OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 25 September 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 25 September 2018

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HEALTH AND SPORT COMMITTEE
24th Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

Miles Briggs (Lothian) (Con)
*Keith Brown (Clackmannanshire and Dunblane) (SNP)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Joy Atterbury (Law Society of Scotland)
Dr Tony Axon (Society and College of Radiographers)
Tracey Dalling (Unison Scotland)
Phillip Gillespie (Scottish Social Services Council)
Ann Gow (Healthcare Improvement Scotland)
Gordon Paterson (Care Inspectorate)
Joyce Thompson (British Dietetic Association Scotland)
Karen Wilson (NHS Education for Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 25 September 2018

[The Convener opened the meeting at 10:00]

Health and Care (Staffing) (Scotland) Bill: Stage 1

The Convener (Lewis Macdonald): Good morning and welcome to the 24th meeting in 2018 of the Health and Sport Committee. I ask everyone to ensure that mobile phones are set to silent. If you are using electronic devices for social media purposes, please do not film or record proceedings; Parliament will do that for us. Apologies have been received from Miles Briggs and David Torrance.

We move swiftly on to our first item of business, which is another evidence session on the Health and Care (Staffing) (Scotland) Bill. Today's session will focus on those who regulate, register and oversee the training of social care staff. I welcome to the committee Gordon Paterson, who is chief inspector of adult services at the Care Inspectorate; Phillip Gillespie, who is director of development and innovation at the Scottish Social Services Council; Ann Gow, who is director of nursing, midwifery and allied health professionals at Healthcare Improvement Scotland; and Joy Atterbury, who is a member of the health and medical law sub-committee of the Law Society of Scotland.

I will begin with a general question about the bill, given some of the evidence that the committee has heard so far. The bill covers both health and social care, which have different cultures and different regulatory arrangements, of which you are all, in one way or another, very much aware. Do you accept the view, as set out in the policy memorandum, that the bill has the potential to help bring the regulation of the two sectors closer together? Will the bill make it easier to promote the integration of the two sectors, as laid out in the wider policy objectives?

Who would like to start on those general points about the drawing together of health and social care?

Gordon Paterson (Care Inspectorate): I am happy to start. Thank you for the opportunity to come along today and provide evidence.

The Care Inspectorate is acutely aware that the quality of care services is critically influenced by high-quality staffing. As the bill has evolved, we have taken a clear position of support for what it seeks to achieve, and we believe that it will achieve its policy objectives.

The social care sector is already regulated, and we believe that the bill as it is currently drafted will enhance and strengthen our existing powers. We believe that it will bring greater focus to the way in which providers are able to determine the optimum skills mix and the optimum numbers of staff to deliver high-quality care. We are very content with the proposition that the process should begin with care homes for adults and, in the first instance—as the policy and financial memoranda indicate—with care homes for older people. We are content, too, that the bill seeks to adopt an enabling approach to allow the Care Inspectorate to work in collaboration with the care sector and with people who experience care. We think that it will bring greater transparency and consistency to the way in which care providers determine the optimum staffing mix for the delivery of high-quality care.

With regard to the bill's contribution to levelling some of the distinctions that currently exist between health and social care, we think that the fact that it is based on a general set of principles that apply to both health and registered care services is important. Regulation 15 of the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 sets out the condition that providers should have in place adequate numbers of "suitably qualified" staff. We understand that the bill applies that to health services as it currently applies to social care. We see the bill as providing and adding value through that development.

Phillip Gillespie (Scottish Social Services Council): Thank you for the opportunity to give evidence this morning.

We believe that there is an effective link between sustainable staffing levels and quality of care, and that the bill offers the opportunity to ensure that staff are appropriately skilled and deployed in the right places at the right time. The bill supports continued progress towards outcome-focused health and social care scrutiny, which we believe is enhanced by the health and social care standards and the new Care Inspectorate methodology.

We welcome the bill's policy intention on collaborative working across the health and social care system, and its intention to enable a more

"rigorous, evidence-based approach to ... staffing requirements"

for employers. The bill takes account of the needs of service users and is inclusive to that effect, in that it provides for reliance on professional judgment and ultimately creates a safer environment for service users and staff.

We welcome the initial focus on care homes, which provides for a consistent approach that can be applied across integration with new and changing service models and multidisciplinary teams. As a workforce regulator, we welcome the prominence that is given to workforce planning; we publish workforce data on skills and qualifications that can enhance and support workforce and workload planning more generally.

