Health and Care (Staffing) (Scotland) Bill

Financial Memorandum

Introduction

1. As required under Rule 9.3.2 of the Parliament's Standing Orders, this Financial Memorandum is published to accompany the Health and Care (Staffing) (Scotland) Bill, introduced in the Scottish Parliament on 23 May 2018.

2. The following other accompanying documents are published separately:

- Explanatory Notes (SP Bill 31–EN);
- a Policy Memorandum (SP Bill 31–PM);
- statements on legislative competence by the Presiding Officer and the Scottish Government (SP Bill 31–LC).

3. This Financial Memorandum has been prepared by the Scottish Government to set out the costs associated with the measures introduced by the Bill. It does not form part of the Bill and has not been endorsed by the Parliament.

4. The purpose of this Financial Memorandum is to set out:

- the best estimates of the administrative, compliance and other costs to which the provisions of the Bill will give rise, as well as likely efficiency savings;
- the best estimates of the timescales over which the costs and savings are expected to arise; and
- an indication of the margins of uncertainty in these estimates.

5. This Financial Memorandum draws upon a variety of evidence sources to present estimations of the costs of implementing the

requirements of the Bill. It does not provide a blueprint for how relevant organisations, individual Health Boards or care service providers will implement the requirements.

6. This Financial Memorandum is structured as follows:

- Part One: Background;
- Part Two: Summary of overall estimated costs;
- Part Three: Costs on the Scottish Administration;
- Part Four: Costs on Health Boards;
- Part Five: Costs on public bodies;
- Part Six: Costs on other bodies, individuals and businesses;
- Part Seven: Costs on local authorities and integration authorities.

Part One: Background

7. The aim of the Bill is to provide a statutory basis for the provision of appropriate staffing in health and care service settings, thereby enabling safe and high quality care and improved outcomes for service users.

8. The Bill creates a coherent overall legislative framework for appropriate staffing across the health and care services landscape by setting out a requirement on Health Boards and organisations providing care services (those care services registered with and inspected by the Care Inspectorate) to consider staffing requirements according to a set of principles. The Care Inspectorate's formal name is "Social Care and Social Work Improvement Scotland" (SCSWIS), and it is this formal legal name that is used in the Bill. "Care Inspectorate" is the informal, more commonly used name, and is used throughout this Financial Memorandum since it is more widely recognised than SCSWIS. The duties of the Bill will impact both Health Boards and providers and commissioners of care services as well as other public bodies, such as Healthcare Improvement Scotland and the Care Inspectorate. The Scottish Government's best estimates of costs are provided in this Financial Memorandum. The figures provided primarily relate to the development and implementation of staffing tools and methodologies. However, the potential financial impact on wider staffing levels and associated costs are also outlined. A focus has been given on how the Bill can be used to maximise the effectiveness of the resources that are currently available.

Summary of Nursing and Midwifery Workload and Workforce Planning Programme

9. Although this Bill places a general duty on Health Boards in relation to all clinical staff groups, the evidence base for use of tools and methodologies is currently predicated in nursing and midwifery as all of the existing tools focus on nursing and midwifery. Therefore this Financial Memorandum uses this evidence base to make an estimate of the financial impact of the Bill's provisions in relation to supporting and enabling development of staffing methods and tools in care service settings.

10. Scotland's existing nursing and midwifery workload tools and methodology have been developed over a number of years to support evidence-based decision-making and risk assessment in relation to setting nursing and midwifery staffing requirements in a variety of clinical settings. In developing the tools, rigorous statistical analysis is used to calculate the whole time equivalent (WTE) for current workload; they have been tested extensively across NHS Scotland before being confirmed as fit for purpose. The output of these tools cannot be used in isolation and requires professional judgement and local context in which the service is operating and measures and indicators of quality to be taken into account when making decisions about staffing requirements. This is what is referred to as the triangulation process. By applying them on a regular basis and by using the triangulation process, Health Boards can make informed decisions when setting the budget for staffing in the relevant clinical area. It is important to acknowledge that there is variation in the level of care and staffing requirements on a day to day basis. It is, therefore, necessary to apply professional judgement daily to assess risk and ensure safety is maintained.

11. This legislation will make it explicit that Health Boards are expected to apply the specialty-specific staffing and professional judgment tools consistently and for them to take account of the outputs along with information relating to local context, quality measures and any concerns raised by staff when assessing staffing requirements. Separate from the Bill requirements, all of this information should be analysed and risk assessed against current staffing levels, any mitigating factors should be identified, and appropriate escalation and prioritisation processes should be in place. In addition, there will be a requirement to involve staff in the process and to ensure decisions made using the method are transparent and communicated to staff.

Summary of current Health Board expenditure on staffing

12. NHS Scotland spends approximately £6.5 billion a year on staffing. NHS staffing stands at 140,261.9 WTE at December 2017, including 12,557 WTE Doctors and 11,609 Allied Health Professionals. Nurses and midwives are the largest staff group within the NHS, followed by administrative services and support services.[1] As at December 2017, there are 44,134.4 WTE registered nursing and midwifery staff in NHS Scotland. In addition to this substantive staffing, supplementary staffing is also utilised to support staffing levels.

13. It has been acknowledged that some Health Boards face difficulties in filling vacancies due to shortages of staff and that supplementary staffing is often used to ensure services can continue to be delivered safely. While this Bill will not directly address these shortages, it is anticipated that robust application of the staffing tools and methodology will improve NHS Board projections on future staffing requirements.

14. In 2016/17 £166,460,733 was spent on nursing and midwifery bank and agency staffing in NHS Scotland. This is broken down to £24,504,912 for agency nursing, and £141,955,821 nurse bank. In 2016/17 £109 million was spent on medical agency and £39.5 million on internal locum.

15. Supplementary staffing is described as staffing resource utilised from staff working more than their contracted hours in the form of excess hours or overtime and bank and agency nurses. Due to variation in activity and other external factors, it is acknowledged that there will be a requirement for some supplementary staffing to maintain safe staffing levels and skills on an on-going basis in the clinical environment to deliver patient care.[2] However, evidence suggests the increasing use of supplementary staffing is not an effective use of resources and may have a detrimental impact upon the quality of care delivered.[3] Although further UK-based research is required, the importance of maintaining high levels of experienced

[1] NHS Scotland Workforce Information - as at 31 December 2017

[2] Flexible Nurse Staffing in Hospital Wards; the Effects on Costs and Patient Outcomes? (2017) Dall 'Ora, C and Griffiths, P

[3] Effects of Flexible Staffing on Patient Outcomes and Healthcare Costs (Jan 2018). Dall 'Ora, C and Griffiths P. Nursing Times

clinicians at the frontline is also recognised[4] and, although supplementary staff have been shown to have similar qualifications and often more experience[5], the impact of team culture upon the quality of care delivered to patients cannot be underestimated.[6] This evidence would suggest that minimising the need for supplementary staffing would enhance both quality and effective use of resources.

