



Royal College
of Nursing
Scotland

Evaluating the impact of the Health and Care (Staffing) (Scotland) Act 2019 on nursing staff in 2024-25



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Executive Summary

Introductory Note

This report is a shorter version, for publication, of a longer, more detailed report which was completed by March 2026. This report focuses on our findings from our research and analysis and omits most of the (sometimes extensive) detail of how we went about that research and analysis.

This report has the advantage of relative brevity, but it does so at the necessary expense of complete clarity on how we got “from A to Z”. To make up for that, the longer more detailed report (85 pages) can be made available on request. To obtain a copy, or if you would like to discuss any aspect of either version of the report, please email policyscotland@rcn.org.uk

RCN will continue to monitor the impact of the Act on the basis that we have done in this report. Whether or not we publish our findings in similar reports to this one in future years will be a matter for decision at the time.

Approach

The Health and Care (Staffing) (Scotland) Act 2019 (“the Act”) does not explicitly set out any intended impact on any staff, nursing or otherwise, and it only uses and defines “outcomes” with respect to service users.

Nevertheless, RCN is of the view that it is reasonable to assert that outcomes for staff are implied by the language of the Act and that it is therefore possible to set those out and to try and ascertain whether or not they are being achieved and if so to what extent.

RCN identified ten key “implied outcomes” for staff but, given who and what we are, we have characterised them in this report as implied outcomes for “nursing staff.”

We then identified eleven “data sources” that we posited might be capable of telling us something about the achievement of these outcomes. These include, but are not limited to, the reporting required by public authorities under the Act.

Findings

Our examination of the reporting required of public authorities under the Act, including by Health Boards, and Health Improvement Scotland, confirmed much of what we had anticipated we would find. This is *mainly* (with some exceptions) that these reports are really only capable of affirming the existence of, and explaining the operation of, systems and processes which are ostensibly intended to achieve outcomes (which are not always clearly defined). But, other than by way of anecdote, they do not report on the extent to which our implied outcomes (or indeed other outcomes as may be inferred by others) are being achieved).

This is unsurprising given that is what these various reports are intended to do. The limitations to this reporting stem from the legislation and the reporting requirements currently in place. They are not the fault of the authors of these reports.

With one exception, other reporting had something useful to tell us about the achievement of our implied outcomes only to the extent of comprising indirect indicators. This other reporting included iMatter, NHS sickness absence figures, NHS bank and agency use figures, and RCN’s most recent employment survey.

The “one exception” is the Nurses4Scotland survey. It remains the most “on point” and resonant data source available to us. This is unsurprising given the deliberate link between the survey questions and the text of the Act itself. It is illuminating to some degree -and the picture it paints is discouraging -but its primary value lies in its having been conducted at a point in time which means it can (and we hope will) serve as a baseline by which the results of future iterations of this study may be measured.

It is difficult to make a fair summary statement that covers everything we have found though our examination of these data sources. But insofar as this is possible, we would say that:

- The implied outcomes for nursing staff that RCN has identified as present in the Health and Care (Staffing) (Scotland) Act 2019 are not being achieved to any significant extent across the health and social care workforce in Scotland, and so nursing staff are not yet benefiting from the implementation of the Act in the ways or to the extent that RCN would expect or want to see.

Proposed Solutions

We offer ten proposed solutions to the problems that we identify. They are referenced by number in the body of the report but set out in full in the final section. Between them they seek to:

- improve the reporting required of public authorities under the Act, including in terms of the data that is collected, including data from “running” the Common Staffing Method in the NHS, and the production, publication, and accessibility to stakeholders, of those reports
- amend the Act to shift the emphasis of its language from there being implied outcomes for staff as a result of compliance with the Act to there being explicit and defined outcomes for staff as a result of that compliance
- align the iMatter survey and the NHS staff governance standard more specifically to the requirements of the Act to better capture the extent to which outcomes for staff are being achieved
- spread good practice in terms of positive approaches to dealing with challenges posed by compliance with the Act to secure positive outcomes for staff, and including to try and bring down NHS nursing staff sickness absence rates.

For RCN’s part we will build on the achievement of the Nurses4 Scotland survey to periodically survey our Scottish membership and report on the extent to which nursing staff in Scotland consider that outcomes for nursing staff are being achieved. We will use the results to support calls for clearly defined actions that we believe will see those outcomes achieved to the extent that they are not being, but also to celebrate success where they are.

Section 1 Introduction

The Health and Care (Staffing) (Scotland) Act 2019 (“the Act”) was implemented from 1 April 2024. This groundbreaking legislation gives greater and clearer legislative underpinning to the public policy intention to ensure safe staffing across all health and care services in Scotland. It builds on, and significantly adds to, existing law¹ and practice.²

The Act introduces various safe staffing requirements. It places a legal duty on NHS and care providers to make sure there are always suitably qualified staff working in the right numbers for safe and effective care. It also imposes a duty on the Scottish Government to ensure that there are sufficient numbers of registered nurses, midwives, and medical professionals available to enable employers to meet the employer’s duty to ensure safe staffing.

RCN Scotland was instrumental in shaping the Act and staffing for safe and effective care continues to be a key RCN strategic priority UK-wide.

RCN, along with many others, has an interest in understanding the impact that the Act is having on people in receipt of health and care services, whether they are described as “patients” or “service users” or by some other term. But understanding that impact is the proper business of the public authorities with responsibility for the health and care of the public.

RCN’s long-held position is that the health and wellbeing of nursing staff is essential to the quality of care that they can provide for people and communities.³ So, as the world’s largest nursing union and professional body, RCN has a very specific interest in understanding the impact that the Act is having *on nursing staff*, and especially on RCN members. They are RCN’s constituency, and they must be our focus. For that reason, and for the further reasons set out below, attempting to gauge that impact is the subject of this report.

But we have found that doing that faces significant challenges, as this report makes clear. These challenges mean that this report is, to some extent, an experiment. RCN has been obliged to consider

1. the extent to which the language of the Act can be read to identify expected impacts on nursing staff (Section 2) and,
2. whether the data sources (in which we include reports) that we anticipated *might* be able to tell us something about that intended impact (Section 3) actually *do* tell us something and if they do what that something is (Section 4)

¹ See, for example, the workforce planning duty in section 12I of the National Health Service (Scotland) Act 1978 as inserted by section 3 of the National Health Service Reform (Scotland) Act 2004

² For example, the duty to ensure appropriate training of staff (section 12II of the National Health Service (Scotland) Act 1978 as inserted by section 4 of the 2019 Act) develops the existing provision in the NHS Scotland Staff Governance Standard that “requires all NHS Boards to demonstrate that staff are appropriately trained and developed.” <https://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard>

³ See the King’s Fund report “The Courage of Compassion” (2020) <https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives>

This report covers the first year of the Act's implementation: 1 April 2024 to 31 March 2025. This is also the reporting year for the Act and so we refer to that time period as "the safe staffing year."

Section 2 What do we mean by impact? Defining outcomes and the challenges of measurement.

Impact and outcomes

When we talk in this report about “impact”, we are talking about the *outcomes* that should result from the implementation of the Act.

The Act does not contain any explicit outcomes for staff. Instead, in our view, its wording creates a very limited number of *implicit* outcomes for staff.

What are the implied outcomes for staff?

We have identified **ten** key implied outcomes for nursing staff

Figure 1.

	Implied Outcome	Act section & Text
1	Health and care nursing staffing has been arranged while taking into account the views of nursing staff.	1 staffing... arranged while... taking account of the views of staff and service users
2	Health and care nursing staff are physically and mentally well.	1 staffing... arranged while... ensuring the wellbeing of staff
3	Health and care employers have been open with health and care nursing staff about decisions on staffing.	1 staffing... arranged while... being open with staff and service users about decisions on staffing,
4	Health and care nursing staff have been allocated efficiently and effectively. ⁴	1 staffing... arranged while... allocating staff efficiently and effectively
5	Multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care.	1 staffing... arranged while... promoting multi-disciplinary services as appropriate
6	NHS nursing staff’s physical and mental wellbeing has informed the arrangement of NHS nursing staffing. ⁵	12IA (Staffing appropriate for) the wellbeing of staff
7	Care nursing staff’s physical and mental wellbeing has informed the arrangement of care nursing staffing. ⁶	7 (Staffing appropriate for) the wellbeing of staff
8	NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.	12IH ensure adequate time given to NHS clinical leaders

⁴ See comment on the Common Staffing Method in section 3.3.

⁵ We have made this implied outcome an outcome in its own right rather than bundling it up with any of implied outcomes 1-5, because it is implied by a legal provision that is of a different quality and purpose to those that imply outcomes to do with the guiding principles, although we accept that there may be some crossover in terms of the practical actions needed to see these different legal provisions properly implemented.

⁶ As per previous note.

9	NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).	12II ensure appropriate staffing: training of NHS staff
10	Care nursing staff have received the necessary training (for the work they are to perform and assistance, including time off work, to gain further qualifications).	8 training of (care) staff.

Section 3 Data sources

3.1 Reporting under the Act by Public Authorities

The statutory reporting requirements in the Act are all placed upon public authorities. That primarily means Health Boards, Local Authorities, Integration Authorities and the Scottish Government.

Healthcare Improvement Scotland (HIS) and the Care Inspectorate (CI) are also public authorities.

There are also public authorities that may choose to report on matters to do with the Act under authority that comes from sources other than the Act itself. Specifically, this means Audit Scotland and the Scottish Parliament, the latter in the form of its committees.

The list of public authority reports and their actual or potential quantity is set out in appendix 1.

RCN's original ambition was to examine all of the available reports from public authorities, but this proved to be impossible based on available resources. And some of the reports described as "conditional" in appendix 1 were not produced for the 2024-25 safe staffing year. Therefore, in this first report we have limited our examination to a selection that we anticipated would be key:

- Health Board annual reports to Scottish Government (s.12IM (1) and s.2 (3) duties)
- Local Authority/ Integration Authority reports on guiding principles in care service staffing and planning (s.3(6) duty)⁷
- Healthcare Improvement Scotland reports
- Scottish Government annual report in response to Health Board annual reports (s. 12IM (2) – (6) duties)
- Scottish Government annual report on staffing in care services (s.9 duty)⁸

3.2 Other data sources

This is data that RCN has identified as useful and that is not part of the reporting under the Act by Public Authorities.

- The Nurses4Scotland Study
- NHS and Care Providers Annual Health and Social Care Staff Experience Report (iMatter)
- NHS Scotland sickness absence statistics for nursing staff
- NHS Scotland data on use of bank and agency nursing staff
- Scottish Social Services Council (SSSC) data on the social care workforce
- RCN Employment Reports⁹

⁷ This was only possible because Local Authorities and Integration Authorities appear to have generally "doubled up" and produced one report covering both entities, so instead of 63 reports there are 31.

⁸ In the event, the Scottish Government produced one report for 2024-25 covering the section 12IM duty and the section 9 duty. It was published on 27 November 2025 <https://www.gov.scot/publications/health-care-staffing-scotland-act-2019-2024-25-ministerial-annual-report/>

⁹ We also identified RCN's biennial Last Shift Survey as a potentially useful data source, but the most recent survey did not cover the relevant time period.

3.3 Unusable or unavailable data sources

- NHS data from the Common Staffing Method (CSM) on staffing numbers required and staff numbers provided. The staffing level data generated by use of the CSM, including that which may tell us something about the skills mix required/provided for different types of health care, is not published.
- Health and social care vacancy figures. For the purposes of this report only, we can treat vacancies as effectively a constant in that, taken at the national or regional level, few if any health and social care services have ever been fully staffed. That being the case, we need to look further than vacancies when considering the extent to which health and care nursing staff have been allocated efficiently and effectively.
- Health and social care recruitment figures, including student recruitment. The Act only applies to people once they have been recruited.

Section 4 What do the data sources tell us?

4.1 Reporting under the Act by Public Authorities

4.1.1 Health Board annual reports to Scottish Government (s.12IM (1) and s.2 (3) duties)

To understand what follows it is necessary to understand that:

- the 2024-25 reporting template¹⁰ is an Excel workbook that is split into worksheets
- all but two worksheets each cover a section of the Act, and each worksheet must show an *overall* RAYG¹¹ scored “level of assurance”¹²
- each worksheet is broken down into subsections each of which must be reported upon with (a) narrative and (b) its own RAYG score

We appreciate that Health Boards have, quite properly, reported on what they were asked to report on. It is therefore not reasonable to criticise them for not having provided information that they were not asked for, and we do not do so.

We are only looking at the reports in terms of what they may tell us about our ten implied outcomes. But before we move on to doing that, we make the following points:

- The Act is process-focused and therefore so is the Health Board reporting.
- There is a light touch requirement to very briefly report on outcomes for service users. But there is no requirement, and so no obvious scope, to explicitly report on outcomes for staff, unless doing that is inherently necessary in order to demonstrate compliance.
- It appears that some Health Boards were unable to provide annual reports covering all four quarters of the 2024-25 safe staffing year in time to meet the deadline set by the legislation, which is essentially by the end of each April following the end of the safe staffing year.¹³ But for want of any viable alternative approach, we have treated them as what they purport to be: annual reports. This includes taking any quarter four projections at face value.
- We did not expect that the reporting on section 2(2) of the Act (to do with Health Board commissioning) would have anything to tell us about our implied outcomes, but that has been confirmed by the brevity of this reporting. Consequently, we will not comment further on section 2(2) in this report.