Ann Gow (Healthcare Improvement Scotland): Healthcare Improvement Scotland welcomes the bill and its guiding principle of providing safe and high-quality services. We also welcome the focus on transparency and on the needs of both service users and staff. We specifically welcome the duty to ensure the use of suitably qualified staff at all times, although we acknowledge that the common staffing method as laid out in the bill does not entirely support that, and we are currently working with the policy team to look at how we ensure that the next iteration of the bill responds to dynamic day-to-day staffing needs in the national health service.

We acknowledge and fully support the use of a triangulated approach, rather than simply the use of a tool, in the common staffing method. In the committee's previous evidence sessions on the bill, which I watched, there was a lot of focus on the tool and the numbers, but the triangulation of quality outcomes with the views of patients and staff will enable boards, at the end of the process, to come to a decision on which staff are needed for specific services with specific local needs, and to put in place governance around that. Having previously been a senior nurse in territorial boards, I have used the tool for nursing and found it very successful, and I think that we can use a similar method to assure and improve services across the NHS.

We welcome the pivotal role for Healthcare Improvement Scotland in implementing this key piece of legislation, and we believe that it will be a key driver in assuring both service users and staff across both sectors that care is safe, effective and person centred. Our role is outlined further in the policy and financial memoranda. We are being given powers similar to those of the Care Inspectorate—the roles should mirror each other, and we believe that the bill will provide vital regulation to allow us to work better together across the health and social care sectors. That is important from the point of view of patients and service users and of staff. It really should not matter where in the social sector people are looked after: they should be entitled to good care and high-quality outcomes, and to an assurance that the right levels of staff will be in place to look after them.

Overall, HIS welcomes the legislation. We feel that it fits with and supports our functions and that it will provide real benefits for staff and patients alike.

The Convener: You used an interesting phrase when you spoke about the further work that you felt was necessary on the common staffing method: you said that you were looking forward to the "next iteration" of the bill. Do you think that a significant change in the bill is required in order to achieve that objective, or would you look to secondary legislation?

Ann Gow: I would leave it to the policy team and legal colleagues to decide what needs to be in the bill and what needs to be in guidance. As I understand it, the common staffing method as outlined in the bill will give us an establishment. It might say that, if we have between 25 and 30 patients in each ward, we need between 28 and 30 nurses. That is how things have worked until now. However, that would not tell us how to deploy those nurses or provide any assurance around that. That approach will now extend to other staff groups. Further provisions could be either in the bill or in guidance. As I said, we are currently working with the policy team to ensure that the method provides not only for sufficient people on the roster, but for sufficient people at all times who are adequately trained to look after people or provide care in the social sector.

Joy Atterbury (Law Society of Scotland): Good morning. The Law Society of Scotland is grateful for the opportunity to be here. My substantive role is as head of litigation at the NHS central legal office, but I am here today as a member of the Law Society's health and medical law sub-committee. Our remit is to look at developments in law and policy in the health and medical law field in the interests of both the public and the profession. You have already heard from the bodies that represent health professionals, and they have submitted written evidence. As a Law Society committee, we have looked at the potential legal effects of the bill.

The aim of the bill is clearly to provide a statutory basis for appropriate staffing in health and care settings. The guiding principles are set out; however, they are very general and multifactorial, and they recognise the need to balance competing priorities. The real point of the bill is to pave the way for the later introduction of regulations that will set out how appropriate staffing is to be achieved and specify the creation of the model and the frequency with which bodies will have to use it.

The policy memorandum refers to a

"policy intention … to enable a rigorous, evidence-based approach to decision making relating to staffing requirements",

but the bill does not show us what the model is going to look at. As a result, we feel that the bill raises for consideration during this period of scrutiny a series of questions that may be regarded as significant. They relate to whether the policy objective, which we absolutely accept is laudable, will be achieved. The issues include the bureaucratic burden; the financial resource implications; whether a single tool could deal with geographic and cultural variation across Scotland; and the impact on training needs, not only locally in the use of the tool but at a national level with regard to the availability of training places to enable staff to meet the bill's requirements.

We also considered the mechanisms for oversight that might be proposed. Would they be restricted to the reporting mechanisms that are contained in proposed new section 12IE of the National Health Service (Scotland) Act 1978, or is it intended that there will be sanctions in the event of non-compliance? Is it intended that any perceived failure to comply with the guiding principles should form the basis for challenge by way of judicial review or provide support for allegations of breach of duty within civil litigation? The bill will stand or fall by the efficacy and robustness of the tools that will be imposed as a consequence of the powers that it sets out, and there is a danger of inflexibility if those tools cannot adapt to changing or unusual circumstances.