16. There is also variation across Health Boards in the proportion of supplementary staffing which is spent on nurse bank and nurse agencies. It is recognised that there is a legitimate spend on supplementary staffing where there are vacancies in order to maintain staffing levels. However, the proportion of bank and agency utilisation is significantly above the number of vacancies, resulting in significant cost differential between utilising nurse bank and agencies.

Summary of current staffing in social care

17. The social services workforce is the largest public service workforce in Scotland, with 200,650 people in paid employment at end of 2016 (latest official statistics).[7] This makes up approximately 7.7% of all Scottish employment.

18. The structure of employment is complex, with the workforce employed in 13,481 active services registered by the Care Inspectorate. 42% of workers are employed in the private sector, 31% in the public sector and 28% in the third sector. At the end of 2015:

- 2,644 employers provided care services in Scotland (excluding child-minders);

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[4] Modelling Safety, Modelling Staffing, Leary, A; STEPPING INTO THE FUTURE: Tomorrow's Workforce Today. 2030 Vision, CNO Scotland Summit Nov 2017

[5] Patient Care Outcomes and Temporary Nurses (2015) Mazurenko,O; Liu, D; Perna C. Nursing Management

[6] The Relationship of Workplace Culture with Nursing Sensitive Organisational Factors (July 2015) Hahtela, N; McCormick, B; Paavilainen, E; Slater, P; Herminen ,M; Suominen,T. Journal of Nursing Administration (July- August 2015) Volume 45, Number 7/8, pp370-376

[7] Scottish Social Service Sector: Report on 2016 Workforce Data – Scottish Social Services Council

- 1,536 were independent sector organisations;
- 1,070 were third sector organisations;
- 80% of service providers employed fewer than 50 people.

19. Research carried out by Scottish Care amongst its members found that 49% of services reported using agency care staff and 33% use agency nursing staff. Services report that they are increasingly relying on agency staff and 5% of services reported using agency nursing staff all the time. As a result of using agency staff, 80% of staff reported a negative impact on their finances and 56% report a negative impact on the quality of care.[8]

Part two: Summary of overall estimated costs

20. This Financial Memorandum will focus on the direct costs associated with this legislation, the development and implementation of staffing level tools and methodologies. It is acknowledged that there may be a consequential impact on staff numbers from implementation of the legislation, but this would be dependent on the staffing decisions taken by Health Boards and care service providers and will, therefore, not be covered in detail by this Memorandum. While there may be an impact on staff numbers The Scottish Government do not anticipate that this will result in an overall increase to the total cost incurred and in this Financial Memorandum we outline the opportunity for the Bill to maximise the effectiveness of utilising total resources available.

21. The Bill does not set a minimum number of staff required to deliver any particular service. Using the common staffing methodology and tools will require Health Boards to consider all aspects of the methodology, including use of supplementary staffing to ensure they are using their total resources in the best possible way to achieve high quality care. The tools and methodology will support Health Boards to plan and use staff and, where required, redesign services to ensure safety and quality measures continue to be met. It is anticipated that Health Boards will ensure an appropriate infrastructure is in place to ensure the requirements of the Bill are met.

22. Due to the on-going work of the Nursing Midwifery Workload and Workforce Planning Programme (NMWWPP) and planned scoping and

[8] Care Home Workforce Data Report 2017 – Scottish Care

research work in social care settings that may contribute to the development of a tool, the costs for on-going activity during 2018-20, before anticipated commencement of the Bill in 2020, have been included.

23. The overall estimated costs of implementing the Bill are set out in Table 1 for the six year period 2018-19 to 2023-24. Costs are estimated at £2.1m in 2018-19, rising to a maximum of £3.0m in 2019/20 and decreasing to £1.5m by 2023/24. Beyond 2023/24 recurring costs are estimated at £1.4m per annum. Some of the costs outlined in Table 1 are already incurred by the Scottish Administration and Health Boards and these are clearly marked as such. It can be seen that the majority of costs relate to the development and implementation of staffing tools. As outlined in paragraphs 20 and 21, no significant additional costs are anticipated in respect of increased staffing levels in health or social care. Instead, it is anticipated that there will be an opportunity to maximise the effective use of existing total resources, potentially reducing spend on supplementary staffing. This is covered in more detail under paragraphs 45 to 49 and paragraphs 80 to 84.

24. Parts 3 to 6 of this document provides the detail on how the costs set out in Table 1 were arrived at and the relevant paragraphs are cross-referenced in Table 1.

Table 1: Summary of costs							
	Para	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**
COSTS ON THE SCOTTISH ADMINISTRATION							
Tool Development*	25-28	£538,185	£538,185	£538,185	£538,185	£538,185	£538,185
Tool Maintenance*	29	£100,000	£100,000	£100,000	£100,000	£100,000	£100,000
Tool and IT Updates*	30	£215,000	£15,000	£15,000			
NMWWPP Infrastructure*	31-32	£464,358	£464,358	£464,358	£464,358	£464,358	£464,358
NMWWPP Infrastructure Expansion	33-34	£286,041	£572,083	£413,577	£255,071	£255,071	£255,071
COSTS ON HEALTH BOARDS							
Staff training*	39-43		£332,215	£332,215			
Additional support for Boards	44	£465,734	£931,469	£465,734			
COSTS ON PUBLIC BODIES							
Research	65-66		£50,000				
Tool and Method Development	67-70			£228,000	£334,000	£275,000	£69,000
Provision of Training	71			£32,000	£48,000	£30,000	£3,000
Additional Resource	72-74				£124,000	£127,000	£53,000
COSTS ON OTHER BODIES, INDIVIDUALS AND BUSINESSES							
Contribution to tool development	76			£200,000	£200,000	£200,000	
Staff Training	77-78			£150,000	£150,000		
Total Costs		**£2,069,318**	**£3,003,310**	**£2,939,069**	**£2,213,614**	**£1,989,614**	**£1,482,614**

*part or all of these costs are already incurred by the Scottish administration or Health boards

Part Three: Costs on the Scottish administration

Development of Workload and Workforce Planning Tools and Methodology

25. The NMWWPP was established in 2007. It has developed a suite of workload tools and a methodology based on best available research to enable a consistent evidence-based approach to identifying nursing and midwifery staffing requirements. On-going costs for maintenance of tools and digital infrastructure would exist in the absence of this legislation. However, costs have been estimated here to give a fuller cost for the possible development of new tools or methodologies in future.

