Healthcare Improvement Scotland

Healthcare Staffing Programme

Staffing Level Tool Review

Summary Report

12IR HIS: Monitoring and Development of Staffing Tools

(REF:12IR/2025/004)

July 2025

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Contents

1.0 Introduction

1.1 The Health and Care (Staffing) (Scotland) Act 2019 (ref 1) came into effect in April 2024.

Within the requirements of the duties (12IR) Healthcare Improvement Scotland (HIS) is responsible for the monitoring and development of staffing level tools including:

- monitoring the effectiveness of any staffing level tool or professional judgement tool which has been prescribed by the Scottish Ministers under section 12IJ (3) (including any new or revised tools which have been developed under this section) (see table 1).

Table 1

Type of health care	Location	Employees
Adult inpatient provision (AIP)	Hospital wards with 17 occupied beds or more on average	Registered nurses
Clinical nurse specialist provision (CNS)	Hospitals	Registered nurses who work as clinical nurse specialists
	Community settings	
Community nursing provision (CN)	Community settings	Registered nurses
Community children's nursing provision (CCSN)	Community settings	Registered nurses
Emergency care provision tool (ECPT)	Emergency departments in hospitals	Registered nurses
		Medical practitioners
Maternity provision	Hospitals	Registered midwives
	Community settings	
Mental health and learning disability provision (MHLD)	Mental health units in hospitals	Registered nurses
	Learning disability units in hospitals	
Neonatal provision	Neonatal units in hospitals	Registered midwives
		Registered nurses
Paediatric inpatient provision (SCAMPS)	Paediatric wards in hospitals	Registered nurses
Small ward provision	Hospital wards with 16 occupied beds or fewer on average	Registered nurses

1.2 The Professional Judgement Tool will be used alongside these specialist staffing level tools, or on its own according to the specialty.

1.3 Healthcare Improvement Scotland (HIS) can recommend to Scottish Ministers to revoke or replace the tools. This is to ensure they remain contemporary and provide meaningful outputs that inform appropriate staffing when used as part of the Common Staffing Method.

This paper describes the Healthcare Staffing Programme staffing level tool review process that will be used.

2.0 Background

2.1 All the specialty specific staffing level tools named in section 12IK (see table 1) are currently hosted on the Scottish Standard Time System (SSTS) platform.

2.2 They provide a recommended staffing level i.e. Whole Time Equivalent (WTE). This is based on workload and/or patient acuity.

2.3 This information provides a recommended Whole Time Equivalent via the Business Objects XI (BOXI) reporting module.

2.4 Many of these staffing tools are several years old. Health Improvement Scotland has a duty to review these tools to ensure that they are contemporary and reflect current practice.

2.5 Work to review the staffing tools was undertaken between June 2024 and February 2025.

2.6 The Maternity, the Mental Health and Learning Disabilities Staffing Level Tools and the Professional Judgement tool were not included in this tool review as new tools for these services are currently in development.

3.0 Aim

3.1 The aim of the process was to review the current staffing tools along with clinical stakeholders to inform prioritisation of future tool updates and developments.

3.2 An expert working group was established for each staffing level tool with members providing clinical advice and subject matter expertise. It was also the group's remit to:

- Provide assurance to the Healthcare Staffing Programme (HSP) that the staffing level tool is valid and current and advise where improvements are required.
- The staffing level tool meets the requirements of the Health and Care (Staffing) (Scotland) Act 2019, specifically duties 121R and 121S, around the monitoring and development of staffing level tools and the duty to consider multi-disciplinary staffing level tools.
- Review tools/resources/systems to clarify that they take account of emerging acuity of service users and workload issues and identify that, if any, further work may need to be at national level.
- Ensure information and reports produced from the tool are contemporary and can support robust decision-making as part of the application of the Common Staffing Method.