Having considered the bill without sight of the regulations, we concluded that effective scrutiny of it by the professions, the public and the committee will be extremely challenging, and we think that there would be considerable merit in undertaking more detailed scrutiny and further consultation once the regulations are in place.

Emma Harper (South Scotland) (SNP): The overarching aim of the bill is to use evidence-based workforce planning tools that will allow us to build and develop healthcare, which is evolving all the time. I am interested to hear about the positives of the bill, and about what is missing and may need to be added.

Ann Gow: With regard to workforce planning and the evidence base, the bill starts from a very positive place. Of course, I have a bias, as I am a nurse, but I have chaired the development of the community nursing tool so I have fairly intimate knowledge of how such tools have been developed and of the work that has been done in nursing over the past 10 to 12 years. The tools are based on current workload, which is based on the needs of the patient population that the nurses and midwives who use the tools are looking after—they take into account the whole workload. As I said earlier, the triangulation with quality outcomes is also very positive and will allow boards and integration joint boards to be flexible in how they use the tools and the numbers.

10:15

That is all very positive but, as I said, there are gaps around dynamic day-to-day management. For instance, what does someone do when they come on shift and a couple of people are off sick? What happens in an acute hospital during a very busy period in the middle of the winter? How do we provide cover if someone on a night shift goes off? How do we provide assurance that people will have adequately trained staff to look after them 24 hours a day, seven days a week, in health and care services? As I said, we are doing a bit of work with the policy team, as part of a wider group, because we recognise that there is a gap in the bill and in the guidance. There are other gaps that relate to tools for the care sector and for the wider health sector, such as multidisciplinary tools and tools that cover non-nursing and midwifery disciplines.

Emma Harper: The policy memorandum mentions that nursing has had the tools for 10 years—they have already been implemented, which is a great place to start. There are more health employees, or nurses, than allied health professionals. The whole process will allow other tools to be developed for allied health professionals, so as we move forward we will develop and include other tools in regulations. Is that not how we will manage it?

Ann Gow: Yes, there is a process for the inclusion of other tools; I am talking about what is in the bill as it stands. Having listened to the committee's previous evidence sessions, I believe that there is an overemphasis on the existing tools and on the methodology to date. Things might change depending on the evidence base, so we need a bit more flexibility. Nurses and doctors are mentioned, but we need to emphasise more strongly other disciplines and groups in the NHS, such as allied health professionals and pharmacists, who are also critical to the safety of, and the quality of care for, people in our sector.

The Convener: Either Phillip Gillespie or Gordon Paterson can comment from a care sector point of view.

Phillip Gillespie: The social services sector in particular is quite a diverse sector with a lot of different employers and organisations of different sizes. The tools can help to start to align them to the national health and social care standards, because they focus on what matters to the individual. From our perspective, the tools fit nicely with our codes of practice on the values, behaviours, skills and competencies that workers are required to have in delivering care. There is

good alignment between the development of tools and standards in the bill and our codes of practice. Given the diversity of our sector, we have to be absolutely flexible with regard to the different types of tools that are required in different settings. The process needs to be sector led, driven by the sector's needs and supported by the SSSC and the Care Inspectorate.

The Convener: Alex Cole-Hamilton has a brief supplementary.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning. Ann Gow, in her opening remarks and in her answer to Emma Harper, talked about the skills mix and said that there might be a gap in the legislation in that regard. We are very good at defining the tools and the appropriate or optimum staff capacity numbers, but do we need to amend the bill to ensure that there is an appropriate blend of training in the staff cohort?

Ann Gow: Yes—the wording could be amended slightly to make that more overt. The tools came from a specific place 12 years ago—they were developed because of things that had happened or were discovered in large-scale reviews. In Mid Staffordshire NHS Foundation Trust, for instance, there was a strong link between harm to patients and nursing numbers. The evidence shows that, when nursing numbers in particular are low, there is greater harm to patients. Mortality and morbidity go up, people fall more and it is not recognised that people are getting sicker. That is where the tools came from; it was very much about harm prevention.

The bill goes a step beyond that to look at quality of care overall and the general wellbeing of both staff and patients, which requires a much more multidisciplinary approach. Having listened to what other people have said about the bill, I think that it possibly does not describe that approach in the way that it should. It could be reworded—I will leave that to my legal colleagues.

The Convener: Does Gordon Paterson have a view?