Figure 2 below sets out the self-determined RAYG scores for the section or subsection of the Act which we consider has the closest connection to our relevant implied outcomes (for the NHS).¹⁴

¹⁰ <https://www.publications.scot.nhs.uk/publication/8097>

¹¹ Levels of assurance: Red (No), Amber (Limited), Yellow (Reasonable), Green (Substantial)

¹² The two worksheets cover related provisions that are contained in more than one section of the Act. That means that for the purposes of reporting they remain internally coherent in the same way that a worksheet covering a single section does, and in a way that should make sense to a person using the template.

¹³ See section 12IM (1) of the 2019 Act.

¹⁴ That is implied outcomes 1-6, 8 & 9. Implied outcomes 7 & 9 are to do with care services only.

Figure 2.

Act & Template Section / Subsection →	2(1) (guiding principles)	12IA (1) (wellbeing)	12IH (time to lead)	12II (training)
Health Board ↓				
NHS Ayrshire and Arran				
NHS Borders				
NHS Dumfries and Galloway				
NHS Fife				
NHS Forth Valley				
NHS Grampian				
NHS Greater Glasgow and Clyde				
NHS Highland				
NHS Lanarkshire				
NHS Lothian				
NHS Orkney				
NHS Shetland				
NHS Tayside				
NHS Western Isles				
National Services Scotland				
National Waiting Times Centre ¹⁵				
NHS 24				
Scottish Ambulance Service				
State Hospital (Carstairs)				

What do these scores tell us at first glance?

- Excepting the footnoted National Waiting Times Centre (NWTC) approach to reporting, no Health Boards reported red: “no assurance” or “no systems”. That is good news.
- Four Health Boards (Grampian, Highland, Orkney, NWTC) have “limited assurance” re: time to lead (amber) with one of the four (Orkney) having limited assurance re: training (amber). Orkney also has challenges re: systems and processes for 2 (1) and 12IA (1) (both amber). One Health Board (NHS Lothian) has those same systems and processes challenges, and another (NHS Grampian) has systems and processes challenges re: 12IA (1) (amber) but not for 2 (1) (yellow).
- Between the two RAYG scoring systems, the majority of Health Boards (fourteen of nineteen or 73.7%) are on the right side of the line across all section/ subsections (yellow or green). This would appear to be good news. We also consider that it is a good thing if a Health Board is open and transparent enough to admit that it is facing challenges, although in saying this we do not mean to imply that any Health Board which appears *not* to be facing challenges is being economical with the truth.

¹⁵ The National Waiting Times Centre summary report, as published (as opposed to the template, a copy of which we were unable to secure) does not provide RAYG scores for the subsections (hence the red code in figure 2) and it is inconsistent between its scoring in the body of the report and in the summary table in its own appendix. We have used the scoring in the body of the report.

This reporting tell us mainly about progress in establishing and implementing systems and processes. The exception is what they can tell us about what we have called the outcome orientated duties (in sections 12IH and 12II) and we deal with those matters as part of the next section.

What does the data tell us about our implied outcomes?

Adapting figure 2 into figure 3 we are able to map our implied outcomes to the reporting template requirements that appear most likely to give us information about our implied outcomes. The reports do not always make clear whether what they claim for “staff” applies more or less emphatically (or at all) to different groups of staff, although we can perhaps assume they do mean “all staff.” Nursing is used to illustrate positive and negative statements about staffing issues, but it is not treated distinctly or used in that way consistently across reporting areas any more than is any group of staff. That means one cannot paint a comprehensive, as opposed to an anecdotal, picture of how nursing is faring.

Figure 3.

	Implied Outcome	Section & Text
1	Health and care nursing staffing has been arranged while taking into account the views of nursing staff.	2(1) (guiding principles)
2	Health and care nursing staff are physically and mentally well.	
3	Health and care employers have been open with health and care nursing staff about decisions on staffing.	
4	Health and care nursing staff have been allocated efficiently and effectively. ¹⁶	
5	Multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care.	
6	NHS nursing staff’s physical and mental wellbeing has informed the arrangement of NHS nursing staffing. ¹⁷	12IA (1) (wellbeing)
8	NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.	12IH (time to lead)
9	NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).	12II (training)

¹⁶ See comment on the Common Staffing Method in section 3.3.

¹⁷ We have made this outcome, which stems from an explicit legal duty, an outcome in its own right because it is not quite the same as the outcomes implied by the principles, as per outcomes 1-5, but there is clearly some crossover.

2(1) (guiding principles)

The reporting here is incapable of telling us anything systematic about the extent to which the guiding principles as a group have been had regard to so as to demonstrate to the achievement of any of our implied outcomes.

There is assertion but little or nothing by way of demonstration. Comments such as “The guiding principles for health and care underpin healthcare planning and delivery and reflect the ways of working within the Board” (NHS Ayrshire and Arran); “The guiding principles are threaded through the systems and processes we deploy” (NHS Forth Valley); and “These principles are reflected in our values” (Scottish Ambulance Service) are typical. But there is also some helpful honesty on challenges: “There are differences in how guiding principles and risk escalation processes are applied, particularly in remote areas” (NHS Orkney).

Health Board narrative on the matters covered by each of the individual guiding principles sometimes appears elsewhere in the template, other than in the worksheet that explicitly covers section 2 (1)). But in a similar way, and not to any great extent.

IO 1 Health and care nursing staffing has been arranged while taking into account the views of nursing staff.

IO 3 Health and care employers have been open with health and care nursing staff about decisions on staffing.

These tend to be implied as having taken place as a result of multidisciplinary representation in governance structures, but without comment on whether, or examples of when, it has actually taken place. That said, there are some helpful practical examples that more strongly suggest that it has: “A monthly newsletter to all HSCP Nursing staff is in place, highlighting learning and educational resources for staff, with an emphasis on the duties of the Act... A survey sent to all Lead Nurses within HSCP highlighted that the majority of areas have a mechanism in place to demonstrate daily safe staffing levels” (NHS Fife) and “supporting documentation to ensure feedback to staff” (National Services Scotland).

IO 2 Health and care nursing staff are physically and mentally well.

There is little or no data to demonstrate the achievement of this implied outcome. There is some mention of sickness absence figures (“Sickness remains above 5% despite efforts to reduce this. Within the Nursing Department there are multiple strands of work focused on reducing absence rates.” The State Hospital) But we cover sickness absence figures elsewhere.

All the reporting concerns the existence of processes intended to achieve staff physical and mental wellbeing. For example, “NHS Grampian continues to develop resources to support staff wellbeing”; “NHS Lanarkshire’s Staff Care and Wellbeing service, developed by the department of Spiritual Care and Wellbeing, continues to provide bespoke services to meet individual and group/team needs” and “There is an expanding range of facilities / activities across the organisation to support staff wellbeing” (NHS Shetland). There are mentions of staff surveys without any mention, or with insufficiently detailed mention, of their results. This is particularly frustrating when it looks like there is clearly good news. For example, NHS Greater Glasgow and Clyde writes “We know from the 2022 Staff Health Survey that menopause is a concern to a significant number

of our staff. In response as part of the Staff Health Strategy, we have been able to offer Virtual Engagement Events (over 700 staff attended) as well as monthly Group Consultations relating to menopause and supported by the NHS GGC Menopause specialist. Feedback has been excellent on both these initiatives.” What was that feedback? They don’t say. And yet it could have told a really good story about staff’s (and very probably nursing staff’s) physical and mental wellbeing that one would hope Health Boards would wish to highlight more emphatically.

We appreciate that it is not fair to assume that these processes are not effective. And there are some examples from the HIS reports (see analysis elsewhere in this report) which would indicate that they can be. And, for example, this from The State Hospital reads, we suggest, as if it must have been written with direct feedback from staff having been made available to the author: “Lots of good support being provided however, workload makes it very difficult to attend/utilise excellent resources.... Wellbeing is a focus within the Nursing Directorate, SCN meetings with Director of Nursing have identified a need to consider how we support the wellbeing of a Senior Charge Nurse who due to workload doesn't find time for themselves.” But overall, we simply point out that the information to demonstrate efficacy of these processes or the achievement or our implied outcome is not generally contained in these Health Board reports.

IO 4 Health and care nursing staff have been allocated efficiently and effectively.

Again, these reports focus, quite explicably, on the processes that have been put in place to allocate staff efficiently and effectively (particularly rostering processes) and not on data that demonstrates that they have worked. That said, perceived challenges to allocating staff efficiently and effectively are commonly raised, which suggests some anxiety about being able to do so. For example, staffing shortages and ongoing unfilled vacancies, the reduced working week, service demands and seasonal challenges. These are perhaps best summed up by National Services Scotland (NSS) re the Scottish National Blood Transfusion Service (SNBTS) as “The very difficult situation across Scotland... in terms of staff, workload... and finance.” But here as elsewhere there is cause for optimism “Staffing levels across Nursing and Midwifery have improved substantially and the ongoing recruitment processes will enable a continued pipeline of suitable staff available to clinical areas.” (NHS Borders).

IO 5 Multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care.

There is virtually nothing to show that that this is happening. A small but nevertheless encouraging exception is this from NHS Grampian: “Workforce teams have delivered two models of Workforce Planning Workshops over the last year to support the development of Multi-professional or Uni-professional Workforce Plans... both have included a session on HCSA.”

12IA (1) (wellbeing)

IO 6 NHS nursing staff’s physical and mental wellbeing has informed the arrangement of NHS nursing staffing.

There is nothing directly regarding the achievement of this implied outcome. The focus, as was the case re: implied outcome 2, is on processes. Sometimes text can be read to infer that this implied outcome may be being achieved. For example, “NHS Grampian (is) committed to achieving both Magnet Recognition and Pathway to Excellence

designations for Nursing colleagues, demonstrating our dedication to delivering outstanding care to our patients while creating a supportive and enriching work environment for our staff.” The inference being that if “delivering outstanding care to our patients” goes hand in hand with “creating a supportive and enriching work environment for our staff” then one might confidently presume that the latter is informing the former. But such examples are rare, and not especially robust.

12IH (time to lead)

IO 8 NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.

The preponderance of “reasonable” assurance given to this duty overall by Health Boards (as per figure 2 above) might be taken to be cause for optimism, certainly in the first safe staffing year. We might look forward to improvements in subsequent years. But it is rarely very clear how the challenges cited *will* be directly overcome, as distinct from what approaches may be used to *try* to do so.

The dominant theme is that nursing leaders do not appear to consistently have enough protected time to lead, largely due to workload pressures, staffing shortages, vacancies, and service demand. For example, “Due to the challenge of recruiting to funded establishment for clinicians and other factors that impact on ‘shrinkage’ e.g. short-term absence, special leave, Senior Charge Nurses are then required to work clinically, directly supporting service delivery” (NHS 24); “allocated time (can be) consumed by other unplanned essential nursing activity” (NSS for SNBTS); “Despite agreement on the need for sufficient leadership time, staffing shortages make it challenging to balance clinical and managerial duties” (NHS Lothian); Clinical teams are delivering care in a very busy healthcare system where other initiatives and work streams may require immediate/urgent actions that impact on leadership responsibilities, service plans and colleague availability/resource” (NHS Grampian).

E-rostering systems either are (or are said to imminently be) in place to assist in allocating time to lead but that does not mean that once it is allocated it can be taken. But in fairness we should acknowledge such apparent successes as are described or may perhaps be inferred, although we understand that our inferences are arguable. For example:

“In N&M groups, clinical leaders have their leadership time clearly defined.... Clinical leads (in health visiting and school nurse teams) are purely managers and do not have a patient case load therefore their time is protected to manage teams across the whole region...SCN (in acute) have been given 3 days to cover all management related duties of which H&CS is part of that” (three days “per what” is not explained, but it would seem reasonable to assume per month, since a 60% allocation of time from a five day working week (or similar) seems unlikely). (NHS Dumfries and Galloway).

“The NHS Fife Nursing and Midwifery Roster Management Procedure states that clinical leaders should factor in 7.5 hours non-clinical time each week to allow leadership time. There is time allocated within managers and supervisors’ remits and job plans, which has been evidenced by the self-assessment service template.” (We are inferring that this evidence consists of self-assessment by clinical leaders that they have received time to lead).

“The time allocated to clinical leadership within key staff Job Descriptions can vary according to the post and scale of the team, ranging from a percentage of time being allocated to being 100% supernumerary in Senior Charge Nurse roles” (NHS Shetland). Our inference being that if a senior charge nurse in NHS Shetland is 100% supernumerary it is more likely than not that senior charge nurses in NHS Shetland are *receiving* time to lead.

“SCN/team leaders identified as non-case holding during tool runs to provide accurate demand of direct patient facing care demand (sic) and inform appropriate staffing levels” (NHS Tayside). Here we make a similar inference as we do with respect to Shetland.

It is interesting to note that the RAYG scoring does not always obviously match the narrative provided against that RAYG scoring. But this must be because the concepts used by the template to underpin the RAYG scoring, and which inevitably influence the narrative, fall to be interpreted by the separate individuals filling in the template for each Health Board, and their interpretations will be different. So, for example, despite the challenges it outlines (above) NHS 24 offers substantial assurance, whereas NHS Fife, with its reference to evidence from self-assessment offers reasonable assurance. This is not a criticism of either Board, but it is obviously a direct result of the fact that the template is based on extensive narrative as opposed to other types of information.

12II (training)

IO 9 NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).

There also a preponderance of reasonable assurance given to this duty overall by Health Boards although they are more optimistic about this duty than they are about the 12IH duty, with eight (42%) giving substantial assurance for 12II (as opposed to three, 16%, for 12IH).