26. Based on extensive experience, the NMWWPP has developed a standard operating procedure for tool development encompassing establishment of a clinical working group, observation studies, testing and

implementation of a tool. The average non-recurring cost of developing one new staffing level tool is estimated at **£538,185** as outlined in Table 2. Costs for input from the national team have not been included as they are included in the national programme infra-structure costs (paragraphs 31-34). Experience suggests it takes four to seven years to develop and sign off a new nursing and midwifery workload tool, depending on the size and complexity of the service and number and types of issues identified during the testing phase.

27. The NMWWPP already has a suite of eleven speciality-specific staffing level tools covering the majority of clinical settings for nurses and midwives and one professional judgement tool. Two further tools are currently in development. It is anticipated that a further three tools will be developed in the next five years.

28. The current suite of staffing level tools covers the majority of clinical areas in nursing and midwifery. However, it is acknowledged as service models evolve there may be a requirement for a multi-disciplinary approach to be taken in a number of areas and the need for development of tools will continue in the future. It takes a number of years to develop a tool and at any one time multiple tools will be at different stages of development and will require funding for part of the development and maintenance process in any one year. It has therefore been assumed for modelling purposes that on average funding for one full process of development will be required each year. It is anticipated that this will be subsumed within the existing budget for the NMWWPP Programme.

Table 2. Estimated Costs for each step of tool development by the NMWWPP		
Step of tool development	**Purpose and timescale**	**Estimated Cost**
Clinical Working Group	Provides clinical expertise and is responsible for developing the tools and instruments used to develop a tool, review outputs and analysis at every stage in the process and for final sign off of tool	£134,631
Development of a workload tool	Identification of workload and acuity measures for particular specialty based on evidence and professional expertise (Approximately 18 months)	Included in clinical working group costs
Development of observation instruments	Tool used to observe activity in the clinical setting is developed. (Approximately 6 months)	Included in clinical working group costs
Observation Study	10 minute observations on each member of staff in clinical areas across Health Boards. Sample size dependent on size of specialty. Studies undertaken across geographical settings. Involves training of observers and collection of significant data (12-18 months)	£393,554
Development of a workload calculator (Independent expert costs)	Statistical analysis of data from observation studies and calculator development using expertise in NHS National Services Scotland and external advisor (6-12 months)	£10,000
Testing	Testing of calculator in clinical settings, starting with one setting and extending dependent on results. Time this takes is dependent on refining required and issues identified at testing (6 months to 2 years)	Included in clinical working group and NMWWPP infrastructure costs
Implementation	National run of tool requires extensive training across Scotland in the specialty (12 months)	Included in clinical working group costs
Refining	Following national run Clinical Working Group review analysis of results, identify any refinements required that were not picked up in testing (6 months)	Included in infrastructure costs (table 8)
National release of validated tool	Clinical Working Group agree how often specific tool should be run nationally and NHS Boards informed of release and expectation of number of runs per annum	Included in infrastructure costs
Total cost per tool – non – recurring		**£538,185**

Tool Maintenance

29. The NMWWPP have developed an electronic platform on which the tools and reporting mechanisms are based. This was developed on an existing pay roll platform that all Health Boards already had. This platform took a significant amount of time to develop (approximately five years) and requires on-going development and maintenance. All tools for NHS settings are contained in this platform. The cost of tool maintenance varies dependent on updates required and have been between £70k and £240k annually during the last five years with an average cost of **£100,000**. It is not anticipated that this cost will increase as a result of legislation.

Tool and IT updates

30. An education and training subgroup of the NMWWPP steering group will be established and led by NHS Education Scotland. It will develop online training resources and revise the current education toolkit to reflect the requirements in this legislation. It is estimated that **£215,000** will be required in 2018-19 and **£15,000** in 2019-20 and 2020-21 to update information technology systems and create an interface between the existing electronic platform and other NHS information systems, in order to support electronic data collection and reduce data burden for staff.

NMWWPP infrastructure

31. The existing NMWWPP national infra-structure is detailed in Table 3. This enables development and maintenance of the tools and provides expert professional advice and leadership to Health Boards and policy leads. This workforce has been sufficient to maintain, review and enhance existing NMWWPP tools, to support the development of approximately one new workforce tool every 18 months to two years and to provide some support to Health Boards in applying and analysing information from NMWWPP tools.

Table 3. Annual staff costs associated with NMWWPP	
Staff	**2017-18**
1 WTE Band 8C Senior Nurse Programme Manager	£83,832
2.8 WTE Band 8A Programme Advisors	£163,007
1 WTE Band 7 Senior Analyst	£50,144
2 WTE Band 6 Analysts	£85,385
1 WTE Band 5 Analyst	£34,495
1WTE Band 5 Programme Support	£34,495
External expert consultancy	£13,000
Total	**£464,358**

(Staff costs calculated at top of Agenda for Change scale with additional 20% employer's cost applied)

32. Increased awareness of the impending legislative requirements has resulted in a substantial increase in demand from NHS Boards for the NMWWPP team to provide strategic support, education and training support and support to build local capacity and capability in order to prepare for the proposed legislative requirements. It is anticipated that this demand will grow and it has been identified that Health Boards will require continuing support in this area.

NMWWPP infrastructure expansion

33. To deliver the requirements of the Bill both from a legislative perspective and to support the service, the capacity within the NMWWPP team is no longer sufficient to provide the essential strategic and expert knowledge required. Additional staffing resources are set out in Table 4.

Table 4. Costs Associated with Expansion of NMWWPP						
Additional Resource	**2018-19 (6 months)**	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**
3 WTE Band 8A Programme Advisors	£87,325	£174,650	£174,650	£174,650	£174,650	£174,650
1 WTE Band 8A Senior Analyst	£29,108	£58,217	£58,217	£58,217	£58,217	£58,217
1 WTE Band 2 Administrator	£11,102	£22,204	£22,204	£22,204	£22,204	£22,204
4 WTE Band 7 - Support for education and training, application of tools and analysis of information.	£100,289	£200,578	£100,289	£0	£0	£0
2 WTE Band 8A - Implementation of Excellence in Care Quality Measures and improvement support to NHS Boards	£58,217	£116,434	£58,217	£0	£0	£0
Total	**£286,041**	**£572,083**	**£413,577**	**£255,071**	**£255,071**	**£255,071**

(Staff costs calculated at mid point Agenda for Change scale with additional 20% employer's cost applied)

34. It is anticipated that the NMWWPP infrastructure will be moved to NHS Healthcare Improvement Scotland and the associated costs will therefore transfer to it.