Gordon Paterson: I want to supplement that answer and respond to Emma Harper's question. It is important to recognise that the bill articulates the need for "safe and high-quality services", which is not simply about keeping people safe by prescribing minimum numbers of staff. As Phillip Gillespie indicated, high-quality services are defined—as they should be—by the new health and care standards. When we work with the sector to look at the development of tools, we will not merely be asking what the minimum number of staff should be to keep people safe. We will look at the mix of staff, including who should perform which roles and who is deployed to do which tasks with which objectives, and those objectives should be about our ambition to meet the health and care standards. They should be about ensuring that people who use care services have good lives, rather than simply being provided with good services. Those people should not be defined by what they lack—they should instead be seen as people with assets, gifts, experience and ambitions.

When we describe "high-quality services" with regard to our care home population, we mean that people should experience community connectedness and should be included in their local communities and be supported to live good lives. We very much welcome the fact that the bill refers to "high-quality services" and that its provisions are linked to the health and care standards.

David Stewart (Highlands and Islands) (Lab): I thank the panel for their contributions today. Most of my questions are about Healthcare Improvement Scotland, so I am afraid that Ann Gow is in the hot seat, but I would welcome contributions from any other panel members. Ann, can you explain and amplify HIS's role in monitoring staffing levels?

Ann Gow: To date, our role in monitoring has been via our inspection regime. As we develop our quality-of-care approach to assurance and scrutiny, about which the committee heard when it was doing work on clinical governance, the bill, with the tools and the common staffing method, will add for us the ability to look generally at the quality outcomes within a board or a system and align them with the use of the common staffing method. It will enable us to triangulate some of those outcomes with the views of staff and patients, so that what happens in the development of the tools mirrors what happens in the service. We can then come up with some sort of conclusion, which we can publish and make publicly available, on the balance between staffing, skill mix, quality outcomes and the views of patients and staff in a very general sense.

In addition, if we have to do specific thematic inspections, the bill will allow us to do a much deeper dive into staffing and the effect that it has on a particular area. That would include SAERs—significant adverse event reviews, for those who are not aware of the term—as well as maternity services and cancer services. It will allow us to align workforce numbers, the workforce skill mix—if we get the tools right—and quality outcomes, and it will give us an extra piece of the jigsaw so that we can provide the necessary open and transparent public assurance.

David Stewart: You touched on staffing tools. As you will know from watching our previous evidence sessions, we have heard a lot of

evidence about tools. One of the issues that has come up in oral and written evidence concerns the difficulty of trying to get a tool or tools that would work for both NHS Greater Glasgow and Clyde and NHS Western Isles. Is that a fair comment on the previous evidence that we have taken?

Ann Gow: I have worked with the tools, and because they are based on current workload and involve professional judgment, they should be variable enough to use in NHS Greater Glasgow and Clyde and in NHS Orkney. There is enough there in that respect.

A lot of people have been focusing only on the number, which on its own would not give us that variability, but the professional judgment and quality-outcome parts of the triangulated method allow for local variability. I am thinking of areas in which I have had professional oversight in the past. For example, for a chemotherapy ward with an out-patient department, the tool would give an average number for a ward of that size. However, because I know that I am running an out-patient department at the same time, my professional judgment would allow me to say that I need an extra five staff in the mornings when out-patients are coming in. That approach should allow for variation across different population groups. Wards certainly vary in size and quality outcomes, as do community teams, but the triangulated method should allow for variability across the board. It remains to be seen whether the same method will work for joint and integrated tools, but that is a piece of work that we could carry out in the future.

David Stewart: Am I right in thinking that HIS is the main organisation for developing and scrutinising the various tools that are available across Scotland?

Ann Gow: We will be at some point in the future, depending on what is in the bill.

David Stewart: So I will be right in the future, but I am not currently right.

Ann Gow: Yes—at the moment, we are scrutinising workforce as part of the overall approach to quality. Development of the tool currently sits with the workforce team, which sits within the chief nursing officer directorate.

David Stewart: Apart from health boards, who are your stakeholders in developing tools?

Ann Gow: In the development of tools, health boards are obviously stakeholders, as are other employers or managers of IJBs, in addition to patients, staff groups and unions. In the future, the Care Inspectorate will also be a stakeholder, given our duty to co-operate with it in the joint development of tools within the integration space.

David Stewart: I have a final question. Again, as I understand it, HIS is a key scrutiny body for healthcare.

Ann Gow: Yes.

David Stewart: How can the public be reassured, first, that staffing is adequate across Scotland, and secondly, that they have some role in the process? In other words, what consultation has there been specifically on the type of tool that we are using across Scotland?