Challenges to ensuring staff receive the necessary training are similar to the challenges to delivering on the 12IH duty (i.e. workload pressures, staffing shortages, vacancies, and service demand). And the current utility of e-rostering (or the promise thereof) receives similar coverage. There are similar issues to do with the “match” between RAYG scores and narrative as were encountered with respect to duty 12IH.

The narrative to do with challenges includes, for example:

“Compliance levels with mandatory and induction completion are monitored and are there are currently system wide issues with compliance... Low compliance with statutory / mandatory training is a live risk on the corporate risk register” (NHS Orkney)

“While structured training frameworks exist, securing adequate time and resources for training remains a challenge, particularly due to staff shortages and service demands” (NHS Lothian)

“the organisation continues to face competing priorities and challenges, such as staffing shortages and service pressures, which can vary across different areas and time periods” (NHS Highland)

(the introduction of protected learning time for Agenda for Change employees)” may identify a level of activity requiring protection (sic) time for professionals that will be challenging to introduce whilst Boards are managing reduced working week and

covering staffing gaps during a period of financial challenge” (NHS Greater Glasgow and Clyde).

By way of apparent successes, we give examples below. Again, sometimes success is a little more implied than explicit, in that if these Boards do chase up and address non-compliance, one might assume that it is more likely than not that staff end up receiving the training that they should receive. But we accept that our inferences are arguable.

“Training has been provided across board on HCSSA and effective rostering to all senior leaders and clinical leaders. This has been via education roll out plan with face-to-face training, virtual training, awareness sessions, sessions at site/service huddles, 1:1 sessions and bespoke sessions Compliance is monitored through Learn pro and TURAS with data pulled from these platforms to NHS L Workforce Information dashboard” (NHS Lanarkshire)

“Time allocated for training is protected time. All disciplines are supported to attend face to face mandatory and statutory training. Nursing staff are issue(d) with their off duties every six week(s) and these off duties include rostered shifts for training.” (The State Hospital)

“All frontline skill sets (HCSW, Nurses, Dental Nurses, Pharmacists, Physiotherapists) receive induction training tailored to the need of each skillset. All frontline skill sets have associated competency frameworks. All frontline staff receive structured/detailed training with competency sign off relevant to role. All training is conducted via strict timetabling with supported protected training in the live environment once competency standard is achieved.” (NHS 24)

“There is a strong training culture in the Organisation and robust monitoring of all mandatory and essential training requirements and compliance is in place, including escalation of non-compliance (when this cannot be adequately met).” (NHS Shetland)

Conclusions

The limitations of the Scottish Government's reporting template for Health Boards have yielded the limited results that RCN expected. There is the anticipated focus on whether or not systems and processes are in place, and there is little or no robust information on the implied outcomes for nursing staff. This is not the fault of Health Boards, but it does mean that it cannot be said that any of those outcomes have been achieved.

The nature of the outcome-orientated duties (12IH and 12II) means the reporting on them is more illuminating but for both the picture is at best mixed, with the challenges reasonably clear but the solutions elusive.

It is certainly true to say that the extent to which clinical leaders are receiving time to lead and staff overall are receiving training cannot be said to be either consistent across Scotland or at the level that we would wish to see, which of course would be the equivalent of a 100% score all of the time.

However, what we do not accept is that it is not possible to collect and/or present more robust data on these two duties in particular (but also more generally) than that currently required by the template or written into it by Health Boards in response, and we would refer to NHS Lothian's approach (an internal "Compliance and Assurance Audit") to illustrate our point. We provide a consideration of that approach in the longer, more detailed version of this report.

[Proposed Solution 1](#)

[Proposed Solution 2](#)

4.1.2 Local Authority/ Integration Authority reports on guiding principles in care service staffing and planning s.3(6) duty

Local authorities and integration authorities are asked to explain how they have had regard to the matters set out in section 3(2) when “planning or securing the provision of a care service from another person” (i.e. third-party commissioning).

There is no duty of any kind on local authorities and integration authorities to report on compliance by care providers with any of the duties in the legislation. Nor is there any duty on any care providers to report on compliance under the Act. There is no duty placed on care providers equivalent to the duty to report on compliance placed on the NHS by section 12IM. The only duty to report on the extent to which care service providers are compliant with the Act actually falls on Scottish Government under section 9.

So, what information must these authorities provide? The Scottish Government template¹⁸ says:

“You should detail how these factors have been considered as part of the planning and securing stage of contracts, agreements or other arrangements made with a third-party provider. For example, detailing how these factors have been incorporated into procurement or commissioning procedures.”

In effect, this “example” is more than that. As far as we can see it is all that is legally required to demonstrate compliance. As for “detailing”, there is nothing in the law that we can see to suggest that any substantive detail is required, as opposed to the local authority or integration authority simply stating that these factors have been incorporated into procurement or commissioning procedures.

And indeed, in those local authority and integration authority reports that we have been able to find (on which see below) in all but a very few cases the authorities have spotted that this minimalist approach to reporting is perfectly permissible. And they have (quite reasonably in our view) reported as briefly as possible. For example, the Glasgow Health Social Care Partnership¹⁹ writes:

“In planning and securing these services, GCHSCP has taken account of the general principles of the Health and Care (Staffing) (Scotland) Act 2019. GCHSCP has also taken into account of the duties relating to staffing imposed on care service providers by virtue of subsection 3(1) and sections 7 to 10 of the Health and Care (Staffing) (Scotland) Act 2019.”

What does the data tell us about our implied outcomes?

The answer is – albeit not unexpectedly – nothing. It is not unexpected because we understood the limitations of the statutory reporting requirements, as covered in detail above, as soon as that text in the Act was finalised.

¹⁸ The template relates to section 3(2) and 3(6) of the Act. It was distributed to stakeholders in April 2024, by email, as an embedded document in issue 8 of the Scottish Government’s monthly newsletter on implementation of the Health and Care (Staffing) (Scotland) Act 2019. RCN has been unable to locate it online. It is referenced in the relevant chapter of the statutory guidance to the Act (chapter 15), but it does not appear in that guidance.

¹⁹ This is the “everyday” name used by the Integration Authority covering the local authority area of the City of Glasgow, which has taken the legal form of an Integrated Joint Board (IJB). The footnote is given for clarity but the labyrinthine structures of health and social care integration in Scotland are not really the concern of this paper.

We reviewed these reports this year by way of discovery. We do not intend to review them in future years.

On the matter of finding reports, we could only find 23 of them. Of those, too many were “buried” in a website, with no clear pathway to them from the home page (including not appearing in “publications” sections). This is an unfortunate interpretation of the phrase “must publish” in section 3(6) and does not support transparency in the public interest.

Conclusions

The information required by the Act and the reporting template in local authority/ integration authority reports on guiding principles in care service staffing and planning is, as RCN anticipated, not capable of telling us anything about the achievement of implied outcomes for staff. Having confirmed that which we anticipated with reference to the first year's reports we do not propose to look at these reports again in future years, unless the reporting requirements are changed.

[Proposed Solution 3](#)

4.1.3 Health Improvement Scotland (HIS) Reports

In this section, we will consider four instances of HIS reporting on activity that took place on dates during the first safe staffing year of the Act (1 April 2024 to 31 March 2025).

Inspections

Eleven reports²⁰ were of relevance covering:

1. Queen Elizabeth University Hospital (NHS Greater Glasgow & Clyde)
2. Royal Alexandra Hospital (NHS Greater Glasgow & Clyde)
3. Glasgow Royal Infirmary (NHS Greater Glasgow & Clyde)
4. Dr Gray's Hospital (NHS Grampian)
5. Western Isles Hospital NHS Western Isles)
6. Lorn and Islands Hospital (NHS Highland)
7. Raigmore Hospital (NHS Highland)
8. Victoria Hospital (NHS Fife)
9. Ninewells Hospital (NHS Tayside)
10. Cleland hospital (NHS Lanarkshire)
11. Queen Margaret hospital (NHS Fife)

For each category of inspection HIS notes “We will also consider the delivery of care in line with the Health and Care (Staffing) (Scotland) Act (2019)”

National overviews

- Safe delivery of care – Acute hospitals national overview report²¹

Reviews of care

- The NHS Greater Glasgow & Clyde Emergency Department Review²²

Health and Care Staffing Act 2019: HIS functions in relation to staffing annual report 2024-2025: April 2025²³

- This report uses data taken from Health Boards’ quarterly internal reports, as made by lead clinicians to the Board under section 12IF(2)(b), on the Board’s compliance with the Board’s new duties

What does the data tell us about our implied outcomes?

We accept that the results of the HIS inspections, and of the national overview (both of which cover acute services), and of the review of care, cannot be representative of anything other than the situation in the services inspected or reviewed. The value in

²⁰ https://www.healthcareimprovementscotland.scot/?s=&category=nhs-hospitals-and-services&updated_after=&updated_before=&search_context=publications and https://www.healthcareimprovementscotland.scot/?s=&category=mental-health-services&updated_after=&updated_before=&search_context=publications

²¹ <https://www.healthcareimprovementscotland.scot/publications/safe-delivery-of-care-acute-hospitals-national-overview-report-september-2025/>

²² <https://www.healthcareimprovementscotland.scot/publications/nhs-greater-glasgow-amp-clyde-emergency-department-review-may-2024/>

²³ <https://www.healthcareimprovementscotland.scot/publications/health-and-care-staffing-act-2019-his-functions-in-relation-to-staffing-annual-report-2024-2025-april-2025/>

analysing these reports is therefore largely anecdotal and illustrative. But it does allow us to spot apparent themes and commonalities.

HIS has already had a look at themes and commonalities itself, both in the national overview and in its report on the discharge of its own functions under the Health and Care (Staffing) (Scotland) Act 2019.

But in RCN's case, we are looking at something different: whether those themes and commonalities have something to tell us about whether or not our implied outcomes (IOs) are being achieved. We have gathered what we consider to be key extracts from the reports and matched them to our implied outcomes. We have excepted implied outcomes 7 and 10 because they are to do with care services, which are not covered by these HIS reports.

HIS reports are clearly set out, and where there is an issue concerning the 2019 Act this is usually referred to explicitly, whether dealt with as a "recommendation", a "requirement" or an "area of good practice."

The volume of text involved makes it impractical to include our matching document in the body of this report, but it can be made available on request.

We recognise that some readers may consider that our "key extracts" miss out something the reader would consider key, but this is an inevitable result of any process of selection. We note that sometimes HIS will talk about "staff" in the round, without distinguishing different staff groups. When this has happened, we have assumed that "staff" includes "nursing staff" unless the context dictates otherwise.

IO 2 Health and care nursing staff are physically and mentally well.

Despite there being a variety of initiatives to support staff health and wellbeing it is not always obvious that they are having the desired effect. That is because most of the reports note that they exist, but don't go much further, so it is not possible to conclude from them that nursing staff are physically and mentally well. Nevertheless, we do acknowledge there was positive feedback from staff in some Boards, for example, "staff told us (the support) was really helpful." Discouragingly, a ward in NHS Highland had "a sickness absence rate of 18.9%", which is almost five times the predicted rate (of 4%) used in workforce planning, but the bulk of the egregiously negative findings were in the NHS Greater Glasgow & Clyde Emergency Department Review, and these are clearly local problems.

There is an interesting illustration from NHS Greater Glasgow and Clyde of our point on the extent to which well-being initiatives' existence can be taken as implying that they work. Each of the three safe delivery of care inspections notes that there are a variety of wellbeing initiatives in place. Yet in the Emergency Department Review (which covers the same three hospitals) says "Although there was some wellbeing support available (for example, a wellbeing room), staff reported having little or no time to take up this support or even take a break."

IO 3 Health and care employers have been open with health and care nursing staff about decisions on staffing

HIS's annual report is fairly emphatic:

- “a recurring theme reported to inspectors by staff is that they often do not receive feedback in relation to decisions that have been made as a result of staffing escalations
- “What is less clear is how these conversations [to do with clinical advice on staffing] are robustly recorded or acted upon and how feedback is provided for staff.”
- “a common theme is emerging that staff do not receive feedback on the outcome of the staffing tools and the subsequent application of the Common Staffing Method.”

IO 4 Health and care nursing staff have been allocated efficiently and effectively

There were extensive findings across the reports, which can only be read as indicating that the efficient and effective allocation of staff is far from universal. For example,

- incomplete and/or inconsistent use of the Common Staffing Method is widespread. HIS’s annual report notes “It is apparent through the data, evidence and intelligence available to HIS, that Boards have yet to fully establish a robust system and process to ensure that they are compliant with the duty to follow the Common Staffing Method”
- a failure to appropriately exercise professional judgement on staffing levels
- a lack of real time staffing data
- short -and in at least one report unsafe -staffing levels, with nursing picked out as a particular problem “The workforce challenges and risks associated with staffing shortfalls, in particular nurse staffing, have been a consistent theme.”

IO 5 Multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care.

Although largely covered by way of simply noting their existence, rather than their promotion or increase, the references to multidisciplinary teams can be read optimistically to hint at their increase.

IO 6 NHS nursing staff’s physical and mental wellbeing has informed the arrangement of NHS nursing staffing.

Several reports include comments that suggest this implied outcome is certainly not being universally achieved. They usually concern the fact that staffing arrangements are causing poor physical and/or mental well-being and since nobody wants to have poor physical or mental well-being one can only conclude that those considerations have not informed the arrangement of staffing. For example, “staff... raised concerns regarding workload and skill mix, which is felt to be affecting staff wellbeing... staff described their working environment having a negative effect on staff wellbeing... reduced staffing was impacting on staff morale.”