Part Four: Costs on Health Boards

Cost arising from guiding principles for health and care staffing and duty to ensure appropriate staffing

35. It is the current responsibility of every Health Board to ensure staffing levels are appropriate for the care requirements of patients in their care. This Bill is effectively making it an explicit statutory duty and providing a set of guiding principles which will provide further clarity on what should be taken into account by Health Boards when making decisions about staffing requirements within their existing budget. The Scottish Government therefore do not anticipate any significant additional costs, however it is anticipated that Health Boards will make more effective utilisation of existing resources.

Costs to Health Boards when planning or securing the provision of health care from another person

36. It is anticipated that Health Boards will be able to meet the duty to have regard to the guiding principles and the need for appropriate staffing

arrangements when commissioning others to deliver services on their behalf through the existing mechanisms used to securing the services of another person. Therefore, it is not anticipated that there will be any significant costs on Health Boards associated with this duty.

Cost arising from duty to follow common staffing method

Staff time to use existing tools

37. Staff are currently expected to use the tools regularly in existing processes. It is therefore not anticipated that there will be an additional cost associated with the time taken to use the tools. Experience of developing and implementing new tools is that no additional staff are required to apply the tool in practice and that this can be absorbed within existing workforce activity.

Staff engagement

38. Staff engagement is an integral part of NHS staff governance. Feedback relating to staffing decisions can be undertaken during routine processes of feeding back to staff on other matters e.g. staff meetings, newsletters etc. Processes for staff escalating concerns are also already in place and can be used for staff to raise concerns about staffing. As these existing processes will be used to gain views from staff and provide them with information on decisions reached, it is not anticipated that significant additional costs will be associated with this.

Training and education

39. Given that provisions in this part of the Bill are broadly based on existing tools and methodologies for nurses and midwives, which have been mandated for use by Chief Executive Letter (2011) 32[9] since 2013, it is important to emphasise that much of the infrastructure, knowledge and experience required to support this legislation is largely already in place, although it is acknowledged that there is lack of consistency in application of the methodology when deciding on staffing requirements across Scotland.

40. It is important that clinical staff have confidence in the output of tools and that they understand the common staffing method to ensure appropriate data is collected when the tools and methodology are applied. There is, therefore, a requirement to ensure clinical staff are appropriately

[9] Chief Executive Letter (2011) 32

trained. In addition, it is important that leaders and operational managers have the skills and relevant knowledge to ensure appropriate analysis of reports and application of the triangulation process. There is a significant cost associated with this initially and for on-going support across Health Boards.

41. When the NMWWPP tools and methodology were launched there was significant investment in training and education of Band 7 Senior Charge Nurses, Midwives and Team leaders. An online educational toolkit was also developed and there was assurance that this group of staff had the appropriate skills to implement the methodology. However, there has been low uptake of the online resource and a significant turnover of those staff who were initially trained. It is, therefore, considered that further investment in training will be required for Senior Charge Nurses, Midwives and Team Leaders to ensure the effective implementation of this legislation. In addition, the importance of ensuring that other senior professional leaders for other staff groups and managers have appropriate skills and knowledge of the common staffing method, risk assessment, mitigation, escalation and prioritisation has also been recognised.

42. It is, therefore, anticipated that approximately 50% of all Band 7 and above nurses and midwives will receive training over a period of two years and that the online resource will require updating to reflect changes brought into effect by this legislation. Time for continuous professional development is included in current nursing and midwifery establishments and it is anticipated that training could be completed within this. It is not, therefore, anticipated that additional resource will be required. However the opportunity costs of staff time spent on training is detailed in Table 5.

Table 5. Estimated Cost of Staff Time for Training

	Band 9	Band 8d	Band 8c	Band 8b	Band 8a	Band 7	Total
Number of WTE nurses and midwives in post*	1	41.5	106.7	295.3	749.9	5,831.90	
Cost per 7.5hr day (£)	£435	£360	£300	£258	£208	£180	
Cost of training 50% of nurses	NA	£7,470	£16,005	£38,094	£77,990	£524,871	**£664,430**

* as of 31 March 2017 (Staff costs calculated at mid point Agenda for Change scale with additional 20% employers cost applied)

43. As discussed above, it is anticipated that these costs are covered and would continue to be covered in Health Boards' current budget and would be part of the individual's personal or professional development. As a result

of this training, there will be sufficient knowledge in each Board to ensure that on-going training can be provided from within each Board as staff changes occur.

Additional support for Health Boards

44. It is anticipated that additional resource will be required to support Health Boards to consistently apply the methodology, to collate, analyse and report information across the organisation and inform transparent decisions about staffing requirements. Following exploration of areas of good practice and the investment required to achieve this the anticipated cost is 16 WTE Band 8A at a cost of **£931,469** apportioned according to Health Board size and assuming minimum investment of 0.5 WTE per Board. It is anticipated that this funding will be required for approximately two years to allow processes to be embedded.

Impact of tools on staffing

45. One of the requirements in the Bill is for Health Boards to consider areas where service redesign may be appropriate based on analysis of information from the tools. When used properly, the tool and common staffing methodology enable services to be delivered in a more effective efficient way and support service redesign where required. Service redesign is an integral part of service delivery, it is therefore not envisaged that there will be significant additional costs associated with this.

46. The tools and methodology have been used in all Health Boards in some capacity. The extent to which each Health Board has successfully used the tools differs and therefore the impact of improved use of the tools will differ. In addition to this the methodology for using tools requires the consideration of local context and allows local decision-making. However, case studies gathered from three Health Boards demonstrate there are a range of possible outcomes of using the tools and method and, therefore, costs and savings resulting from effective use of them. The case studies are presented in Annex 1.

47. The case studies are examples of effective use of the existing workload and workforce planning tools and methodology and demonstrate that they do not prescribe a minimum staffing level nor do they prescribe a consistent service design across all settings or Health Boards. Effective use of the tools and methodology can provide evidence upon which to

redesign a service to suit the local context; to demonstrate use of funded establishment, bank and agency staff; to ensure efficient use of existing resources; and to support a risk-based approach to decision-making.