Ann Gow: Your question about consultation on the tools that we currently use across Scotland is probably more for the existing team. I cannot give you a detailed answer on that.

With regard to transparency for the public on the work of Healthcare Improvement Scotland and what we hope to do in the future in scrutinising the tools, we publish reports, and we ask service users about the quality of their services as part of our quality-of-care reviews, our Healthcare Environment Inspectorate inspections and other inspections. In the bill or the policy memorandum—I cannot remember which—there is an obligation on boards to report annually on whether they have used the tools. Again, we believe that that will provide for more public scrutiny on whether staffing levels are right and whether adequate attention has been paid to them.

David Stewart: I did say that that was my final question, but I have a final final question. Obviously the public is very interested in this area—I will rephrase my question slightly. In my understanding, certainly from casework in my region, many constituents will be interested not in management tools but in knowing that if they, or their granny or auntie or uncle, go into a care home or hospital setting, it will be adequately staffed. All the committee members find that staffing levels come up in casework—there are complaints about staffing, and we all know about the wider picture. Given what you have observed in your role in HIS, is that a reasonable observation?

Ann Gow: Yes, it is a reasonable observation. In my role in HIS, and previously as a nurse in the system, I have found that people look first at the quality of the outcomes and the care that they have received. If those elements are not right, they start to unpick the process and ask whether enough staff were looking after them or their relative. In other systems, and in some units in the NHS in Scotland, staffing numbers are published on ward doors—they show the levels that patients can expect today and what they should be able to expect in general. It is not in the bill, and we have not looked at it, but as part of our excellence-in-care approach, making available to the public

information on what we should and do have is an option, and some boards are working towards that.

10:30

Brian Whittle (South Scotland) (Con): I am interested in the current situation. In particular, how does the Care Inspectorate assess whether a provider has appropriate staffing? What support do you give to providers in relation to staff planning?

Gordon Paterson: That links to Mr Stewart's question about our role in monitoring staffing methods. There are approximately 832 care homes for older people in Scotland, and we inspect them at least once every year—often twice and, in some situations, three or four times.

We inspect for outcomes. We are concerned about how people's lives and wellbeing are being enhanced by the experience of living with the service. We recognise that the bill and the tools are not about outcomes, but we are sensitive to the relationship between inputs, processes, resources, outputs and outcomes. We see the tools as an input, we see the application of those tools as a process, and we see the determination that they bring as an output in terms of the number of staff working to do various tasks at various levels with various skills.

The bill in itself will not guarantee outcomes, but it will contribute to that chain, which is probably only as strong as its weakest link. We view the outcomes in relation to how people experience care, which we pick up through our inspection activity. We know that having large numbers of staff does not guarantee outcomes, but not having any staff guarantees poor outcomes. There are balances to be struck and judgments to be made about what makes a difference and what contributes to good care.

We think that the bill and the validated tools, which do not currently exist in the care home sector, will add value and contribute to improved outcomes. We see the provisions working closely with other developments that are under way. For example, we are involved in work with Scottish Care and the Convention of Scottish Local Authorities on a dependency tool, which is a means of assessing the level of dependence—I would prefer to say "independence" or "interdependence"—of people living in care homes. However, that does not lend itself to making determinations on how many staff are needed to meet the aggregated needs of a care home population. We see the tool as part of a package or raft of measures that will contribute towards improved outcomes for people.

Brian Whittle: We all agree that positive outcomes are the most important thing that you have highlighted. As you said, when the Care Inspectorate goes in, it considers outcomes. I presume that if the outcomes are not up to standard, you work your way back. I am interested in how you feel the bill and the way in which you assess things will enhance and improve that process.

Gordon Paterson: We think that the tools, once they are developed, will bring consistency and transparency, and that they will add something to the measures that are available to care home providers to ensure that they are providing good-quality care. When it comes to cases in which we identify failings, under section 44 of the Public Services Reform (Scotland) Act 2010, the Care Inspectorate has a statutory duty on further improvement. We do not take the view that we are led only by compliance; we think about how we can support improvement, how we can advise and how we can co-ordinate the improvement activities of others so that the quality of care improves.

We have that commitment and that obligation, and we very much see our inspection activity as providing a diagnostic. Beyond that, it is our responsibility to ensure that improvement is made, either by ourselves—we have the improvement support team—by the IJB, by the provider or by those who commission the services.

