Government over the iterations of this chapter prior to the public consultation on the statutory guidance, we made some detailed comments about the nature of the measures that the Scottish Government has proposed using to structure the reporting requirements in health care. A distinction was made between:

1. Process measures: where the measure of success is that a process is in place and is being used.

2. Outcome measures: where there is an attempt to evidence the changes to the health and wellbeing of patients and staff because of the use of a process.

The Scottish Government originally proposed the use of both types of measure. In the last round of stakeholder engagement on the guidance chapters, the Scottish Government gave a draft of the template that is mentioned in section 13.5 of this consultation. That template contained process measures only. The change was said to reflect the fact that, with some small exceptions, process measures are all that the Act requires.

This is a complex issue and before making our points we want to say that we recognise:

- that the guidance does make the link between processes and outcomes in other places, for example, in chapter 4. The Health and Social Care Standards are said to contain "headline outcomes" and the Act itself refers to these outcomes.

- the role of Healthcare Improvement Scotland in monitoring the implementation of the Act and in ensuring that services are held to the Health and Social Care Standards

- that Heath Boards should meet Local Delivery Plan (LDP) Standards, which feed into the National Performance Indicators https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/introduction/ and https://nationalperformance.gov.scot/measuring-progress/national-indicator-performance

- the existing Patient Experience Programme, which includes local and national surveys https://www.nhsinform.scot/care-support-and-rights/health-rights/feedback-and-complaints/feedback-complaints-and-your-rights

However, all of these predate the 2024 target date for implementation of the Act. That means they don't contain outcome measures or associated performance indicators that are specifically intended to show the success, or otherwise, of the

implementation of the Act. It also means there are no agreed datasets to inform any analysis of implementation.

RCN members expressed particularly strong support for establishing a suite of outcome measures and associated performance indicators to be used consistently and uniformly across all relevant organisations. Without that, our members were very concerned that:

1. It would be very difficult to make any firm connection between the implementation of the Act and changes to health care outcomes for patients/ service users.

2. Health Boards could use different measures and indicators from one another, making it impossible to compare performance and so identify good practice or the need for support. For the avoidance of doubt, our members were clear that they did not support using this information to establish a "league table" of Health Boards.

We might or might not need new outcome measures or associated performance indicators. What is critical is that those organisations delivering safe staffing:

1. know which measures and indicators should be used to show the success, or otherwise, of the implementation of the Act and

2. should all be using the same set of measures and indicators, for the purposes of comparability.

We understand that the relationship between statutory guidance and legislation means that the guidance is not the place to set out a suite of outcome measures. We therefore welcome the Scottish Government's intention, made in previous feedback to us, to continue to test the template with Health Boards throughout the testing period. The testing period is current and runs into early 2024.

We propose that the Scottish Government builds on that activity - and on existing performance regimes - by committing to work with Health Boards, Healthcare Improvement Scotland and stakeholders to agree a shared suite of outcome measures and associated performance indicators that can be used by all Health Boards across Scotland. We understand that it would not be appropriate to make a commitment like this in statutory guidance, but we would welcome it being made by other means.

Our members described the need for a shared suite of measures and indicators as fundamental to gauging the success of the Act. Some suggested that Excellence in Care (EiC) might ultimately be an appropriate vehicle for disseminating the agreed suites, although they understood that EiC would need to be adapted to fulfil that function. In this context, they were also supportive of recommendation 2 of our 2023 Nursing Workforce in Scotland report. This recommendation calls for the publication of baseline data:

"In partnership with the trade unions and other professional bodies, the Health and Care (Staffing) (Scotland) Act must be implemented in full by April 2024, and be

accompanied by the investment and resources to allow health and care employers to meet their duties under the Act. An accurate, transparent baseline must be published before April 2024 to enable trend data to emerge over time," https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/sco-parl-nursing-workforce-in-scotland-report-030523

Comment 20
Our previous comments on the following aspect of the guidance were able to refer to a draft reporting template, provided by Scottish Government. We have taken on board feedback about our comments on that template.

The second paragraph of section 13.4 of the guidance says: "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."

The last but one paragraph of section 13.4 makes it clear that "the purpose of the annual reporting requirement" includes "to identify challenges relevant organisations are facing in meeting requirements in the Act and what steps they have taken / are taking to address these."

If we understand the guidance correctly it supports reporting on challenges, risks and steps taken to address them across the entire range of duties set out in section 13.4. We very much welcome this comprehensive approach to reporting.

Section 14
We are content with this chapter.

Section 15
Comment 21
In section 15.8 the line 'The principles to be met are' might better read 'The principles that must be abided by are'.

Comment 22
Section 15.30 covers the training of staff. It should include an explanation that training must also be given on how to use any method for care service staffing developed by the Care Inspectorate under section 12 of the Act. It should direct the reader to chapter 17 for more details.

Section 16
Comment 23
We accept that the Act does not use the word "duty" about section 3(2) and so that section may be legitimately described as a "requirement" in this chapter. However, section 10(2) of the Act does define section 3(1) as a duty. The line that describes section 3(1) as a requirement, shown below, should therefore be changed to describe it as a duty: "the requirement on care service providers to have regard to the guiding principles (section 3(1) of the Act)."

Section 17
Comment 24

At paragraph 17.3 and elsewhere in this chapter, the word “obligations” is used. We suggest saying "duties and other obligations" rather than simply “obligations.” Part 3 of the Act does not use the word obligations, and our suggested phrasing may be clearer to the non-legally minded person. Such a person may not appreciate that a duty is a form of obligation and so they might be confused by the omission of the word duty in this part of the guidance.

Section 18: Glossary

We are content with this chapter.