48. It is recognised that different Health Boards are at varying stages of maturity in the use and application of the workload and workforce planning tools and methodology and that improved application of the tools and methodology could result in some NHS Boards requiring an increase in their established staffing levels. However, where this is the case it is expected there will be opportunities for this to be offset by a reduction in supplementary staffing as illustrated in case study 1 (Annex 1). If this is not the case but tools require an increase in staffing levels or a different skills mix Health Boards would be expected to consider the need for service redesign where appropriate.

49. There is variation in the reliance on supplementary staffing staff across Health Boards. Not only does use of agency staff result in higher staff costs (on average an agency staff member costs between 1.5 and 3 times more than an equivalent funded establishment staff member[10]) but use of agency staff can impact on the quality of care (see paragraph 15 above). Although effective use of tools and methodology as required by this legislation may identify staffing deficit in current funded establishment, supplementary and agency staff are being used to ensure safety is maintained. This is an ineffective use of funding and, as exemplified in case study 1 (Annex 1), use of the tools and methodology can support diversion of this spend into funded establishment and, as a result, in some cases can reduce overall staffing costs for Health Boards. Table 6 details agency and bank spend across Health Boards since 2009 showing a steady increase in both.

[10] Audit Scotland using ISD workforce data as at March 2017 and Scottish Health Service costs data for 2015/16

Table 6. Nursing and Midwifery Bank and agency spend across Health Boards by year.				
	Bank	**Agency**	**Total Bank & Agency**	**Nursing & Midwifery spend excluding bank and agency[11]**
2009-10	£98,055,782	£8,182,083	£106,237,865	£1,995,766,835
2010-11	£86,158,730	£4,353,286	£90,512,016	£2,043,668,194
2011-12	£90,541,950	£3,939,107	£94,481,057	£2,042,634,964
2012-13	£104,226,750	£6,390,142	£110,616,892	£2,054,014,064
2013-14	£118,190,306	£9,325,810	£127,516,116	£2,122,702,669
2014-15	£129,608,992	£16,001,526	£145,610,518	£2,185,093,963
2015-16	£134,570,932	£23,483,306	£158,054,238	£2,228,794,813
2016-17	£141,955,821	£24,504,912	£166,460,733	£2,287,087,050

50. Effective application of the tools and methodology is expected to provide NHS Boards with the opportunity to maximise the effective use of total resources available (including spend on supplementary staffing). Overall, it is not, therefore, anticipated that introduction of the Bill will significantly increase overall staff costs but may in fact provide the opportunity to reduce spend on supplementary staffing, enabling a reallocation away from supplementary staffing towards funded establishment.

Reporting

51. The Bill requires Boards to report on their compliance with the duties in the Bill but this can be done through existing annual reporting mechanisms. The costs for reporting are, therefore, minimal. However, ensuring a consistent robust approach for application of the methodology, risk assessment, mitigation, escalation, prioritisation and staff engagement as required by the legislation is anticipated to have no additional costs to Health Boards.

Supporting development of future staffing tools

52. Contribution to the development of new staffing tools requires input from a range of staff across all Health Boards to participate in the clinical working groups and in carrying out observation studies.

[11] ISD Scotland High Level Summary Tables (2017-18); ISD Scotland Workforce Statistics, data as at 31 December 2017

53. A clinical working group meets every six to eight weeks over an average of three years. The average number of hours per attendee is 150 hours and has around 42 representatives on the group. Using the top salary point of an Agenda for Change Band 7 as an average of those attending, the cost of a clinical working group over a three year period is £134,631.

54. It should be noted that this amount is currently included in the salary costs within Health Boards and is therefore identified as an opportunity cost for Boards. This cost is factored in to the average cost of developing a tool set out in Table 2.

55. Observation studies are required in order to develop the calculation in a workload tool which ultimately provides WTE staff recommended. An observation study involves a series of 10 minute observations on each member of staff in clinical areas. The number of units in which an observation studies is carried out is dependent on the size of that clinical specialty and differs for each tool. The average cost for one observation study is £28,111.

56. The number of units required to undertake observation studies is calculated using statistical analysis of size and nature of the service and does vary (from 12 to 18 based on statistical analysis of size of service). However, for the purposes of the Financial Memorandum, an average of one unit per Health Board (14) units has been used to estimate the cost of an observational study. Therefore, the cost for an observation study required to validate one staffing tool is £28,111 per board across 14 boards = £393,554. This cost is factored in to the average cost of developing a tool set out in Table 2.

57. The average costs of clinical working groups and observation studies are spread across all Health Boards depending on grade of staff involved from each Board. This cost of attendance at clinical working groups is currently absorbed by Health Boards as opportunity costs as staff contribute as an integral part of their existing role.

Part Five: Costs on public bodies

Healthcare Improvement Scotland

58. Healthcare Improvement Scotland provides public assurance about the quality and safety of healthcare. It does this through development of

evidence-based advice, guidance and standards, provision of support for continuous improvement and through scrutiny of services. Healthcare Improvement Scotland has previously been commissioned by the Scottish Government to develop nursing/midwifery specific quality measures for the Excellence in Care programme. This will provide a framework on which to measure and continuously improve quality in nursing and midwifery and will provide valuable information about the impact of nursing and midwifery staffing on the quality of care to be used as part of the common staffing method in conjunction with the staffing tools.

Tool development

59. Currently, tools are being developed and tested by the NMWWPP which is supported by the Scottish Government. This infrastructure and function to develop future tools will be transferred to Healthcare Improvement Scotland (HIS) and therefore the costs associated with this as set out in (paragraphs 25 – 34) will be taken on by HIS.

60. Improvement and scrutiny expertise already exists within HIS and, as monitoring and support will be undertaken as part of the existing Quality of Care Framework, it is therefore not anticipated that additional resource will be required. Expertise in NMWWPP methods and tools will be provided from the NMWWPP as the programme is moved in to HIS and as part of expansion costs.

Oversight

61. HIS's current models of improvement support and intervention will be initiated where non-compliance is identified. Support for improvement expertise and capacity already exists in HIS and, as this legislation is to be monitored through existing Quality of Care reviews, it is not anticipated additional resource will be required.

Care Inspectorate

62. As part of inspection and registration, the Care Inspectorate currently assesses care providers on their compliance with regulation 15 of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, which stipulates that providers must ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health, welfare and safety of service users. Providers are also required to ensure that persons employed in the provision of the care service receive

training appropriate to the work they are to perform; and suitable assistance, including time off work, for the purpose of obtaining further qualifications appropriate to such work.