Only in extreme circumstances would we take the ultimate sanction of proposing to cancel a care home's registration. Our initial steps are always about making the situation better, even if a service is highly performing, and showcasing what is working well, so that those in the rest of the sector can benefit and learn from that in order to improve their services.

We also have enforcement action, which involves setting out requirements where there has been a breach of a regulation, or, potentially, applying for an improvement notice, which gives a care provider notice that we might seek to withdraw their registration if they do not achieve improvements within a set timescale. A raft of measures is available to us.

On the bill, we would commend a tool that adds value to care providers and enables them to better understand the needs of their residents and how those might best be met through a combination of different methods in relation to skill mix and staffing.

Brian Whittle: Given the Care Inspectorate's role in that sort of continuous improvement, is legislation required to get to that end goal?

Gordon Paterson: We think that the proposed legislation will strengthen and enhance that role and give greater focus to the importance of having appropriate staffing. We think that the tools, once they are developed, will be an enabler. We are

keen that the bill should be framed in such a way that it does not prescribe.

The tool, like any tool, should be fit to do the job that it is required to do and should add value when it is deployed by people who have the competence and skills to use it. We are very keen that it should be seen as something that will support the sector in developing effective staffing models.

Alex Cole-Hamilton: I will follow on from Brian Whittle's questioning to the Care Inspectorate; I then have a broader question for the rest of the panel.

It is fair to say that Gordon Paterson's organisation has been on a bit of a journey with the bill. In your original response to the Scottish Government consultation, you talked about the anxieties that your organisation had about a further statutory requirement on the care sector, but it seems that your position has moved a bit. In your joint submission with the SSSC, you say that you welcome the bill. What has changed to bring you on board?

Gordon Paterson: Our position has evolved as the proposals have evolved. The original consultation discussed the application of existing tools to social care. By that, we understood that the nursing tools would be imposed on the social care sector. We were not confident that there was an understanding, in the consultation exercise, of the complexity and diversity of the social care sector.

We have become content with where the bill has settled, in so far as care services are already regulated but the proposals would enhance that regulatory power, and we see enormous potential in the narrowing down of the definition of "care service" to care homes for adults and older people. We have revised our position as the Scottish Government has developed its proposition.

Alex Cole-Hamilton: I will turn to my broader question. The committee has great concerns—we have had them since Parliament first sat after the election—about the pressures on the integration agenda and the fact that silos are still very much in our care landscape. Are you content that the bill does nothing to compound that silo culture? Does it offer an opportunity to break down the walls?

Phillip Gillespie: I welcome the opportunity. I said earlier that models of care are changing and becoming more integrated. They lend themselves well to multidisciplinary teams. The nature of the care system is changing, and the bill offers a more consistent approach. If the tone of the bill is right, it is about involving employers and organisations in developing the tools that work for them, with local variation.

The focus on care homes is really important, because there are huge dependency levels in care homes. That is variable, and the tools will offer flexibility to understand the levels of need in care homes and respond accordingly. The public would expect that in relation to safety, too.

Ann Gow: The key lies in the close working relationship between the Care Inspectorate and HIS, with both organisations' implicit understanding of both health and social care. On the idea of giving the development of the tools entirely to one or other organisation, Gordon Paterson's feedback on earlier iterations of the bill and the wording and language that were used—the proposals were written very much from an NHS perspective—gives us a bit of an insight into how important it is to have people who understand the culture and the language that is used in each agency, and then to bring things together on the front line, ensuring that we get the right numbers and the right skills mix of staff.

I think that the bill will enhance such an approach and enhance care. If we get it right and ensure that it focuses on good-quality care, which is the term that we generally use in the NHS, and on good outcomes, which is the focus in social care, the bill will enable much more and much better front-line working.

Alex Cole-Hamilton: I see that you are also responsible for AHPs in HIS. Is that right?

Ann Gow: Yes.

Alex Cole-Hamilton: Are you concerned about their slight absence from the bill?

Ann Gow: This is not just about AHPs. We need to start to discuss multidisciplinary teams within the NHS, as well as multidisciplinary and multisector teams when it comes to IJBs, the care sector and elsewhere.

I can see where the proposals have come from. To go back to one of my earlier answers, the tools initially came from areas where it was safety critical to get minimum numbers of nurses—and doctors, according to the next thinking—to reduce harm. If we are talking about quality of care, quality outcomes and wellbeing for staff and patients, then not just AHPs but all staff groups need to be considered within the NHS and the integrated context. One of the changes to the bill that is perhaps required is to have wording that reflects that and gives us the flexibility to ensure that we have the right skill mix of staff, depending on which setting we are working in.