4.0 Methodology

4.1. All the current staffing level tools prescribed within the legislation were reviewed with the exception of three which were in the process of being refreshed or under new development. The excluded tools were:

- Mental Health and Learning Disabilities
- Maternity
- Professional Judgement

4.2 The process followed is demonstrated in the staffing level tools review process map.

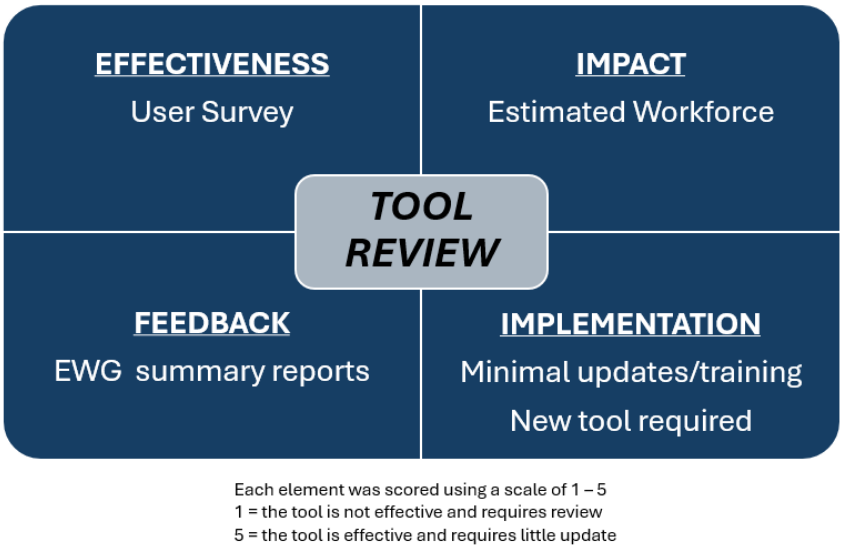
4.3 Key milestones included:

- Review of the literature pertaining to each staffing level tool
- Analysis of the data outputs for each staffing tool
- Schedule of meetings with expert working groups to review and discuss:
    1. Content and recommendations from literature review
    2. Circulation of a survey to staffing tool users to provide feedback (see table 3)
    3. Staffing level tool background, methodology and analytics
    4. Functionality and user experience of the staffing level tool
    5. Review and relevance of current levels of care for each staffing level tool
    6. Information produced on the Business Objects XI (BOXI) reports and user experience with interpretation of the data
    7. Potential for a standardised calculation for 1:1 care for relevant staffing level tools
    8. Seek feedback from relevant expert working group members to inform decision making around removal of breaks to staffing tool calculations.
- Analysis of survey results
- Summary report of feedback from the expert working group discussions
- Development of decision matrix taking cognisance of any requests for new tool development
- Feedback to EWG

5.0 Findings

5.1 Information from the expert working groups and the user feedback survey was analysed and input into a decision matrix (see figure 1) focusing on four key elements.

Figure 1 decision matrix



5.2 Each element was scored on a scale of 1-5 with 1 being least effective, requiring review, and 5 demonstrating the staffing tool to be effective requiring little update.

5.3 **User Survey:** Analysis was undertaken on the survey questions which were distributed to users in the boards, with different weightings applied to each question to provide an overall 'Effectiveness' score (see table 2).

Table 2 weighting of survey questions

Survey Question	Weighting
The level of care descriptors are up to date and relevant	15%
All level of care descriptors are appropriate for the area / specialty	15%
It is easy to enter data into the SSTS system	5%
Completion of the tool (including data capture) is time consuming	5%
The tool provides outputs that are reflective of service requirements over the given time period	60%

5.4 **Feedback:** Each expert working group summary report was reviewed with highlights and key themes scored as shown in table 3.

Table 3 themes and scoring from expert working group summary report

Key themes	**Score**
No changes required to resources or tool at present	5
Updates required to resources including training materials, data capture templates etc.	4
Updates required to language/terminology within guidance	3
Levels of care require review	2
Significant challenges in implementing tool due to change in service delivery	1

5.5 **Impact:** An estimate of the relevant workforce for each staffing level tool was taken from the National Workforce Statistics as of 30 September 2024. The workforce population was then rated on a scale from small – large and scores applied and shown in table 4.

Table 4 impact of staffing level tool on workforce population

Workforce population	**Score**
Small (<1000)	5
Medium (1000 – 5000)	3
Large (5000+)	1

5.6 **Implementation:** A score was applied to each tool based on the previous three elements of the matrix, alongside independent expertise from the Healthcare Staffing Programme which took into consideration factors such as recent or planned updates to tools, political sensitivity and scale of implementation as shown in table 5.