HIS’s annual report notes “Another common theme identified through HIS inspections and other assurance work is staff raising concerns about the impact of staff shortages on patient and staff wellbeing.”

IO 8 NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.

Around two thirds of the reports highlighted challenges with enabling this to happen and, with one or two exceptions, we cannot say they provide much evidence that this implied outcome is being achieved. HIS's annual report notes that there are "challenges to ensure (sic) compliance."

IO 9 NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).

All the reports noted problems of one sort or another with the provision and/or receipt of training. HIS's annual report notes "Poor compliance with staff training is a recurring theme". There is little evidence that this implied outcome is being achieved.

The national overview report notes that "Other emerging themes and areas of improvement... include ensuring senior nurses have sufficient protected leadership time, staff receive adequate protected learning time to undertake required training for their role."

Conclusions

Naturally, HIS reports on selected services must paint a mixed picture, but even so it is clear that there is still some distance to travel to see our implied outcomes consistently achieved across Health Boards. Where HIS has identified problems with respect to the matters that our implied outcomes cover, several really do seem to be confined to the individual service or individual Health Board. That is encouraging in a sense, in that some problems are not widespread, although there are some pretty shocking examples of bad practice amongst the findings. But there are definite themes and commonalities. In the main there were issues relating to our implied outcomes nos. 2, 3, 4, 8, and 9 in all reports, and to nos. 5 and 6 in around half of them. There was less coverage of issues related to no. 1.

[Proposed Solution 4](#)

4.1.4 Scottish Government annual report in response to Health Board annual safe staffing reports s. 12IM (2) & (4)-(5) duty and,

4.1.5 Scottish Government annual report on staffing in care services s.9 duty

The Scottish Government produced one report for 2024-25 covering the section 12IM duty and the section 9 duty. It was published on 27 November 2025 ²⁴

What does the data tell us about our implied outcomes (health)?

In terms of our implied outcomes, we are looking to see whether anything in this report can tell us anything about the achievement of nos. 1-6, 8, and 9 (7 and 10 are care-service specific).

We have noted above the limitations of the Health Board reports upon which this section of the Scottish Government report is based. It is important to bear in mind that what the Scottish Government is able to say in its report is as much constrained by what information the template yields as the Health Board reports are constrained by what information the template requires. The Scottish Government report acknowledges that the “template evaluates systems, processes, and governance structures in place to meet the legislative requirements” and in doing so reminds us that it does not present comprehensive information on outcomes for patients resulting from these “systems, processes, and governance structures”,²⁵ and certainly does not present any information on outcomes for staff.

Our report and the Scottish Government report do not set out to look at the same things. That being the case we are not looking for the opportunity to disagree with the Scottish Government's assessment of the situation. So, when the Scottish Government, in its forward to the report, says of the Act, “the foundations laid in its inaugural year are promising” it may well be justified in saying so, based on the material it has considered in the way that it is obliged to consider it. But in this regard, it might be said to resemble a person doing no more than closing their eyes against the sun.

That said, sometimes the Scottish Government report comes closer to having something to say about our implied outcomes than at other times, and we briefly comment on those instances.

There is no meaningful consideration of (1) the extent to which any of the Health Boards report having had regard to the guiding principles in the Act or (b) compliance with the duty in section 12IA to ensure appropriate staffing as described in that section accounts for the well-being of staff as per section 12IA (1) (c).

As anticipated, the focus of the template on process means the focus of the Scottish Government report is on process

Taken together these two preceding points mean that, much like the Health Board reports, the report has nothing substantial to say about our implied outcomes 1-7.

Matters are a little different with respect to our implied outcomes 8 and 9, given they are drawn from what we have called the “outcome-oriented duties” in the Act.

²⁴ <https://www.gov.scot/publications/health-care-staffing-scotland-act-2019-2024-25-ministerial-annual-report/>

²⁵ Acknowledge that reporting on outcomes for service users is asked for (in general and in brief) in two worksheets of the template.

IO 8 NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.

“Section 12IH Duty to ensure adequate time given to clinical leaders... The majority (63%) of Boards indicated reasonable assurance with regards to this Duty, followed by 21% advising of limited assurance and 16% of substantial assurance.”

The comments made in the report are again largely about processes, whereas the nature of this duty means that the level of assurance should refer to the extent to which clinical leaders are actually *receiving* adequate time and not refer to the existence of processes intended to try to make sure that they do.

For RCN this is one of the most important duties in the Act, as it goes to the heart of the nurse staffing crisis in the NHS, because an inability to allow clinical leaders the time to lead is a significant indicator of problems with staffing levels and with the efficient and effective allocation of staff. There are few other professions where somebody elevated to a leadership or management role is expected to simultaneously continue to do the role from which they have been elevated because there isn't anybody else to do it. It is therefore very disappointing that only 16% of Boards (i.e. three of nineteen) were able to offer the substantial assurance which we would have hoped to see at this stage, after one year of “dry running” (2023-24) and a full year of implementation.

It is indicative of the problem with the reporting template that the Scottish Government report can say “Several Health Boards cited that these systems allow for the identification of protected clinical leadership time for the identified staff and allows for more easily demonstrative data to evidence compliance to Health Board monitoring groups” without being in a position to present that demonstrative data itself (because the template does not require Health Boards to do that), which would presumably give a much clearer understanding of the extent to which the duty had been complied with.

But if we allow ourselves to interpret the level of assurance data as having something to tell us about the extent to which our implied outcome 8 is being achieved, we have to say that in 84% of Health Boards (sixteen of nineteen) it is not being achieved.

IO 9 NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).

“Section 12II Duty to ensure appropriate staffing: training of staff... The majority (53%) of Boards indicated reasonable assurance with regards to this Duty followed by 42% advising of substantial assurance and 5% of limited assurance.”

This looks like an encouraging set of statistics particularly the substantial assurance score of 42%, which if added to the reasonable assurance score of 53% means that 95% Health Boards (i.e. all but one of the nineteen) were at least at the right end of the four-point assurance scale as described by Scottish Government in its report (on pages 13 & 14).

Unfortunately, all the information provided in the Scottish Government report (much as is the case in the Health Board reports) is only to do with the fact that training “systems and processes” are in place. There is no meaningful information as to whether or not staff have actually *received* the necessary training and so no meaningful information with respect to the extent to which our implied outcome 9 has been achieved.

On the section 2 duty for the planning and securing of services, we do not have any implied outcome directly related to this duty. But our implied outcomes would be applicable to any nursing staff working in services commissioned by those parties subject to the duty.

However, as we have confirmed above, the brevity of reporting on section 2(2) by Health Boards means that it does not have anything to tell us about our implied outcomes.

And this brevity also means that nor do the subsequent sections of this part of the Scottish Government report (“Key Themes”, and “Part 2: Healthcare: Duties on Scottish Ministers”).

These sections cover various policies and measures intended to achieve various outcomes that may also support the successful implementation of the Act, and some of which may be relevant to our implied outcomes. But they do not cover whether any of those policies and measures currently in place have worked or are working. For example, the section on page 32 to do with processes relevant to student intake makes no reference to comparative intake figures, which most recently showed a drop in intake.

Regular readers of Audit Scotland reports will be familiar with this problem inherent in the Scottish Government's long-standing approach to reporting,

Conclusions

In keeping with the content of the Health Board reports, upon which the Scottish Government annual report on health is based, there is little or no robust information on the implied outcomes for nursing staff and such information as can be discerned is limited and does not indicate that those outcomes are being satisfactorily achieved.

Our [Proposed Solution 1](#) should be taken to apply here also.

What does the data tell us about our implied outcomes (care)

In terms of our implied outcomes, we are looking to see whether anything in this report can tell us anything about the achievement of nos. 1-5, 7, and 10 (6, 8, and 9 are NHS-specific).

This part of the Scottish Government's report describes what it will cover as follows:

- How Local Authorities and Integration Authorities have carried out their duties under sections 3, 7 and 8 of the Act when providing, planning or securing care services
- The effect that staffing levels in care services have on the discharge of those duties
- The steps that Ministers have taken to support staffing levels in care services in order to assist the discharge of those duties

- How the matters detailed above will be taken into account in determining the future supply of registered nurses, medical practitioners and any other care professionals who fall within the scope of the duties imposed by sections 3 and 7
- The steps that Ministers have taken to ensure that funding is available to any person who provides a care service in order to assist the discharge of those duties.

We have already covered the matter of what local authorities and integration authorities are reporting. The section in the Scottish Government report entitled “Duties on Local Authorities and Integration Authorities” reflects our findings that the duty has been complied with primarily through the use of “procurement and contract frameworks and procedures” and “contract monitoring mechanisms.”

More useful is the Scottish Government’s attempt to use Care Inspectorate data about care service providers to illuminate progress in the section “Duties on Providers.” Most of this is to do with the Care Inspectorate’s support to care service providers to aid compliance, but the report does cite “a Provider Survey to gather valuable insight from providers who have no obligation to report under the Act.” The results are set out in page 44. In summary they are that providers have in place process for/provision of:

“Supervision and check-ins... Open communication and listening... Wellbeing initiatives and activities... Training and development... Work-life balance and flexibility... Mental health and emotional support.”

It is a good thing that providers have such things in place but as we have noted in other parts of this report, the existence of a process does not tell anybody anything about its efficacy and in this case, it doesn't tell us anything about our implied outcomes.

Of more potential use is the report on the Scottish Social Services Council (SSSC) “Have Your Say Workforce Wellbeing Survey 2025’ conducted between January and February 2025 and cited on page 45.²⁶ The Scottish Government report seems (unless we have misunderstood something) a little confused about the applicability of the survey results saying both “this survey falls outside of the reporting timeframe for the Health and Care Staffing Act 2024 Ministerial Report” (page 45) and “This (Ministerial) report covers the period of 1st of April 2024 to 31st of March 2025” (on page 9).

In our view, any survey conducted between January and February 2025 would very much fall into the remit of the ministerial report and so we have found it useful to look at the SSSC report.

Unfortunately, whether or not a respondent was in a registered nurse role or another type of nursing role was not one of the questions in the survey so that workforce cannot be disaggregated from the results. Respondents were asked to select a description of their role but, while some of the options appear more likely to be the ones that would be selected by somebody with a nursing role in social care, none of the options can safely be said to naturally include nursing roles.

That makes it nigh on impossible to make any definitive claims about the views of nursing staff based on the results of this survey. However, if we accept that there were likely to be some respondents who would meet our membership definition of “nursing support

²⁶ <https://data.sssc.uk.com/8-pages/405-sssc-have-your-say-survey>

worker,”²⁷ and that some of those respondents could very well be RCN members, we would risk doing those people a disservice if we did not at least consider what the survey tells us in terms of our implied outcomes.

In terms of the survey’s “key findings” (pages 3-6) the results set out under four of the eight²⁸ subheadings, in figure 7 below, are of most interest to us.

²⁷ <https://www.rcn.org.uk/membership/Nursing-support-worker-join>

²⁸ The other four subheadings were Joining the sector, Terms and conditions, Incomes, Views of the sector

Figure 7.

RCN Implied Outcome No.	SSSC Survey “indicator”	% response
	Likelihood to leave, staff turnover and management/leadership	
2	likely to leave their role in the sector in the next 12 months	22
2	likely to leave their role in the sector in the next 5 years	45
2, 4	reasons why: overworked	50
2	reasons why: low pay	40
2,	reasons why: poor employment or working conditions in general	33
2, 4	staff turnover is high	48
2, 4	reasons why: stress	87
2, 4	reasons why: workload	82
2	reasons why: lower staff morale	8
	Satisfaction with current job	
2	completely/mostly/somewhat dissatisfied	35
2	completely/mostly/somewhat satisfied	56
2	recommend their organisation as a great place to work	47
4	colleagues help and support them	75
2	job gives them a feeling of satisfaction	60
4	manager helps and support them	58
2	morale is good always/most of the time.	56
4	the right staff are in place to deliver services	48
2	morale amongst colleagues is good	40
2	felt valued by colleagues.	76
	Wellbeing at work	
4	have enough time to do their job well	43
2, 7	support is in place for dealing with stress.	30
2, 7	reasons for stress: too much work to do/not enough time to do their work	51
2, 7	reasons for stress: paperwork/ bureaucracy	48
4	reasons for stress: lack of support from managers or colleagues if they need help	34
2	experienced bullying, harassment or discrimination at work	37
	Skills and training	
10	training and learning opportunities available	73
10	have enough training/learning opportunities to fulfil their CPL requirements	69
10	get the right training to do their job well.	69
10	supported to gain qualifications for registration purposes,	65
10	barriers: lack of time	29
10	barriers: employers not allowing time off for training	24
10	barriers: availability of courses	24

IO 2 Health and care nursing staff are physically and mentally well.

Most respondents intend to stay in their posts; but of those who don't, half cite being overworked as the reason. A third cite poor employment or working conditions in general. Almost half of respondents say that staff turnover is high, with stress and workload being the two main reasons.

Over a third are dissatisfied at work, but there were still some positive scores when it came to describing the workplace to do with mutual support and morale.

The picture is therefore mixed, although it is clear that there are issues with stress and overwork, and it is hard to say more than that some staff are physically and mentally well and some are not.

IO 4 Health and care nursing staff have been allocated efficiently and effectively

It is difficult to assert that this has been the case in care services when issues of overwork and stress are so prevalent. Efficient and effective allocation should see a reduction in overwork and stress. The figures showing

- that less than half of respondents say that the right staff are in place to deliver services, and
- that barely half have enough time to do their job well; speak for themselves.