Alex Cole-Hamilton: Do you think that the bill can be amended to cover the concerns of AHPs and the multidisciplinary workforce that you describe?

Ann Gow: Yes.

Alex Cole-Hamilton: I look forward to working with you on that.

The Convener: Will Joy Atterbury comment from the Law Society's point of view? At the beginning, you talked about the need to know what is going to be in regulations in order to have full scrutiny. What is your view of the bill? Clearly, there is scope for amendment. How much amendment do you think it requires in order to be fit for scrutiny, quite apart from being fit for purpose?

Joy Atterbury: Our difficulty is that the bill is stand alone. I am not aware of that ever happening before. If we had had a set of draft regulations to go with it at this stage, it would have been very much easier to answer the questions that have been raised with us. To be fair, most of the questions have been reflected by colleagues on the panel.

The whole issue of competing priorities and implications for multidisciplinary teams and professionals allied to health had occurred to us. If there is an opportunity to introduce that issue into the bill, then a number of the concerns that colleagues have expressed could be resolved and we would not have the gap in understanding that will continue to exist until the regulations are drafted.

The Convener: That is helpful. Thank you very much.

Will Phillip Gillespie talk about the current role of the SSSC and the extent to which you anticipate having a role in the development of workforce tools as they are applied to the social care sector?

Phillip Gillespie: We hold considerable intelligence on the social services sector workforce. More than 100,000 workers are registered with us. We hold a wide range of information about skills and competencies, where they are and where they are employed. Our role in supporting the national workforce plan is to provide data for planners at local level, so that they can do integrated planning. We also publish official statistics on the number of mental health officers and on workforce skills, so we have a rich library of information that we can lend to support workforce planning more generally. We are doing work under the national workforce plan, which goes in tandem with the bill.

The Convener: To what extent do you foresee having an active role in developing tools for the care sector?

Phillip Gillespie: We would certainly want to be a key partner in that regard, working alongside the Care Inspectorate. That was outlined in our submission. We see ourselves having a key role.

10:45

Sandra White (Glasgow Kelvin) (SNP): I thank everyone on the panel for their evidence. I want to pick up on something that Phillip Gillespie said. The committee has read that the Scottish Social Services Council desires to take a key role, along with the Care Inspectorate. It is unfortunate that the SSSC is not really mentioned in the bill. Is that an oversight? Should that be changed, considering what Phillip just said about starting to work together to ensure that staffing is safe and appropriate?

Phillip Gillespie: I welcome the prominence that is given to workforce planning and workload planning. We have a key role, which needs to be enhanced within the bill. We already have powers under the Regulation of Care (Scotland) Act 2001 for workforce planning. We would like those powers to be enhanced, as we are a key contributor to workforce planning and workload planning in supporting employers and working with the Care Inspectorate.

Sandra White: I see you nodding your head, Mr Paterson—I assume that you are in agreement.

Gordon Paterson: Absolutely. We have made representations to the bill team on the matter. We think that the bill should explicitly refer to the SSSC as being among the partners with which we would collaborate on the development of tools. If that does not come about through amendment, it might well be articulated in the regulations and guidance that follow.

Sandra White: I want to go further on how the bill could—and, I hope, will—work in relation to the SSSC. How will the bill as introduced help to balance the duties of the SSSC regarding regulation, registration and that type of thing? Mr Gillespie mentioned the diverse workforce in social care and spoke about motivation and how some people want to spend their career. We know that people who work in social care are often over 45. How will the bill affect what you are doing just now? Will it enhance it? Should there be changes?

Phillip Gillespie: I think that it will complement the work that is being done on national workforce planning. We are leading on the development of career pathways for social services so that people can plot a career in care and, potentially, a career in health. There have been attempts to integrate some of those pathways.

As part of our function, we investigate fitness-to-practise cases and potential staffing issues. We share that intelligence with the Care Inspectorate. We have a body of evidence that will be helpful to employers. Ultimately, the data that we hold on the workforce and its diversity will support workforce planners and IJBs at a local level.

Sandra White: To go further on that point, if the SSSC is a stakeholder and that is specified in the bill or its subordinate legislation, I assume that others—including you, Ms Gow—will work towards providing for training and so on, because the development of the social care workforce is an issue. How will the bill help to do that? Will it be helpful in that respect?