Table 5 overall implementation score for each tool

Tool	Feedback	Effectiveness	Impact	Implementation	Overall Score
Weighting	**15%**	**60%**	**5%**	**20%**	
Emergency care provision (ECP)	1	2.3	3	1	1.9
Paediatric inpatient provision (SCAMPS)	2	2.2	3	2	2.1
Clinical nurse specialist provision (CNS)	3	2.4	3	4	2.8
Community nursing provision (CN)	3	2.7	1	4	2.9
Small Wards	3	3.0	3	3	3.0
Community children's nursing provision (CCSN)	3	2.5	5	4	3.0
Adult inpatient provision (AIP)	4	3.2	1	3	3.2
Neonates	4	2.9	5	4	3.4

5.7 Based on the overall scores from the decision matrix, the Emergency Care Provision Staffing Level Tool is considered the least effective. The review highlighted all tools require a level of review and updating to ensure they reflect latest evidence and contemporary practice.

5.8 While a schedule of prioritisation for tool development is being drafted, all tools currently prescribed in the legislation can be effectively utilised as part of the Common Staffing Method.

5.9 Emerging issues requiring urgent attention include:

- Concerns from the emergency care expert working group regarding the validity and accuracy of the outputs from the staffing level tool.
- Undertaking a tool run for the Emergency Care Provision Staffing Level Tool presents a significant data burden for staff. The Healthcare Staffing Programme (HSP), within Healthcare Improvement Scotland, will explore potential solutions to minimise this while awaiting the development of the new Emergency Care Provision Staffing Level Tool (expected to be complete in 2027).
- Review the data collection method which derives a level of care for a baby within the Neonatal Staffing Level Tool (which will be a necessity prior to transitioning over to SafeCare). This change will continue to align with the British Association of Perinatal Medicine (BAPM) standards (2021) (ref 2) of which current practice is based upon.

6.0 Standardisation of 1:1 care within the staffing tools

6.1 NHS Scotland currently has four staffing level tools that have a 1:1 patient level, with the adult inpatients and small wards tools having a 1:1 multiplier which has not currently been deployed within the tool.

6.2 A multiplier is a validated calculation that generates a recommended whole time equivalent. The definition of 1:1 care enables this multiplier to be based on a calculation.

6.3 The multipliers can also be displayed as the Care Hours Per Patient Day (CHPPD) and table 6 below, demonstrates the variances between each tool.

Table 6 variance in 1:1 care for each staffing level tool (based on contracted hours being 37)

	1-1 Level of Care in tool	1-1 Care multiplier	Care Hours Per Patient Day (CHPPD)
Adult Inpatient and Small Wards	No	5.27	22.74
Maternity	Yes	5.77	24.88
Neonatal	Yes	5.68	24.49
Scottish Children's Acuity Measurement in Paediatric Settings (SCAMPS)	Yes	5.23	22.56

6.4 The Care Hours Per Patient Day (CHPPD) is the total hours of care per patient over a 24-hour period, this includes direct care, indirect care, associated workload and personal time attributed to each patient. Each staffing tool will convert the average The Care Hours Per Patient Day (CHPPD) to a recommended WTE, inclusive of Predicted Absence Allowance which is currently set nationally at 22.5%. The Care Hours Per Patient Day (CHPPD) is the total care hours and does not provide any guidance on skill mix.

6.5 Each tool was developed independently of each other, hence the variances in the care hours per patient day value attributed to 1:1 care.

6.6 While there is little documented in the literature for 1:1 care, a paper produced by the North West Neonatal Operational Delivery Network (NWNODN) in 2020 (ref 3) set out to provide a consistent approach to setting nursing establishments with consideration for national standards such as National Institute for Health and Care Excellence (NICE) and British Association of Perinatal Medicine (BAPM). The model advocates 26 hours are required to provide 1:1 care inclusive of 2 hours per day for shift handover and supervision.

6.7 If progressing with a calculation-based approach to 1:1 care hours, the proposed calculation is detailed below:

24 hours + 60min handover period (based on 2 shift pattern) + 60min personal time (paid comfort breaks/tea breaks)

= 26 hours of care required

6.8 The expert working group membership for the relevant tools, were asked to discuss what the clinical perspective is on how 1:1 care is managed within the different specialties and care settings which will have an impact on the number of care hours required and whether this is currently set at a level that is reflective of contemporary service delivery.

6.9 The Expert Working Group were asked to consider if:

- For Adult Inpatients and Small Wards whether Level 5 (1:1 Care) should be deployed in the tool.
- All groups should consider what calculation is most reflective of their service i.e. current level, calculated level or whether to wait for a more in-depth review of the tools informed by observational studies

7.0 Removal of breaks from staffing level tools

7.1 In late 2023, the Healthcare Staffing Programme (HSP) carried out testing of staffing level tool multipliers within the SafeCare module of the National eRostering System. The testing was successful, and this led to the deployment of the adult inpatient multipliers in early 2024.