IO 7 Care nursing staff's physical and mental wellbeing has informed the arrangement of care nursing staffing

Overwork and stress are prevalent. They are not conducive to good physical and mental wellbeing. If overwork generally, and in some instances to do with specific tasks (e.g. paperwork/ other bureaucracy), can be taken to be caused by the way that staffing has been arranged (because staff wouldn't be over worked if it had been arranged appropriately) then it suggests that care nursing staff's physical and mental wellbeing has *not* informed the arrangement of care nursing staffing.

IO 10 Care nursing staff have received the necessary training (for the work they are to perform and assistance, including time off work, to gain further qualifications

There is a more positive story here with high scores in terms of training opportunities, sufficiency, and appropriateness, and in terms of overall support for gaining qualifications for registration purposes, especially because being given support to gain qualifications is a specific requirement of the safe staffing legislation. But it is discouraging to see that around a quarter to a third report the barriers described, and that is especially so given that allowing time off for training also a specific requirement of the legislation.

A note on section 7

The Scottish Government report then moves on to reporting on section 7 of the Act (the overarching safe staffing in care). In terms of our implied outcomes the provisions of Section 7 are, in theory, capable of supporting the achievement of implied outcomes nos. 2, 4, and 7. In keeping with the Scottish Government's earlier assertions about a lack of data, there is little data available on the extent to which the Section 7 duty is being met

by the care providers upon whom it falls. All that the report is able to say is that it appears that commissioners and providers are seeking to implement that section's provisions, and that processes to do so are in place. But there is no data referenced that is capable of telling us anything about the extent to which our implied outcomes nos. 2, 4, and 7 are being achieved.

A note on section 8

The section 8 duties (to do with staff training) are in theory capable of supporting the achievement of implied outcome no. 10. The report notes the requirements of SSSC registration with respect to training, but this doesn't tell us anything about the extent to which section 8 has been properly implemented. The reports relies on the same assurances to do with commissioning and other process and resources as noted above with respect to other parts of the legislation. This is of little assistance for our present purposes. The Have Your Say survey is referred to again by way of evidence.

Subsequent sections of the report deal with staffing levels and matters of workforce size and supply, amongst other things, but they do not tell us anything substantial about our implied outcomes. Such issues of interest as they do cover have been looked at by RCN elsewhere in this report.

Conclusions

The reporting structure of the Act with respect to care services does not provide for meaningful data to be collected or published in terms of our implied outcomes,¹ and so, as anticipated, no meaningful data is available directly through the operation of the Act. Insofar as meaningful data may be obtained from elsewhere, the SSSC "Have Your Say" survey has some limited use, but we could only rely on it speculatively. What it does show is that, generally speaking, respondents to it displayed a mixed picture as to their physical and mental health, with stress and overwork common, which strongly suggest staffing is rarely arranged effectively or efficiently or with staff wellbeing in mind. But there is a more positive story to tell about access to, and receipt of, training.

Our [Proposed Solution 1](#) should be taken to apply here also.

[Proposed Solution 5](#)

4.2 Other data sources

4.2.1 The Nurses4Scotland Study

The Nurses4Scotland Study was a collaborative endeavour between the University of Pennsylvania in the USA and Edinburgh Napier University. RCN worked with the researchers to help make the study relevant to the Scottish context, but RCN did not fund it, and the study is a wholly independent piece of research. One paper has already been published²⁹ and more are due to follow.

The study was conducted with nursing staff within the NHS (so it does not cover care settings) between May 1 and July 31, 2024. So, although the Act had been applicable for one month by the time the study began and for four months by the time it ended it still covers the very early days of the Act's implementation. This is an important point. The first published paper describes itself as "The Scottish Safe Staffing Act at Baseline: Quantitative Findings" and, as that title indicates, the purpose of this first study was very much to establish a baseline from which progress in subsequent years could be gauged by way of future studies.

Whilst the potential to track trends over time was always going to be the study's main strength it also afforded us the potential opportunity to get some approximate indication of

- the extent to which matters which should already have been being addressed by employers appear to have been being addressed at the precise point of implementation (i.e. 1 April 2024), given the Act (in the main) codifies good (and in many cases existing) practice rather than introducing any fundamentally new concepts and,
- the extent to which those matters were addressed in the first few months of the Act's implementation.

We have mapped the relevant questions from this survey with eight of our implied outcomes in figure 8. We have removed the two implied outcomes solely to do with care (nos. 7 & 10) because of Nurses4Scotland's NHS focus.

The researchers were kind enough to provide us with the exact percentage scores from data that informed the published paper as already footnoted. But other than being able to be exact about all percentages, we have not included anything here that does not already appear in that published paper.

²⁹ <https://sigmapubs.onlinelibrary.wiley.com/doi/10.1111/jnu.70013>

Figure 8.

RCN Implied Outcome No. & N4S Report Fig Ref.	RCN Implied Outcome Text & N4S Report Text	Frequency or Agreement	%	Frequency or Agreement	%
1	Health and care nursing staffing has been arranged while taking into account the views of nursing staff				
Fig. 3	(Staffing level) ensures taking account of the views of staff and service users.	Disagree, Strongly Disagree	64.59	Agree, Strongly Agree	35.42
Fig. 4	I am engaged in the staffing decision process for my clinical area.	Never, Rarely, Occasionally	80.13	Frequently, Always	19.91
Fig. 4	Appropriate clinical advice is provided when considering staffing.	Never, Rarely, Occasionally	77.65	Frequently, Always	22.35
Fig. 5	Clinical advice on staffing is sought.	Never, Rarely, Occasionally	69.92	Frequently, Always	30.08
2	Health and care nursing staff are physically and mentally well.				
Fig. 3	(Staffing level) ensures the well-being of staff.	Disagree, Strongly Disagree	77.65	Agree, Strongly Agree	22.35
3	Health and care employers have been open with health and care nursing staff about decisions on staffing.				
Fig. 3	(Staffing level) ensures being open with staff and service users about decisions on staffing.	Disagree, Strongly Disagree	70.4	Agree, Strongly Agree	27.59
Fig. 4	I am informed of outcomes in staffing decisions.	Never, Rarely, Occasionally	74.39	Frequently, Always	25.61

4	Health and care nursing staff have been allocated efficiently and effectively.				
Fig. 2	How often is nursing staffing appropriate to provide safe, high-quality care?	Once a week, Less than once a week, Never	53.81	Several times a week, every shift	46.2
Fig. 3	(Staffing level) ensures efficient and effective allocation of staff.	Disagree, Strongly Disagree	75.11	Agree, Strongly Agree	24.9
Fig. 4	Staffing levels are set based on what is available/funded rather than what is needed for patient care.	Never, Rarely, Occasionally	17.05	Frequently, Always	82.95
Fig. 5	Appropriate staffing levels of individuals that are suitably qualified and competent is achieved.	Never, Rarely, Occasionally	70.45	Frequently, Always	29.55
Fig. 5	Appropriate staffing levels are achieved by employment of bank and/or agency workers	Never, Rarely, Occasionally	59.84	Frequently, Always	40.16
5	Multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care				
Fig. 3	(Staffing level) ensures a multi-disciplinary approach to care.	Disagree, Strongly Disagree	33.17	Agree, Strongly Agree	66.83
6	NHS nursing staff's physical and mental wellbeing has informed the arrangement of NHS nursing staffing.				
Fig. 3	(Staffing level) ensures the well-being of staff	Disagree, Strongly Disagree	77.65	Agree, Strongly Agree	22.35
8	NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.				
Fig. 5	Adequate time and resources are given to clinical leaders (e.g. senior charge nurses/community team leaders) to:				

Fig. 5	Supervise clinical care	Never, Rarely, Occasionally	84.98	Frequently, Always	15.02
Fig. 5	Support the development of staff	Never, Rarely, Occasionally	84.31	Frequently, Always	15.69
Fig. 5	Lead the delivery of safe and high-quality care	Never, Rarely, Occasionally	79.66	Frequently, Always	20.34
		<i>Average across three tasks:</i>	82.98	<i>Average across three tasks:</i>	17.02
9	NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).				
Fig. 5	Time and resources for training of staff is appropriate.	Never, Rarely, Occasionally	84.48	Frequently, Always	15.52

What does the data tell us about our implied outcomes?

We made public comment on the results at the time of the publication of the first paper.³⁰ But beyond that in terms of this present report, we can say with confidence that the survey results provide little or no evidence that any of our implied outcomes nos. 1-4, 6, 8 & 9 were being achieved to any significant extent at the time of implementation or during in the first four months of the Act's implementation. This is somewhat dispiriting given the codifying aspect of the Act as described above.

There is perhaps a sliver of good news with respect to implied outcome 4. Whilst plugging gaps in staffing levels with bank and/or agency workers is not an ideal approach, almost 60% of respondents say that gaps are being plugged, which is something, if not a great deal.

We acknowledge that there is one “stand out” positive result with respect to our implied outcome 5. 66.83% of respondents agree or strongly agree that “(Staffing level) ensures a multi-disciplinary approach to care”, which we consider is capable of indicating that “multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care.”

Conclusions

The Nurses4Scotland survey remains the most “on point” and resonant data source available to us when trying to gauge the impact of the Act on nursing staff in terms of our implied outcomes. This is unsurprising given the deliberate link between the survey questions and the text of the Act itself.

The survey results are disappointing but given the survey only covers the first four months of the Act's implementation, we prefer not to draw a disproportionate amount of negative inference from them. Rather than do that, RCN will be looking to ensure that this valuable independent study can be repeated in future years on the basis that its strength lies in its capacity to track trends over time.

[Proposed Solution 6](#)

³⁰ <https://www.nursingtimes.net/policies-and-guidance/scottish-nurses-doubtful-about-ability-to-meet-safe-staffing-law-28-05-2025/>

4.2.2 NHS and Care Providers Annual Health and Social Care Staff Experience Report (iMatter)

iMatter is Scotland’s Health & Social Care Staff Experience Survey. It reaches staff by being distributed through the Health and Social Care Partnerships.

Although iMatter reaches beyond NHS staff, iMatter is structured around the NHS Scotland staff governance standard and its five “strands.”³¹

We were not convinced that iMatter was a useful data source for our purposes. But in the spirit of enquiry, we decided to treat the iMatter results at face value and see what the scores for the strands can tell us about our implied outcomes. We have therefore attempted to map our implied outcome (IO) to the five strands -but not their component questions –in figure 9.

The actual iMatter scores for 2024 and 2025 for the strands and their component questions are shown in the table in appendix 2.

Figure 9.

	Implied Outcome	Staff Governance Strand 1-5 Text
1	Health and care nursing staffing has been arranged while taking into account the views of nursing staff.	3 involved in decisions
2	Health and care nursing staff are physically and mentally well.	5 provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community
3	Health and care employers have been open with health and care nursing staff about decisions on staffing.	1 well informed
4	Health and care nursing staff have been allocated efficiently and effectively.	5 provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community
5	Multi-disciplinary services involving health and care nursing staff are being promoted / increasing in health and care.	(No map)
6	NHS nursing staff's physical and mental wellbeing has informed the arrangement of NHS nursing staffing.	5 provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community
7	Care nursing staff's physical and mental wellbeing has informed the arrangement of care nursing staffing.	5 provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community
8	NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.	4 treated fairly and consistently, with dignity and respect, in an environment where diversity is valued (Loose map)
9	NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).	2 appropriately trained and developed
10	Care nursing staff have received the necessary training (for the work they are to perform and assistance, including time off work, to gain further qualifications).	2 appropriately trained and developed

What does the data tell us about our implied outcomes?

The lack of movement between 2024 and 2025 (see appendix 2) suggests that the introduction of the legislation has made absolutely no difference at all and so can only tell us that, as far as can be told from iMatter, none of our implied outcomes have been achieved.

However, we recognise that:

- The outcomes we have identified are implied, not explicit, and therefore contestable and, in any case, iMatter is not intended to serve as an indicator for them or for anything else connected with the legislation.
- Despite the high national response rate from nursing and midwifery (45.2% see above) which implies considerable year-to-year consistency in the members of nursing and midwifery staff completing the survey, those who did so in 2025 will not be exactly the same as those who did so in 2024.
- Given that the requirements of the staff governance standard are to some extent similar to the requirements of the legislation, we can see that it is possible to argue that the lack of movement in scores between years could be taken as showing that at least some of the matters that the Act was intended to address were already being addressed by way of the staff governance standard and that the lack of movement represents not an absolute failure but a form of consistency.
- The NHS Nursing and Midwifery strand scores (out of 100, see appendix 2) are reasonably high. One might conclude from them that, accepting the sample of respondents *is* representative, most of the Nursing and Midwifery workforce in the NHS, is well-informed (79), appropriately trained and developed (77), treated fairly & consistently, with dignity & respect, in an environment where diversity is valued (79), and provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community (77), if a little less involved in decisions (71). If this is generally true, one might assume this reflects that workforce's view of the extent to which certain implied outcomes in the Act are being achieved, or even merely the extent to which they were satisfied with staffing matters – even if respondents were not thinking in the specific terms of the Act. On the one hand, these can only be assumptions, which the iMatter data can hardly be said to support in any robust way. On the other hand, the idea that those with serious deep-rooted concerns about staffing, or anything else, would nevertheless provide such positive scores, without letting those concerns drag those scores down, seems a little unlikely. 34,824 staff self-categorising as 'Nursing and Midwifery' in the NHS answered the survey. No further breakdown is given but according to TURAS, the total NHS Nursing and Midwifery workforce figure during the survey period (May to July 2024), was 66,725 (30 June 2024), which means that just over half of that workforce completed the survey. To dismiss the relatively positive scoring as unrepresentative is therefore not possible.