Duty to follow a staffing method

63. The Care Inspectorate will be given a function to lead and facilitate work with relevant stakeholders on the development of tools and methodology for care homes for adults should there be an identified need to do so. It is anticipated that the initial focus would be on developing a tool and methodology for care homes for older people. The development of tools may place additional burdens on the Care Inspectorate, those involved in developing tools and care home providers. An estimate of the impacts of developing a particular tool, using a tool, inspection of tool use and possible impact on staffing levels are set out in the following sections.

64. As there is currently no staffing tool validated for use in the social care sector, details of how the tool would operate and how it would be developed are uncertain. For the purposes of providing an estimate of cost in this Financial Memorandum it, has therefore been assumed that a tool would be developed in a similar way to those developed by the NMWWPP. It should be noted that there is not a requirement to develop a tool in this way, nor is there a requirement for the Care Inspectorate to develop specific tools for care homes if there is not a need or identified way to do so.

Research

65. In order to assess the evidence of need for a tool in a specific type of care setting and possible benefits from use of a tool, it is possible that the Care Inspectorate would commission independent analysis from workload and workforce planning experts before commencing work. The anticipated cost for doing so would be circa **£50,000**. This cost is in line with initial requirements for academic and analytical support required by the NMWWPP when first developing tools for nurses and midwives. It will be important to ensure similar academic rigour is applied when developing tools in the care sector. It may also be possible for the Care Inspectorate and NMWWPP to collaborate to ensure existing experience is utilised to support this work. This work could be started in advance of commencement (expected to be 2019-20) of the Bill to ensure that there is clear evidence of whether a tool is required or not.

66. This research would likely determine what outcomes would indicate that a tool is improving staffing or care provision. Part of this research would assess what tools or processes are already in use and whether they should be included in a new tool or methodology. As the development of tools is explored, consideration will be given to whether existing dependency tools e.g. the Indicator of Relevant Need (IoRN) tool, or existing procedures such as personal plans, can be incorporated into tools and/or methodology for care homes. Some of the projections provided here may need to be revised in light of this research.

Tool and method development

67. The intention is that care homes for older people would be the first setting in which the development of a tool and method is explored. Experience of timescales for developing a tool in health has been that the process for developing, testing and validating a tool takes four to seven years. This is dependent on the size and complexity of the service, availability of an evidence base and time taken to gain consensus from stakeholders. All costs provided here make the assumption that tool development would take four years.

68. Should work to develop a tool and methodology be commenced, the Care Inspectorate would be required to collaborate with relevant stakeholders in development of the tool. It is anticipated that the Care Inspectorate would require additional staff for this work. This is likely to include staff for stakeholder and programme management and a development lead. It should be noted that, as this work is to be coordinated by the Care Inspectorate but led by the sector, and the way in which a tool is developed will be informed by previous research (see paragraph 66), some of these costs may be spread across organisations other than the Care Inspectorate. However, an estimate of likely staff requirements is given in Table 7 assuming they would be employed by the Care Inspectorate.

69. The majority of tools developed for health settings have required observation studies to be carried out in a proportion of clinical areas as part of the tool development. This would be carried out by somebody with a knowledge of the tools and the clinical setting. It is likely that, if a tool is developed for care homes for older people, observation studies would be carried out by persons with knowledge of the tools and work settings. The Care Inspectorate is likely to be best placed to fulfil this role and the implementation leads identified in Table 7 would undertake this work.

70. Additional costs for the development of a tool, based on the process used by NMWWPP, are likely to include research and analysis, academic input and administrative support, and are outlined in Table 7.

Table 7. Care Inspectorate Infrastructure to Support Tool and Method Development

Activity	Resource	2020-21 Year 1	2021-22 Year 2	2022-23 Year 3	2023-24 Year 4
Stakeholder manager for programme and reference partners	1 WTE Grade 8	£65,000	£66,000	£67,000	£69,000
Development lead	1 WTE Grade 7	£58,000	£59,000	£0	£0
Implementation leads to work with partners, care services and inspectors	2 WTE Grade 6	£0	£102,000	£104,000	£0
Literature review, research, data gathering, processing, analysis	1 WTE Analyst Grade 5	£44,000	£45,000	£46,000	£0
Administrative support	1 WTE Admin Officer	£31,000	£32,000	£33,000	£0
Travel, meetings and consultation costs		£20,000	£20,000	£15,000	£0
Academic engagement		£10,000	£10,000	£10,000	£0
Total		**£228,000**	**£334,000**	**£275,000**	**£69,000**

Provision of training

71. Once a tool and method has been developed it is anticipated that training could be offered to providers to ensure proper use of the tools. Unlike in health, there is no standard programme of training for those who would be responsible for running the tools. It is proposed that training would be delivered to service providers through a series of events run by the Care Inspectorate. Online tool resources would be created and hosted by the Care Inspectorate. An estimate of associated costs is provided in Table 8.

Table 8. Support provided for use of tool/methodology in Care Homes					
Activity	**Resource**	**2020-21 Year 1**	**2021-22 Year 2**	**2022-23 Year 3**	**2023-24 Year 4**
Knowledge spread and comms production of tools	0.2 WTE Comms Resource	£7,000	£7,000	£7,000	£0
Online tool resource		£0	£13,000	£13,000	£0
ICT Equipment and Miscellaneous		£25,000	£28,000	£10,000	£3,000
Total		**£32,000**	**£48,000**	**£30,000**	**£3,000**

Oversight

72. While Care Inspectorate inspectors already consider staffing as part of inspection, it may be the case that additional training for inspectors is required to ensure that they can adequately assess the use of any tool and methodology developed and the evidence provided for staffing decisions, and provide support where required. It is estimated that, to train all inspectors of care homes, would require approximately 700 hours of training time across two years in advance of implementation of the tool and method. Estimated costs for this are £28,000 and £29,000 in years 2 and 3 after commencement.

73. In advance of implementation of any tool, inspectors may work with care service providers to ensure they are prepared for use of the tool and method and are supported in doing so. Estimated costs for this are £96,000 and £98,000 in years 2 and 3.