7.2 At the time, the 'Staffing Level Tools and Real-Time Staffing Steering and Oversight Group' provided the governance for this work. As part of the governance process, detailed calculations were shared with the group and this led to the questioning on the appropriateness of the percentage removed from some staffing level tools in relations to breaks.

7.3 There are six staffing level tools that remove a percentage of time for breaks. Each of these tools were developed using observation studies, with the percentage of time removed for breaks determined from the studies. This has led to varying percentages being removed, per tool or sub-speciality within adult inpatients (16 sub-specialities).

7.4 The percentage currently removed includes paid and unpaid breaks.

7.5 The primary purpose of the staffing level tools is to recommend a Whole Time Equivalent (WTE). It is important to note that Agenda for Change (AFC) (ref 4) staff are not paid for breaks and that WTE conditioned/contracted hours are based on working hours only.

7.6 Paid breaks this includes complimentary breaks e.g. refreshment breaks. This is something that couldn't be based on a calculation due to the varying local practices. It would be unreasonable to expect staff to work continuously for their full paid element of the shift, without granting staff time to hydrate, have social interaction with colleagues etc. If this time wasn't granted it could lead to staff burn out and reduced levels of concentration that may negatively impact patient care. These breaks are complimentary, and at times of high workload pressure may not be granted. Consideration needs to be given to the appropriateness of removing time for paid breaks.

7.7 The Healthcare Staffing Programme proposed to the expert working group that all tools remove only unpaid breaks from their calculation at a set 8%. If agreed, this becomes standard for all current inpatient tools and new inpatient tool developments.

7.8 The Royal College of Nursing stated that their position is that no time for breaks should be removed from the staffing level tools. The Healthcare Staffing Programme position is that as per Agenda for Change terms and conditions, unpaid breaks are not included in conditioned hours and should therefore be removed from the recommended Whole Time Equivalent calculations. A change in Agenda for Change terms and conditions stating that staff were to be paid for all breaks would be required for this to change. A paper was submitted to Scottish Government detailing the Healthcare Staffing Programme rationale for this decision.

7.9 The expert working groups were advised that if staff members are not receiving their breaks this should be captured within the Professional Judgement Tool.