Conclusions

The mapping of our implied outcomes onto the staff governance strands might have allowed us to glean more than we have been able to glean if there had been any movement in the iMatter scoring between 2024 and 2025. But there wasn't and so there isn't.

This doesn't mean that iMatter will be incapable of telling us anything in future years. But having looked at the survey in detail this year, and bearing in mind our comments above, we remain somewhat doubtful.

We note that some Health Boards have cited iMatter results as possible evidence of compliance with the Act. But using iMatter in its current form to do this raises the same issues for Health Boards that we have outlined above with respect to our own purposes. For example, NHS Glasgow and Greater Clyde (GGC) does so, and writes in its annual report to Scottish Government "Our 2024 results will be considered against those in 2025 and consideration on how the Acts aim and duties may have influenced this positively." That comparison is now possible for the staff complement if treated as one group, if not for nursing and midwifery separately (because board-level results are not broken down by staff grouping in the published data). That comparison shows that GGC's strand scores show no change from 2024 bar a one-point rise in strand 3 (involved in decisions). To be fair to GGC, only one Health Board records a two-point rise and that is for one strand (NHS Forth Valley, for strand 2) and some Health Boards see falls of 1-2 points. Plus, GGC is not an outlier compared with other territorial Health Boards. But nevertheless, we imagine that GGC would have preferred to see a more marked change. And if it had, one could not fault it for using that change as possible evidence. Health Boards are only using such tools as are available to them.

We do believe that the advent of the Act means that it is now time to revisit iMatter in the ways set out in our proposed solutions and that doing that would assist others in using iMatter to demonstrate compliance with the Act as much as it would assist RCN in gauging the extent to which our implied outcomes are being achieved.

[Proposed Solution 7](#)

4.2.3 NHS Scotland sickness absence statistics for nursing staff

4.2.4 NHS Scotland data on use of bank and agency staff

Official figures for bank and agency use³² for nursing are published annually, with both spend and hours used as measures.

In figure 10, we have mapped the two sets of NHS data against our implied outcomes in a similar way to the way we mapped for the Nurses4Scotland survey questions. In our view, the data only had the potential to illuminate two of our implied outcomes (nos. 2 and 4).

Figure 10.

RCN Implied Outcome No.	RCN Implied Outcome Text	What the data tell us
2	Health and care nursing staff are physically and mentally well.	<p>“Working time lost due to sickness absence has increased in the majority of NHS boards with an average nursing absence rate of more than 7% across NHS Scotland.”</p> <p>“the nursing absence rate average across NHS Rates in the vast majority of territorial and special NHS boards are not only above the sickness absence rate of 4% included in the predicted absence calculations for staffing levels, but recurrently and substantially above... Indeed, the nursing absence rate average across NHS boards... was 7.7% for April to December 2024, close to double the rate included in the predicted absence rate.”</p>
4	Health and care nursing staff have been allocated efficiently and effectively.	<p>Bank: Total cost of £353.4 million, an increase of £14.5 million, from £338.9 million (4.3%) Total hours of 13.2 million, a decrease of 0.5 million from 13.7 million (3.7%)</p> <p>Agency: Total cost of £56.7 million, a decrease of £94.5 million, from £151.2 million (62.5%) Total hours of 1.3 million, a decrease of circa 2.1 million from circa 3.3 million (62.2%) (figures subjected to rounding)³³</p>

What does the data tell us about our implied outcomes?

³² <https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/02-december-2025-workforce/dashboards/nhs-scotland-workforce/?pageid=15193>

³³ The exact figures are 3,304,866 million for 2024 and 1,250,309 for 2025, which gives the % figures of 62.2.

IO2 Health and care nursing staff are physically and mentally well.

An average sickness absence rate of 7.7% still means that the average attendance rate is over 92% and we shouldn't lose sight of that. But our employment survey (see below) shows that many nursing staff go to work even when they are sick, which is a deeply regrettable state of affairs. And since most people in the workforce are not sick most of the time, whether they are nursing staff or otherwise, the average attendance rate is not necessarily a helpful comparison. We are not of the view that proportionately small variations in the normal are as significant as proportionately large variations in the abnormal.

There is no ideal sickness absence rate and so one can argue endlessly about whether any rate can be said to indicate whether the workforce is “physically and mentally well”. For our purposes, in terms of our implied outcome 2, we would at least expect to see the workforce becoming *increasingly* physically and mentally well as the Act is implemented. Unfortunately, this has not been the case and in the first safe staffing year matters are heading in completely the wrong direction.

IO 4 Health and care nursing staff have been allocated efficiently and effectively.

Although bank costs have risen, bank hours have decreased. Affording ourselves the positive assumption that the decrease does not simply equate to unfilled shifts, the decrease is to be welcomed insofar as it is capable of indicating that there has been less *need* to secure bank cover for shifts

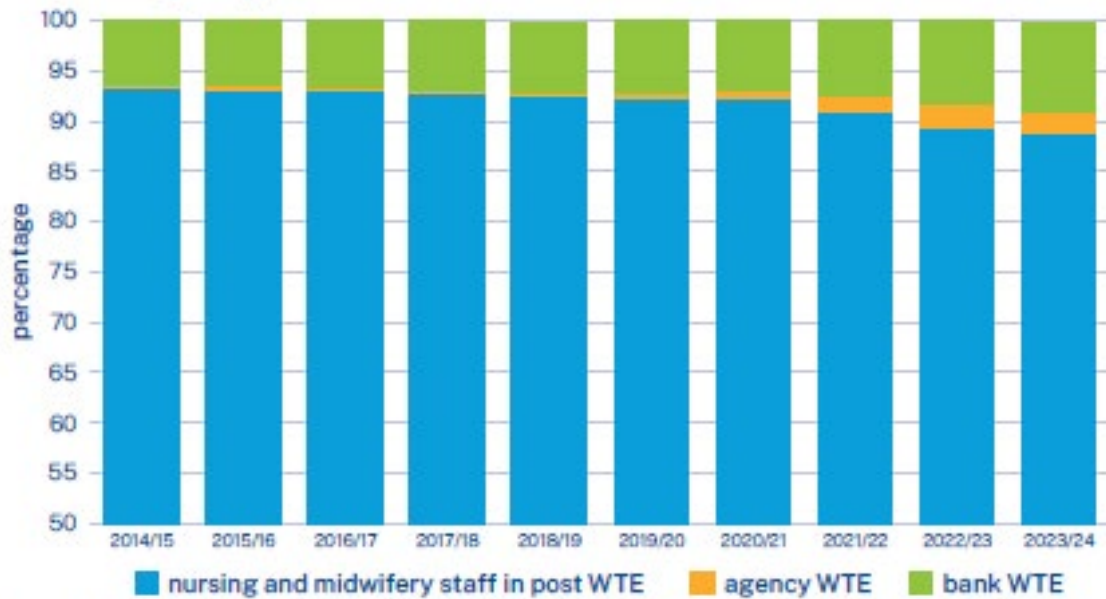
As we noted in our 2025 workforce report, “The Nursing Workforce in Scotland 2025”,³⁴ it may be that the now dramatic drop in agency use is further evidence of “the impact of the Scottish government commitment to reducing reliance on high price agencies not on the NHS Scotland national procurement framework.” If we afford ourselves the same positive assumption about this drop as we do about the bank decrease, the drop is to be welcomed, and for the same reasons.

It is therefore reasonable to construe the changing figures on bank and agency use as indicative evidence of *rising* efficiency and effectiveness in the allocation of staff, primarily through their normal employment. We acknowledge that such a rise, even if it is quite small, is good news.

There may also be further support for this good news if we take figure 18 (which runs to 2023/24) on page 38 of our 2025 workforce report and then look at the figures for 2024/25.

³⁴ <https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/the-nursing-workforce-in-scotland-2025>

Figure 18: Total nursing and midwifery workforce (WTE) (staff in post, bank and agency)



Source: NHS Education for Scotland NHS Scotland Workforce Statistics

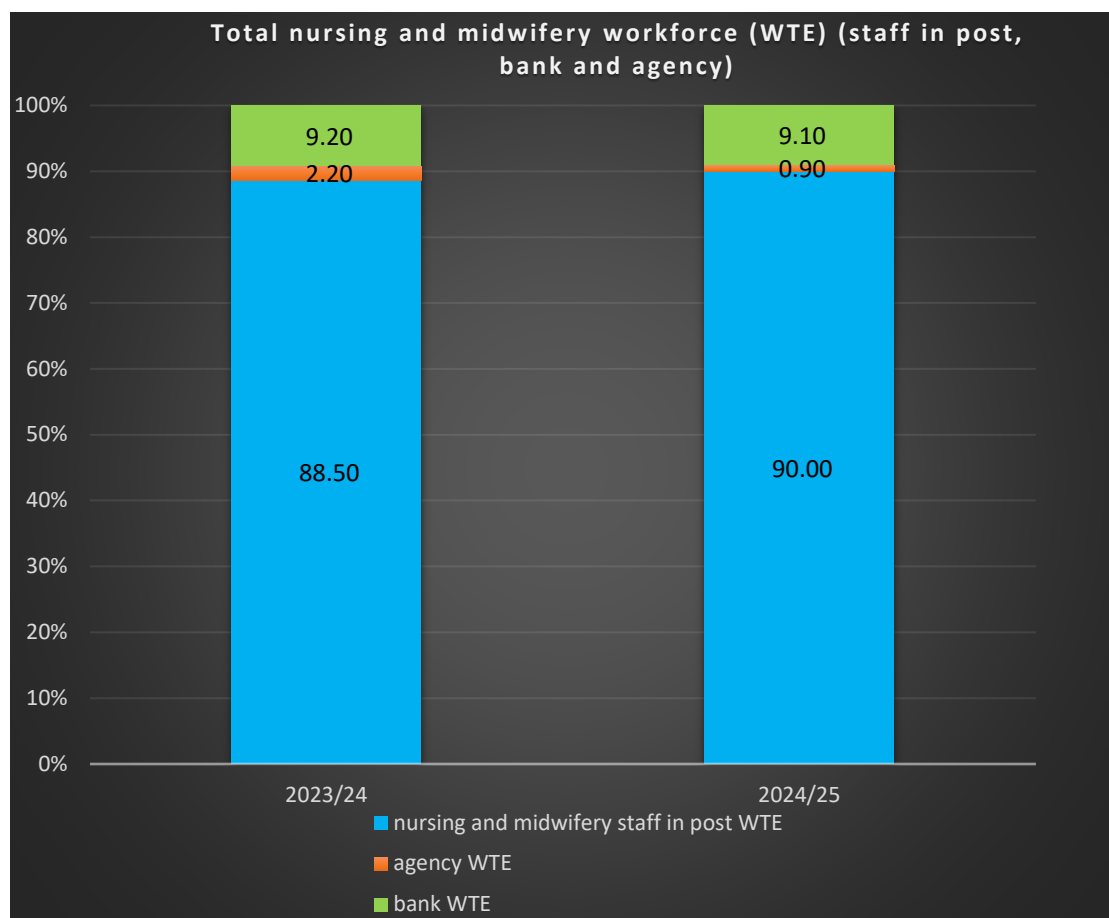
At 31 March 2025 total nursing and midwifery staff workforce capacity has decreased to 75,213.6 WTE. That’s a drop of 666.4 from 75,880 in 2023-24 or 0.9%. But in fact, the decrease is all in the use of bank and agency. The WTE figures for both have dropped as follows:

- Bank: down 167.7 to 6849.2 from a 2023-24 total of 7016.9 (a 2.4% drop)
- Agency: down 1,045 to 649.8 from a 2023-24 total of 1694.8 (a 38.3% drop)

The figure for employed nursing and midwifery staff in post is up by 546.3 to 67,714.6 from a 2023-24 total of 67,168.3 (a 0.8% rise).

Representing the 2024/25 figures in the same way as Figure 18 (that is, as percentages of the total nursing and midwifery workforce (WTE)), we see that capacity from bank staff has decreased from 9.2% to 9.1%, while capacity from agency staff has decreased from 2.2% to 0.9%. Capacity from employed staff in post has increased from 88.5% to 90%.

Figure 11.



What this comparison is capable of indicating, at least to some extent, is that more extensive use is being made of employed staff in post as opposed to bank and agency staff. And since bank and agency staff are essentially used to “plug gaps”, when there are insufficient employed staff in post to provide the required coverage, this supports the above contention that there has been some small progress in the achievement of our implied outcome 4.

We do understand that this sole indicator cannot tell the whole story, but we do not make any claim that it does. That should not detract from such optimism as we may draw from it. Nevertheless, before we get too Panglossian, we continue to be of the view that, at 10%, the proportion of supplementary staff providing capacity to NHS Scotland’s nursing and midwifery workforce is still too high. And that, as we say in our 2025 workforce report:

- “agency use plus the use of bank nursing to supplement the workforce continues to demonstrate the scale of gaps in the nursing workforce”
- “This data shows only the shifts that have been filled by bank and agency staff, so does not represent a true reflection of demand for short-term supplementary

staffing. There will be a proportion of requested shifts left unfilled or filled by existing staff doing additional hours or overtime.”