74. As a tool and method has not been developed, it is not possible to accurately predict how much, if any, additional time inspectors might require to scrutinise service provider reports of staffing considerations using the tool and method. Scrutiny of staffing considerations following tool use may not take any more time than is currently dedicated to scrutiny of existing staffing requirements. If more in-depth analysis of reporting is required across all 856 care homes for older people this may require an additional time for inspectors. The Care Inspectorate estimates this could be up to the equivalent of one WTE at a cost of £53,000 per annum starting from implementation of the tool i.e. year 4 post commencement. Estimated costs associated with inspection of the use of a tool and methodology are given in Table 9.

Table 9. Additional Resource for Inspection and Support of Tool/Methodology Use

Activity	Resource	2020-21 Year 1	2021-22 Year 2	2022-23 Year 3	2023-24 Year 4
Inspector training and development	Backfill for 700 hours	£0	£28,000	£29,000	£0
Professional discussions in 1200 care homes	Backfill for 2400 hours of inspector time	£0	£96,000	£98,000	£0
Building scrutiny into CI inspections	Equates to 1 WTE Inspector	£0	£0	£0	£53,000
Total		**£0**	**£124,000**	**£127,000**	**£53,000**

Part Six: Costs on other bodies, individuals and businesses

Cost arising from guiding principles for health and care staffing and duty to ensure appropriate staffing

75. This legislation restates and replaces an existing regulation which care service providers must comply with. Therefore, it is not anticipated that there will be any significant increase in staffing levels as a result of the general duty to ensure appropriate staffing nor any additional burdens on providers. The guiding principles applied to the general duty align with the existing principles for health and social care integration delivery and planning and the Health and Social Care Standards[12], which set out what service users should expect when using health, social care or social work services in Scotland. The guiding principles should, therefore, not carry any additional costs or burden on providers.

Cost arising from duty to follow a staffing method

Contribution to tool development

76. It is essential that key stakeholders within the sector and providers would be involved in contributing to the development of a tool and method. This would be the equivalent of the clinical working group required for the development of a tool in the NMWWPP. It is, therefore, likely that resources will be required in other organisations with an interest in tool and method development. On average, the development of a tool by the NMWWPP requires 6300 hours (approx. 3.6 WTE) from up to 42 representatives across Health Boards over three years and it is expected the same level of input would be required for the development of a tool and method for cares homes for adults. The group would be comprised of

[12] Health and Social Care Standards – The Scottish Government

representatives from key organisations in the sector and staff working within the sector, the mix of which should be determined by the sector. The Scottish Government estimate that this would cost up to **£200,000** per annum over three years.

Staff training

77. Staff within care homes may require training on the use of a tool and methodology. Based on the time taken to train nursing and midwifery staff, it is estimated that care home providers would have to release each member of staff to be trained for one day. As a minimum, one member of staff per care home would have to undertake training and would be responsible for disseminating this training to those using the tool, with support from the Care Inspectorate. Our estimation assumes that two members of staff in each care home will each receive one day of training. This may result in a cost of up to **£150,000** per year over two years across all care homes, which the Scottish Government would consider providing support for. This training would be delivered in preparation for the release of a tool and method so the timing of this may change.

78. To ensure effective use of the tool and methodology by staff on a regular basis, sufficient time would have to be factored into staff planning for care homes. A tool and method for care homes is likely to be run at a low frequency due to the low turnover of service users compared to a clinical setting. The adult in-patient tool, which is used in settings with stable patient numbers, is used annually as a minimum and it is expected that a tool for care homes may be used at a similar frequency. However, it may be the case that a tool for care homes would build on the preparation of personal plans, which care homes are required to create for each service user every six months. The use of a tool would allow staff planning building on these plans and therefore would be run every six months but be included in that existing work.

Reporting on use of tool

79. Use of a tool and methodology would be reported to the Care Inspectorate as part of the annual reporting already required of all care service providers. It is anticipated that reporting will carry no significant additional financial implications for service providers as a result of this legislation.

Staffing levels

80. It is recognised that many care services are facing significant challenges in recruiting staff. It is important to note that this legislation is not intended to address wider workforce planning or staff recruitment issues. This legislation will provide a framework for the future development of tools to enable social care providers to assess their staffing needs in a consistent way and support them to design their services based on the best available evidence of workload and workforce planning to ensure delivery of high quality, outcome focussed care. As is the case for the existing tools in health, it is not anticipated, were a staffing issue to be identified, that an increase in the number of staff would be the only way to resolve the issue.

81. Research carried out by the Care Inspectorate found 59% of providers of care homes for older people reported having vacancies[13]. It is notable that, despite the number of providers carrying vacancies, only a small proportion are marked as inadequate or weak by the Care Inspectorate. If a tool were to be developed for care homes for older people, the intention would be that it would facilitate the Care Inspectorate in its role to support improvement and help providers ensure risk mitigation plans were in place.

82. Despite the focus on service redesign and appropriate risk mitigation, it may be the case that evidence generated by use of the tool supports the need for an increased number of staff. A minority of care homes have been graded as inadequate or weak by the Care Inspectorate in quarterly statistics from January 2018 (2.9% for care and support, 2.3% for staffing and 3.6% for management and leadership). A proportion of those graded as inadequate or weak for care and support and management and leadership may also find staffing issues as a result of using a tool or methodology. However, some of these services would already be included in the percentage marked inadequate or weak for staffing.

83. There are a number of factors which could contribute to identified staffing issues including skill mix, number of existing staff and availability of additional staff. It is, therefore, difficult to predict with any accuracy what, if any, increase in staff numbers may result as a use of tools. It is not expected that the percentages of service providers required to take action on staffing as a result of using a tool or methodology would exceed the number currently identified as weak or inadequate by the Care

[13] Staff vacancies in care services 2016 – Care Inspectorate

Inspectorate. For those who are required to take action there are a number of options such as changes to service redesign and skill mix which should be considered before increasing staff numbers. As has been seen in health, it is expected that the use of a tool could contribute to a reduction in agency spending which may offset any increase in staffing required.

84. However, the Scottish Government recognise the uncertainty of estimations given that there is currently not a tool in this area; but must consider that, before any regulation making power is used to require the use of a new tool due parliamentary scrutiny, including consideration of relevant impact assessments, will be carried out. The Scottish Government is, therefore, committed to work in partnership with key stakeholders, in particular the Care Inspectorate, Convention of Scottish Local Authorities (COSLA), local authorities, integration authorities, the Coalition of Care and support Providers in Scotland (CCPS) and Scottish Care. Any new information that comes to light from this process will be taken into account by the Scottish Government in future implementation.