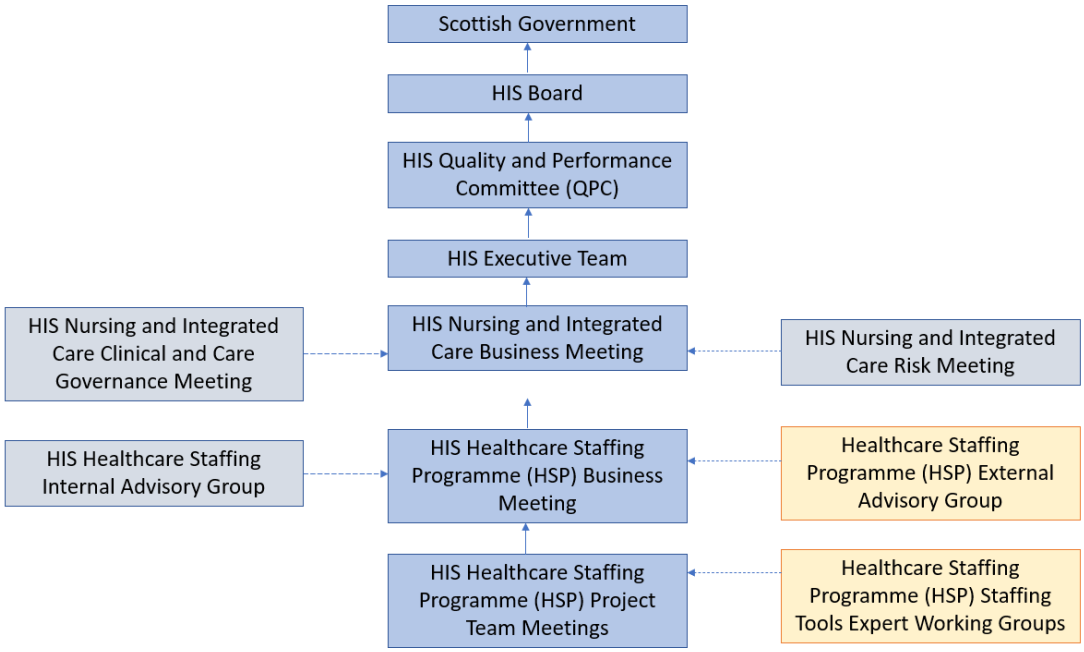
8.0 Governance

8.1 Until April 2024 the work was overseen by the Healthcare Staffing Programme (HSP) Staffing Level Tools and Real Time Staffing Steering and Oversight Group. This group reported into the HSP Programme Board which promoted external involvement in the work of Healthcare Improvement Scotland. This included representatives from the Scottish Government, the Care Inspectorate, relevant professional bodies, and trade unions.

8.2 From April 2024 the governance groups under 8.1 have been replaced by the Healthcare Staffing Programme External Advisory Group but continues to have widespread representation and engagement. This includes the representatives mentioned in 8.1 as well as an extended invite to include professional regulators.

8.3 This forms part of a new governance structure (see Figure 1) for the Healthcare Staffing Programme in recognition of the roles and responsibilities of Healthcare Improvement Scotland outlined in the Health and Care (Staffing) (Scotland) Act 2019.

Figure 2 Healthcare Improvement Scotland (HIS) Healthcare Staffing Programme Governance Structure



8.4 In addition, reformed with new members, the Healthcare Staffing Programme expert working groups have been established and contributed to this review of the current tools. All Health Boards, Integrated Joint Boards (IJBs) and key stakeholders have been written to and invited to provide representation, where relevant. Relevant professional bodies and trade unions have also been written to and invited to provide representation.

9.0 Recommendations

9.1 While all the staffing level tools prescribed in the legislation require a full review and update, they currently provide meaningful outputs to help inform decision making for workload planning as part of the Common Staffing Method.

9.2 The Healthcare Staffing Programme will develop a prioritisation plan for reviewing and maintaining the current suite of staffing level tools.

9.3 The Emergency Care Provision Staffing Level Tool was identified as the least effective of the current tools. This along with recommendations in the NHS Greater Glasgow & Clyde Emergency Department Review: March 2025 (ref 5) indicates that the Healthcare Staffing Programme should prioritise the development of a new tool to reflect the current operating context and multi-disciplinary working to ensure safe and effective care in emergency departments. In response to the published

recommendations and our prioritisation exercise, this has resulted in this tool being prioritised for development and is now in the early stages of planning.

9.4 While development of the new Emergency Care Staffing Level Tool is ongoing, the Healthcare Staffing Programme will explore at pace potential solutions to ease the data burden for staff and improve accuracy with data capture as they continue to use the existing tool as part of the common staffing method.

9.5 The Healthcare Staffing Programme will convene a short life working group with stakeholders and professional bodies representing neonatal services to review the levels of care and work to align these to the British Association of Perinatal Medicine (BAPM) (2021) standards.

9.6 The membership of the adult inpatient and small ward expert working groups agreed to the inclusion of 1:1 care within the staffing level tools, alongside the proposed calculation for 1:1 care. The Healthcare Staffing Programme will progress this work and inform stakeholders once completed.

9.7 The paediatric expert working group discussed 1:1 care. Although a consensus was not obtained, it was agreed that this would go back to the Healthcare Staffing Programme for consideration. The neonatal expert working group meeting did not go ahead due to low board representation.

9.8 The Healthcare Staffing Programme considered the views of the paediatric group via the Healthcare Staffing Programme Business Meeting, a formal decision making group within the governance structure. The group agreed that by definition 1:1 care is consistent across all specialties, therefore the associated care hours assigned to a patient requiring 1:1 care should be standardised across all tools.

9.9 All relevant staffing level tools will remove only unpaid breaks from their calculations at a set 8%. This becomes standard for all current inpatient tools and new inpatient tool developments. The Healthcare Staffing Programme will communicate to stakeholders once this work has been completed.

10.0 References

1. The Health and Care (Staffing) (Scotland) Act 2019.

2. British Association of Perinatal Medicine (BAPM), Service and Quality Standards for Provision of Neonatal Care in the UK (2021).

3. Neonatal Workforce Tool (2020), North West Neonatal Operational Delivery Network (NWNODN).

4. Agenda for Change Handbook, Master Scottish Copy 2025 : section 10.

5. HealthCare Improvement Scotland, NHS Greater Glasgow & Clyde Emergency Department Review: March 2025, page 173.

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