There are other factors (and relevant NHS data) that we covered in our 2025 annual workforce report (and in previous workforce reports) that might be said to be capable of either facilitating or militating against efficiency and effectiveness in the allocation of staff in the NHS. For example,

- Growth or reduction in the nursing workforce, including matters of recruitment and retention, nursing student numbers, numbers leaving employment including retirement)
- Rises or falls in nursing vacancies
- Patterns of patient/service user demand

But we do not consider data on these matters to be sufficiently capable of serving as a proxy indicator for our implied outcome 4 in this present report.

We accept that some readers may be of the view that the bank and agency data is not “sufficiently capable” either and we do recognise its limitations. That is why we have drawn only cautious and modest inferences about our implied outcomes from that data.

The clearest way of demonstrating efficiency and effectiveness in the allocation of nursing staff is by comparing the number and nature of the nursing staff that were deemed required for any given type of care on any given shift (both in terms of numbers and in terms of skill mix) and the number and nature of nursing staff that were in fact provided, accompanied by an understanding of where they were provided from, i.e. employed staff, bank, agency.

The greater the congruence between those sets of data, and the greater the proportion of staff provided from employed staff in post (and accounting for the matter of those staff working additional hours or overtime), the more efficient and effective allocation there has been. And vice versa. We consider that the data set most likely to robustly support such a comparison is to do with the application of the Common Staffing Method (CSM). But this data is not published. And we have made comment on that point already in this report in section 3.

Conclusions

The sickness absence figures for nursing show an increase which suggests the Act is not, in its first year, having the effect hoped for in terms of the physical and mental well-being of staff.

The bank and agency use figures show small positive changes that should give us cause for optimism. But there is a considerable way to go before we can confidently say that these figures are markedly heading in the direction that we hope they will, in light of the Act being in effect, and to more comfortably ascribe such changes to its provisions

[Proposed Solution 8](#)

[Proposed Solution 9](#)

[Proposed Solution 10](#)

4.2.5 Scottish Social Services Council (SSSC) data on the social care workforce

On the matter of social care data, there are similar challenges with the relevance of the available data for the purposes of this report. The most substantial data source is the SSSC annual report on workforce data.³⁵

What does the data tell us about our implied outcomes?

Unfortunately, the data in the report cannot be used as legitimate indicators of the achievement or otherwise of any of our implied outcomes.

Conclusions

We have established that Scottish Social Services Council (SSSC) data on the social care workforce is not a suitable data source for our purposes and we will not look to it in future years.

No Proposed Solutions.

³⁵ <https://data.sssc.uk.com/data-publications/22-workforce-data-report>

4.2.6 RCN Employment Reports

RCN conducted its most recent biennial UK-wide employment survey, “State of the Profession Report RCN Employment Survey 2025” in the period 17 July to 9 August 2025 and published it on 2 December 2025.³⁶ Scottish data was disaggregated and published in a stand-alone report “State of the Profession Report RCN Employment Survey 2025: Scotland” also on 2 December 2025.³⁷ There were 1,883 respondents working in Scotland. The Act had therefore been in place for over a year when RCN members working in Scotland answered the questions. The survey before that was conducted in 2023, prior to the Act’s commencement.³⁸

There is obviously not a direct map from the survey questions to our implied outcomes, since the former were not formulated with the latter in mind. But we consider that the survey statistics can be nevertheless mapped to seven of our ten implied outcomes (the exceptions being nos.1, 3, and 5) in the sense that they have something to tell us about the achievement of those outcomes. That mapping and the two sets of figures are shown in figure 12, with the 2023 and 2025 figures compared graphically in figure 13.

³⁶ <https://www.rcn.org.uk/Professional-Development/publications/rcn-employment-survey-2025>

³⁷ <https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/employment-survey-2025> not to be confused with the 4-page summary here <https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/rcn-employment-survey-2025-scotland-summary-briefing>

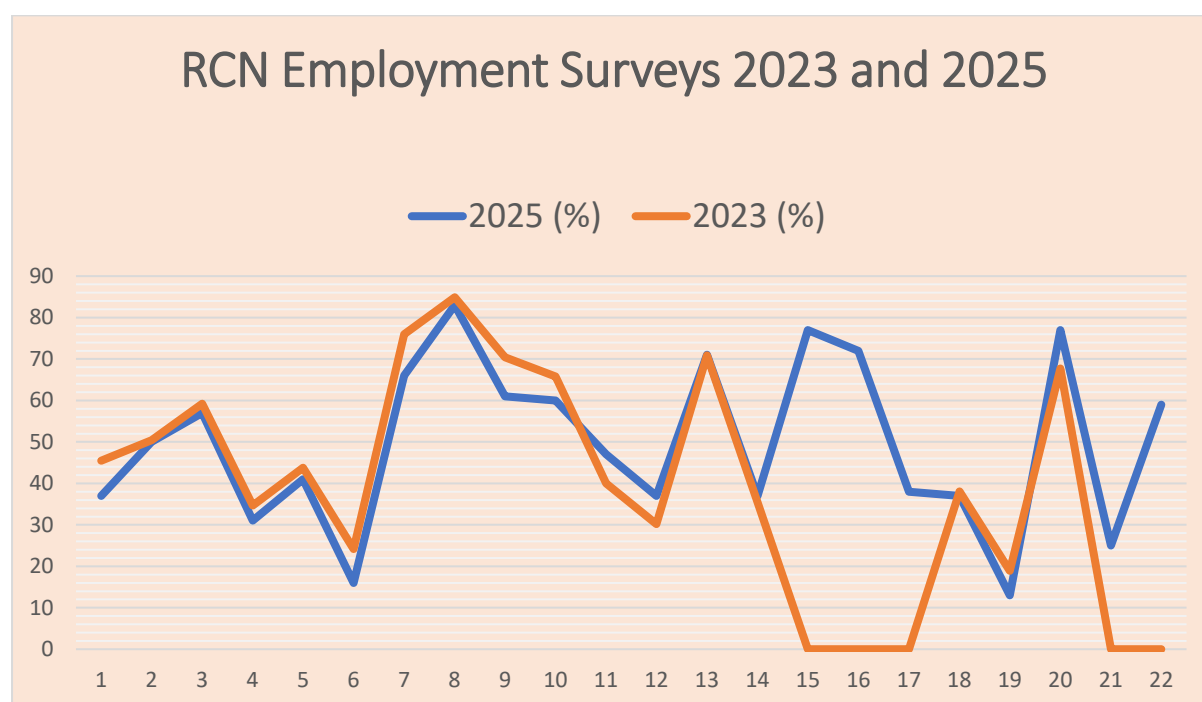
³⁸ <https://www.rcn.org.uk/Professional-Development/publications/rcn-employment-survey-2023-uk-pub-011-484> and <https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/rcn-employment-survey-2023-scotland-summary>

Figure 12.

RCN Implied Outcome no.	Issue for respondents	2025 (%)	2023 (%)	Movement (%)
2	1 actively planning on leaving or thinking about leaving their job, pointing to a significant level of workforce instability.	37	45.5	-8.5
2	2 enthusiastic about their job most days	50	50.4	-0.4
2	3 nursing is a rewarding career	57	59.2	-2.2
2	4 would recommend nursing as a career	31	34.7	-3.7
2	5 disagreed with the proposition that they would not want a job outside nursing – suggesting a readiness to leave the profession.	41	43.8	-2.8
2	6 regret their career choice	16	24.2	-8.2
2, 4, 6/7	7 work over their contracted hours at least once a week with 53% (54%) saying that these hours were unpaid.	66	76	-10
2, 4, 6/7	8 worked when unwell on at least one occasion over the previous 12 months, despite feeling too ill to do so	83	84.9	-1.9
2, 4, 6/7	9 under too much pressure at work.	61	70.4	-9.4
4	10 too busy to provide the level of care they would like	60	65.8	
4	11 satisfied with working hours	47	40	+7
2, 6/7	12 feel able to balance their work and home lives	37	30.2	+6.8
2, 6/7	13 experienced verbal abuse by patients/service users or relatives	71	70.9	+0.1
2, 6/7	14 experienced physical abuse.	37	35.4	+1.6
2, 6/7	15 Of those who experienced verbal abuse, not satisfied with employer response	77	N/A	N/A
2, 6/7	16 Of those who experienced physical abuse, not satisfied with employer response	72	N/A	N/A
2, 6/7	17 feel that reporting leads to meaningful action or change	38	N/A	N/A
2	18 reported experiencing bullying or harassment from a colleague in the past 12 months	37	38.1	-1.1
2, 6/7	19 been the target of sexual harassment from patients/service users, their relatives or other members of the public.	13	18.9	-5.9

9/10	20 completed all their mandatory training in the previous 12 months	77	67.7	+9.3
9/10	21 mandatory training was done in their own time	25	N/A	N/A
8	22 had an appraisal/development review with their line manager in the last 12 months (not covered in 2023).	59	N/A	N/A

Figure 13.



The x (horizontal) axis numbering in figure 13 is taken from the “Issue for respondents” column in figure 12.

What does the data tell us about our implied outcomes?

It is good news that there have been improvements since 2023 across twelve of the above issues (nos. 1, 5-12, 17-19), although some of those are only by extremely small margins (e.g. 1.9% for no. 8), and it is still the case that too many respondents are reporting negative experiences to the extent that they are. So, it is bad news for us to see matters worsening across nos. 2-4, and 13.

IO 2 Health and care nursing staff are physically and mentally well.

IO 4 Health and care nursing staff have been allocated efficiently and effectively.

IO 6 NHS nursing staff’s physical and mental wellbeing has informed the arrangement of NHS nursing staffing.

IO 7 Care nursing staff’s physical and mental wellbeing has informed the arrangement of care nursing staffing.

IO 8 NHS nursing clinical leaders have received the necessary time and resources to enable them to discharge their various responsibilities.

The survey issues numbered 1-6 in figure 12 can only tell us about physical and well-being in the very broadest sense in as much as positive or negative feelings about employment maybe something of an indicator. In a very loose sense, we may say they provide some positivity in that a minority of respondents characterise their job/career in negative terms, albeit in some cases the minority is far too large for comfort e.g. 50% are not enthusiastic about their job most days.

In terms of the issues 7-9, overworking, working when unwell, and being under too much pressure suggest detriment to physical and mental well-being, even if there is no connecting “bright line.” It also suggests the existence of working environments where staff have not been allocated efficiently and effectively, as do the figures on issues to do with being too busy to provide the care preferred, working hours, and work life balance. If efficient and effective allocation was the norm there would be less “need” to overwork or to work when unwell, and pressure would be reduced, alongside greater contentment with care provision, working hours, and work life balance.

If clinical leaders have problems with all those issues these figures may also hint that it is unlikely that they have received the necessary time and resources to enable them to discharge their various responsibilities (implied outcome 8). But in this instance, we do not feel we can make any sort of meaningful link between that very specific issue and the survey results. Nevertheless, since appraisal and development fall squarely within the legislative definition of the duties which clinical leaders are supposed to have time and resource to discharge, the fact that 41% of respondents have *not* received one in the last 12 months is a good indicator that those clinical leaders (many of which will be senior charge nurses given the nature of the respondent group) are not being afforded that time and resource.

There may be no connecting bright line for issues 13–19 either. But even if any given individual did not consider that verbal and physical abuse and poor responses to it, as well as bullying, harassment, and sexual harassment, had had a direct effect on their physical and mental well-being then the typically deleterious health effects of these negative behaviours on the person subject to them are now so well established that we do not see any need to cite authority to that effect.

It appears unlikely from the survey that nursing staff’s physical and mental wellbeing has informed the arrangement of nursing staffing across the board. If it had, we would Presumably see a much more positive story in terms of figures for the issues in figure 11 numbered 7-9, 12-17, and 19. That said we do accept there is cause for optimism. For example, whilst the 13% figure with respect to sexual harassment is abominable, its corollary is that 87% of respondents had not been the target sexual harassment, which can only be a good thing.

IO 9 NHS nursing staff have received the necessary training (to provide safe and high-quality services, and to ensure the best health care / care outcomes for service users).

IO 10 Care nursing staff have received the necessary training (for the work they are to perform and assistance, including time off work, to gain further qualifications).

The statistics here have positives: It is a good thing that 77% of respondents have completed all their mandatory training.

But sadly, 25% said this was done in their own time, despite there being a specific an explicit duty in the legislation to give NHS staff “such time and resources as (the NHS) considers adequate to undertake such training” (where the definition in the Act of “such training” can only be read to include mandatory training) and to give care staff “suitable assistance, including time off work.”

Conclusions

The survey results can only tentatively and speculatively suggest the extent to which our implied outcomes are or are not being achieved, but that does not mean it is unreasonable to make informed, if limited, speculation, as we have done. The key takeaway is that whilst there are small positive movement since the 2023 survey (and a more clearly positive score on the matter of training completed), the “negative” scores remain far too high and there remain real challenges in particular to do with nursing staff’s physical and mental wellbeing and the organisation of their work. And these have not yet reduced to the extent that we would hope to see happen in the longer term now that the Act is in place.

The employment survey which we will conduct in 2027 will help us better appreciate trends over safe staffing years, but we will continue to look to the Nurses4Scotland survey as the most on-point survey that RCN can at last to some extent, drive forward at its own hand.

Our [Proposed Solution 6](#) should be taken to apply here also.

Section 5 Overall Conclusions

RCN set out to examine a matter that the legislation is not explicitly written to address: positive outcomes for nursing staff. In identifying implied outcomes for nursing staff in the law, we began from a position of trying to see whether something had been achieved that, on the face of it, the law was not seeking to achieve, and that no reports required under the law were intended to report upon.

Inevitably, this made our task somewhat difficult.