Part Seven: Cost to local authorities and integration authorities

Costs to integration authorities and local authorities as providers and commissioners of care services arising from the guiding principles for health and care staffing and duty to ensure appropriate staffing

85. As outlined above, this legislation restates and replaces an existing regulation which care services provided by local authorities must already comply with. Therefore, it is not anticipated that there will be any significant increase in staffing levels as a result of the general duty to ensure appropriate staffing nor any additional burdens on local authorities as providers. The guiding principles are in line with the existing principles set out in the Public Bodies (Joint Working) (Scotland) Act 2014 and are already associated with best practice.

86. The Bill also places a duty on every local authority and integration authority to have regard to the guiding principles and the duties placed on care service providers when planning or securing the provision of care services.

87. The Care Inspectorate will ensure care providers are compliant with the relevant duties and therefore this will provide assurance to local authorities and integration authorities that care service providers are meeting the relevant duties placed on them. This duty is therefore likely to have minimal financial impact.

Costs to integration authorities and local authorities as providers and commissioners of care services arising from development of staffing methods for care services

88. A proportion of the costs set out above for other bodies, individuals and businesses will apply to local authorities as direct providers of care homes. 15.5% of care homes for older people are provided by the public sector.[14] Costs for staff training in these homes are included in the costs set out previously.

89. Staff employed in care homes provided by local authorities and local authority staff are likely to be involved the development of any new tools and methodology through the working group. The cost of supporting staff involvement in this work is included in the costs set out previously.

90. Should a tool and method be developed for care homes for older people, it is not anticipated that there would be a significant impact on total expenditure on services and staff as the Bill provides an opportunity to maximise the effectiveness of utilising total resources available. As above, this legislation will provide a framework for the future development of tools to enable care service providers to assess their staffing needs in a consistent way and support them to design their services based on the best available evidence of workload and workforce planning to ensure delivery of high quality, outcome focussed care. It is not anticipated, were a staffing issue to be identified, that an increase in the number of staff would be the only way to resolve the issue. However, despite the focus on service redesign and appropriate risk mitigation it may be the case that evidence generated by use of the tool and method supports the need for an increased number of staff. It is recognised that, should there be an impact on staffing costs, this may impact on local authorities as providers of care services through their own services which they deliver directly, and as

14 http://data.sssc.uk.com/images/WDR/ASW/AdultsServices_2016_FINAL.pdf

commissioners of care services procured from third and independent sector providers.

91. It is recognised that estimations of impact are uncertain given that there is currently not a staffing tool or methodology in this area and it is challenging to predict the demand profile with complete accuracy. The Scottish Government is, therefore, committed to work in partnership with local authorities and integration authorities and key stakeholders, in particular the Care Inspectorate, Convention of Scottish Local Authorities (COSLA), Coalition of Care and support Providers in Scotland (CCPS) and Scottish Care, if any new information comes to light about the cost estimates. The Scottish Government would be prepared to consider any such information. In particular, if a tool and method are developed and used appropriately, any additional funding requirements as a consequence of this would be considered in funding decisions taken by the Scottish Government.

Costs to integration authorities and local authorities arising from requirements on Health Boards

92. Requirements on Health Boards are linked to the planning and provision of healthcare services, so where those services (i.e. functions) are delegated to an integration authority as per the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 – whether an integration joint board, Health Board or local authority – then that body must also comply with them when planning and delivering those services. It is section 25 of the 2014 Act that has the effect of making the requirements flow through to integration authorities. Any costs that would fall on integration authorities or local authorities as a result would be part of the costs already outlined in the sections of the Financial Memorandum outlining the costs to Health Boards.

Annex 1

Case study 1

93. Over the period of a year, Health Board 1 transitioned all acute services from one hospital to another. Four years later, as part of a regular annual review of all of the acute wards in the Health Board, the Adult Inpatient Tool and associated NMWWPP methodology was carried out to measure nursing and midwifery staffing requirements. This identified that the nurse staffing levels were appropriate in nine of the inpatient wards. However it also identified gaps within five of the 14 ward areas, and in these ward areas bank and agency staff were being used to keep services safe.

94. In this case study it was decided that investment of **£680,346** was required to increase nurse staffing levels in the five wards with identified gaps. This investment resulted in improved quality of care and patient experience. Following the investment, a reduction in bank and agency spend of **£956,346** was realised. Taking account of investment required, an overall reduction in spend of **£276,000** was realised in one year.

Case Study 2

95. Health Board 2 has a nursing and midwifery workforce of circa 6000 WTE (June 2016). Prior to 2015, Health Board 2 implemented the NMWWPP tools in line with Chief Executive Letter 32 (2011) but did this primarily in response to identified service pressures or nationally programmed work, not as a system-wide approach.

96. Health Board 2 applied the tools and methodology across all specialties, but identified that they had no system wide approach to identification of risk and prioritisation. They have subsequently developed a system-wide approach which involves: a review of each service workforce profile (funded establishments, vacancies, use of supplementary staffing, absence levels, etc.); analysis of recent outcomes from workload/workforce analysis (if available); recording of two ratings – Workforce Priority Level and Workforce Factor Score; and consideration of mitigating actions. This was used to create a consistent risk factor across all services.

97. The approach provided a consistent platform to review the nursing and midwifery workforce and gave quantitative data to prioritise issues. This common understanding of nursing and midwifery workforce issues has

been helpful in informing service planning and providing a framework to take a risk based approach to investment and identification of efficiency savings.

Case Study 3

98. Health Board 3 is a remote and rural Health Board which has actively used the workforce planning tools to support the development of multi-professional models of care that assist in the delivery of sustainable and safe services.

99. Developing models of care that are flexible enough to match increasing patient numbers, acuity and dependency of care needs was challenging for Health Board 3, because it cannot easily increase staffing levels (because of geographical remoteness) and it is important that its nurses and midwives have key, generalist skills. Often supplementary staffing solutions such as bank and agency staff are not available, or practitioners do not have the broad range of skills required to meet care requirements.

100. Following use of the workload and workforce planning tools, Health Board 3 concluded that it required an additional WTE 1.6 nurses at Band 6 to be able to provide the necessary levels of care. However, because Health Board 3 has significant variations in its patient case mix (e.g. there is not a constant need for specific levels of care) it needed to devise a model that would enable it to support patient care in a consistent and sustainable way. It therefore undertook service redesign and developed a model of on call care which suited its needs.

This document relates to the Health and Care (Staffing) (Scotland) Bill (SP Bill 31) as introduced in the Scottish Parliament on 23 May 2018

Health and Care (Staffing) (Scotland) Bill

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