We nevertheless looked at eleven³⁹ data sources which we thought might be capable of telling us something – anything – about the achievement of these implied outcomes. We did this fairly widely for the first “safe staffing year” (2024-25) because we knew we would not know what might be learned from them until we had properly examined them. This approach would allow us to use whatever of value they might contain whilst at the same time making decisions about what not to look at again subsequent years on the basis of it having little or no value to what wanted to know.

Most of these data sources (six, five of which constitute reporting by public authorities under the Act⁴⁰) were specifically intended to provide insight into the effectiveness of the legislation in practice. But only one of the six – the Nurses4 Scotland study – was intended to provide any insight at all into the matters pertaining to the achievement of RCN’s implied outcomes for nursing staff. And even it was not designed to provide comprehensive insight into them in the way we have sought to do in this report.

As for the other five data sources in this group of six; we confirmed much of what we had anticipated we would find, both in terms of our implied outcomes and the character of the data sources more generally that being that:

- with the exception of some low-level illumination of matters of “time to lead” and training, the Health Board reports are really only capable of affirming the existence of and explaining the operation of systems and processes
- the local authority / integration authority reports are but brief affirmations of the existence of appropriate contracting
- the HIS reports on individual services contain revealing anecdotes that can inform our understanding of the achievement of our implied (and other) outcomes but, even accounting for the HIS annual report’s treatment of themes, by their very nature these reports cannot identify universal problems or provide a systemic overview.
- the Scottish Government annual report on health inevitably inherits the limits of the Health Board reports upon which it draws
- the Scottish Government annual report on care is unfortunately circumscribed by the absence of any legislative requirement for anyone to provide it with the data it needs to address what this report is intended to cover

We must stress again that these limits stem from the legislation and the reporting requirements currently in place. They are not the fault of the authors of these reports.

The remaining five data sources were in no way intended to provide insight into the effectiveness of the legislation in practice. But having looked at these, we may say that

³⁹ Counting the Scottish Government annual reports on health and on care as two data sources even though they were combined into one document and counting the SSSC “Have Your Say” report as part of the Scottish Government annual report on care.

⁴⁰ All five in section 4.1 and the one in section 4.2.1, of this report.

four of them (the exception being the SSSC workforce data) had something useful to tell us about the achievement of our implied outcomes but that, in terms of those outcomes:

- the iMatter survey is not aligned to the provisions in the Act but it could be and it is clearly time that it should be, but until it is, its results can only be indirect indicators
- NHS sickness absence figures are similarly strong, but still indirect, indicators
- the same applies to NHS bank and agency use figures
- and to the results of RCN's employment survey.

Where appropriate we have addressed some of these issues in our proposed solutions as they appear throughout this report and as collated in the next section. And for future iterations of this report in future years, we will narrow down what data sources – or elements thereof – we will examine to account for these issues, as well as examining any newly available data sources that look like they will be useful.

But, as we say above, it is clear that the Nurses4Scotland survey remains the most “on point” and resonant data source available to us when trying to gauge the impact of the Act on nursing staff in terms of our implied outcomes.

That takes us to one last our proposed solution which, since it is for us, we will couch in terms of a promised action.

It is clear from the above that if we are to understand whether or not our implied outcomes for nursing staff are being achieved, including any reconsidered versions of them, nursing staff require to be regularly asked whether or not they are, in a way that makes sense to those staff and that aligns explicitly with the language of the legislation. Doing anything else by way of proxy is a substitute which we would not want to make long term. That being the case:

- RCN will build on the achievement of the Nurses4 Scotland survey to periodically survey our Scottish membership and report on the extent to which nursing staff in Scotland consider that outcomes for nursing staff are being achieved, and use the results to support calls for clearly defined actions that we believe will see them achieved to the extent that they are not being, but also to celebrate success where they are.

Section 6 List of Proposed Solutions

Proposed Solution 1

The Scottish Government should:

- i. further revise the reporting template for Health Boards in accordance with RCN's existing positions so that reporting on outcomes achieved for staff as a result of compliance with the legislation is required throughout the template as opposed to simply in the summary section, and this revision should make it clear that there is little or no point in Health Boards repeating annually that systems and processes that they have put in place continue to be in place but that what is required is evidence as to their efficacy in terms of the outcomes that they are intended to achieve
- ii. consider the extent to which the approach to understanding compliance as represented by NHS Lothian's Compliance and Assurance Audit may be required of all Health Boards, or at least consider what support can be offered to those Health Boards who may wish to adopt it voluntarily
- iii. introduce legislation to amend section 1 (1) (b) (i) of the Act so that it reads "improving standards and outcomes for service users **and staff**", and
- iv. introduce legislation to amend section 12IA (1) (c) of the Act, to remove the words "insofar as it affects either of those matters" and so make the wellbeing of staff a core part of the duty to ensure appropriate staffing and thereby prevent that wellbeing from being merely contingent on, and ancillary to, the provision of safe and effective care for patients.
- v. introduce legislation to amend section 1 (2) of the Act so that it defines standards and outcomes for service users and staff, as opposed to only for service users, those standards and outcomes for staff to be agreed between Scottish Government and representatives of those staff prior to legislative amendment.

Proposed Solution 2

The Scottish Government should either:

- i. require Health Improvement Scotland to proactively support all Health Boards to meet the requirement of section 12IM (1) to report on the entirety of the safe staffing year (i.e. all four quarters of it) which their annual reports are meant to cover, by the statutory deadline of "Before the end of the period of 1 month beginning with the last day of each financial year", or
- ii. introduce legislation to amend section 12IM (1) to extend that deadline.

Proposed Solution 3

The Scottish Government should either

- i. publish all of the local authority/ integration authority reports on guiding principles in care service staffing and planning on its own website (just as it does for the Health Board reports⁴¹) or

⁴¹ <https://www.gov.scot/publications/health-and-care-staffing-act-2019-duty-12im-health-board-annual-reports/>

- ii. require local authorities and integration authorities to publish them on the section of their websites marked as “publications” which should be locatable from the home page.

Proposed Solution 4

Health Improvement Scotland should

- i. continue with its clear approach to examining compliance with the Act in its inspecting, reviewing (etc.), and reporting and that, assuming it already collates and disseminates to Health Boards examples of good practise in addressing issues with compliance, it publishes those examples outwith the reports in which they may originally appear on a separate section of the HIS website so that all interested parties may see them.

Proposed Solution 5

The Scottish Government should

- i. continue to work with Social Care and Social Work Improvement Scotland (SCSWIS), otherwise known as the Care Inspectorate, to establish, and financially resource as necessary, the most effective and proportionate method for the Care Inspectorate to collect the data from care service providers that will directly enable the Scottish Government to fulfil its reporting requirements under the Act with respect to care services. This should build on the work of the Care Inspectorate’s Safe Staffing Programme, especially its “Provider Survey” and its “support to Scottish Government reporting via use of Annual Return, consultation and survey data” but any agreed method must also ensure that data about the extent to which outcomes for staff are being achieved is included at least to the same extent that it is included in the reporting requirements for health, and
- ii. introduce legislation to amend section 7 (1) (c) of the Act, to remove the words “insofar as it affects either of those matters” and so make the wellbeing of staff a core part of the duty to ensure appropriate staffing and thereby prevent that wellbeing from being merely contingent on, and ancillary to, the provision of safe and effective care for service users.

Proposed Solution 6

The Scottish Government should

- i. when considering how the statutory reporting on the achievement of outcomes for staff might best be developed (and whether the Act is amended in response to our proposed solutions or not), also consider how an approach similar to that taken by the Nurses4 Scotland study might form part of that developed reporting,

Proposed Solution 7

The Scottish Government should work with RCN and other stakeholders to

- i. fundamentally change the iMatter questions to reflect such outcomes for staff as are implied by the Act either using RCN’s schema or one otherwise agreed

- ii. alter the NHS staff governance standard so that its strands are changed in the same way,
- iii. change the iMatter staff grouping categories to align with the staff grouping categories used by TURAS for the NHS, and by the SSSC for social care.

Proposed Solution 8

NHS Education Scotland (NES) should

- i. publish NHS sickness absence figures on the Turas website disaggregated by job family as a matter of course so that interested stakeholders need not have to obtain them via Freedom of Information requests.

Proposed Solution 9

The Scottish Government should

- i. if sickness absence figures in nursing continue to rise beyond the predicted figure, require Health Boards to report in more detail in their annual reports (further than that suggested by the focus on outcomes in our proposed solution 1), on the demonstrable effect of their various health and well-being programmes on staff, as opposed to simply on their existence, and if this demonstrates that they are apparently effective, to further comprehensively identify the reasons for the rise in sickness absence in nursing with a clear target to reduce it.

Proposed Solution 10

Healthcare improvement Scotland should

- i. establish the extent to which it is currently possible to collate and aggregate all the data produced by Health Boards from every instance in which they “run” the Common Staffing Method (whether for those types of health care that currently have associated staffing level tools or not) with a view to being able to see at the national level the extent to which the number and nature of nursing staff required matched the number of nature of nursing staff provided within any chosen time period, and, if this is judged not to be currently possible, to draw up a plan to make it possible, to include what this would require in terms of information technology and finance.

Appendix 1: List of reports by public authorities under the Act and related

Section references are to the National Health Service (Scotland) Act 1978 or, in the case of the Care Inspectorate, to the Public Services reform (Scotland) Act 2010, both as amended by the Health and Care (Staffing) (Scotland) Act 2019.

Mandatory Reports	Total per year
Internal quarterly reports from clinical leaders to Health Boards in all territorial Health Boards and relevant special Health Boards (19 Health Boards in total) s.12IF(2)(b) duty	76
Health Board annual reports to Scottish Government (s.12IM (1) and s.2 (3) duties)	19
Scottish Government annual report in response to Health Board annual reports (s. 12IM (2) –(6) duties)	1
Scottish Government annual report on staffing in care services (s.9 duty) ⁴²	1
Local Authority reports on guiding principles in care service staffing and planning s.3(6) duty	32
Integration Authority reports on guiding principles in care service staffing and planning s.3(6) duty	31 ⁴³
Total	160

Conditional Reports	Total per year
Health Board quarterly reports to Scottish Government on Agency Spend if thresholds breached s.12IB duty	76 at a maximum if every one of the 19 Health Boards breached the threshold every quarter (160 plus 76 is 236).

Discretionary reports	Total per year impossible to predict
Healthcare Improvement Scotland reports on monitoring and review of common staffing method s.12IQ (6) duty	
Healthcare Improvement Scotland information that may go to Scottish Government but that is not described as reporting s.12IR, 12IS duties	
Healthcare Improvement Scotland reports otherwise	
Care Inspectorate reports on duty of care service providers to ensure appropriate staffing s.82D duty	
Care Inspectorate information that may go to Scottish Government but that is not described as reporting s.82A, 82C, 82E	

⁴² In the event, the Scottish Government produced one report for 204-25 covering the section 12IM duty and the section 9 duty. It was published on 27 November 2025 <https://www.gov.scot/publications/health-care-staffing-scotland-act-2019-2024-25-ministerial-annual-report/>

⁴³ In 2024-25 local authorities and integration authorities generally chose to produce joint reports usually under the auspices of the integration authority. Joint reports are not mandated by the Act (hence we have retained both sets of figures in this table) but nor are they prohibited. We consider this to have been a sensible approach to reduce unnecessary bureaucracy, thereby reducing the number of reports produced from 63 to 31, and reducing the 2024-25 total from 160 reports to 128.

Care Inspectorate inspection reports on inspections made as part of the Care Inspectorate's day-to-day role	
Audit Scotland reports	
Scottish Parliament Committee reports	

Appendix 2: iMatter scores 2024 & 2025

Nursing and Midwifery Staff Governance Standard Strand and Component Scores	2024	2025	Movement
Well Informed	79	80	0
My direct line manager is sufficiently approachable.	89	89	0
I feel Board Members are responsible for the wider organisation and are sufficiently visible.	53	54	1
I understand how my role contributes to the goals of the organisation.	83	83	0
I am clear about my duties and responsibilities	89	89	0
I get the information I need to do my job well.	83	84	1
Appropriately Trained and Developed	77	77	0
I am given the time and resources to support my learning and growth.	74	75	1
I get enough helpful feedback on how well I do my work.	77	77	0
I have sufficient support to do my job well.	81	81	0
I feel appreciated for the work I do.	76	76	0
Involved in Decisions	71	71	0
I have confidence and trust in my direct line manager.	86	86	0
I have confidence and trust in Board members who are responsible for my organisation	58	58	0
I am confident my ideas and suggestions are listened to.	77	77	0
I am confident my ideas and suggestions are acted upon.	74	74	0
I feel sufficiently involved in decisions relating to my organisation.	53	54	1
I feel involved in decisions relating to my job.	73	73	0
I feel involved in decisions relating to my team.	78	78	0
Treated Fairly & Consistently, with Dignity & Respect, in an Environment where Diversity is Valued	79	79	0
I am treated with dignity and respect as an individual.	85	85	0
My team works well together.	84	84	0
I am treated fairly and consistently.	83	83	0
I am confident performance is managed well within my team.	80	79	-1
I am confident performance is managed well within my organisation.	62	62	0
Provided with a Continuously Improving and Safe Working Environment, Promoting the Health and Wellbeing of Staff, Patients and the Wider Community	77	77	0
I get the help and support I need from other teams and services within the organisation to do my job.	71	71	0
My work gives me a sense of achievement.	83	83	0
I feel my direct line manager cares about my health & wellbeing.	87	87	0
I feel my organisation cares about my health & wellbeing.	68	68	0



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Published: July 2026