Phillip Gillespie: It will give employers an overview of the skills that people have and the qualifications that they are working towards. As you know, the people who are registered with us either have a qualification or are working towards a qualification. That intelligence will be helpful to employers in considering what they need to do and how they should plan to ensure that they have the right people with the right qualifications and skills to carry out the job. We have that information, which we can share with employers with regard to their workforce planning.

Sandra White: I have a question for all the panel—I am sorry to have kept asking questions of Mr Gillespie. Brexit is looming on the horizon, and we are potentially facing shortages of social care staff. What outcome will there be if Brexit happens and the bill goes through? Do you have any thoughts on that, in particular on the lack of staff?

The Convener: We will not have a debate on Brexit, but—

Sandra White: It is part of my question.

The Convener: If there are aspects of the bill that are affected by it, the panel should feel free to comment.

Gordon Paterson: It is important that we recognise the significant staffing crisis in social care at the moment, which will no doubt be compounded by Brexit when—if—it happens. It says in paragraph 80 of the financial memorandum to the bill:

"this legislation is not intended to address"

the wider recruitment challenges. That does not mean that those are not important but, as Phillip Gillespie said, work is going on elsewhere in relation to the national health and social care workforce plan that seeks to address some of those challenges or mitigate the risks.

For us, the bill will potentially identify the challenge. It will potentially identify a shortage in some areas of the workforce. It might not do that, however. It might identify that there are more effective ways of using the staff that we have at the moment to work to grade or at a different level and deliver good care through different configurations and arrangements.

The committee might be interested in work that we did a couple of years ago with 40 care providers in Scotland, which were struggling to recruit nurses. They were overreliant on agency nurses, which was costing a significant amount of money and not providing good continuity of care. We worked with 40 care homes that were looking to reconfigure their staffing approach by reducing nursing, bringing in peripatetic nursing and nursing assistants, upskilling senior carers, reconfiguring how they provided nursing overnight and examining how community nurses could inreach. That might not necessarily be provided by the care homes themselves. We worked with the care homes and tried to enable innovation, recognising that safety and good quality of care must be maintained. They were able to reconfigure. We required them to have arrangements in place to discuss their proposals with the local commissioners, as well as quality indicators and measures to determine whether or not they were effective.

A year later, we went back to inspect those 40 care homes. The grades of four of them were lower after we inspected, nine of them had improved and 27 remained the same. Four out of any 40 care services' grades would change over the course of a year—they would deteriorate. However, the care providers were able to look differently at how they configured their existing staff, to be innovative, to bring forward solutions, to engage with partners and to develop an approach that recognised the importance of nursing but acknowledged how scarce that resource was, such that the resource was used only on tasks that needed to be done by a nurse.

Only 40 care homes sought to do that with us. We would like to create the conditions in which all care homes can have a tool that allows them to do that in a more consistent way and deliver outputs relating to the numbers they need, as well as outcomes for ensuring that people are getting good care.

Sandra White: The panel members can just nod your heads or whatever in response to this question. Do you think that the bill will include that? Will it enhance the innovation that Gordon Paterson described?

Gordon Paterson: I think so—by designing, co-producing and collaborating with Scottish Care, COSLA, organisations in the sector, care providers, SSSC and HIS, as we did when we developed the care standards jointly with HIS on behalf of the Government. That means having a real collaborative approach. We think that we will be able to develop a tool that will add value and that people will want to use. Greater consistency and transparency will be brought about by using a validated tool. We will be clearer—linking back to your question about workforce planning—about where the staffing pressures are. That work can

be taken elsewhere as regards workforce developments nationally.

Ann Gow: As Gordon Paterson said, the bill does not compel employers to have a specific number of staff; it encourages them to do some of the redesign work to ensure that services are safe and of high quality. If we get the workforce tools right across the whole multidisciplinary sector, that should give us the information on a deep dive into workload that will allow us to ensure that we have the right people with the right skills in the right place and to make the most of our workforce in future.

Whether that is affected by Brexit or by population changes, as people get older and we have fewer and fewer young people coming into each sector, the bill should allow us to become more efficient in the use of our workforce as it stands.

Emma Harper: Just to reiterate, the policy memorandum uses the words,

"multi-agency working across a range of professionals and staff groups."

It refers to the

"ability to redesign and innovate",

using

"multi-disciplinary and multi-agency teams".

That is all in the policy memorandum: it specifically considers

"the emergence of local multi-disciplinary teams",

so that those from

"both health and social care backgrounds"

are able to develop tools together.

I am aware that different urban accident and emergency units, urban med-surg units and even care homes might use different staff to do different things. Some A and E units might have more nurses or doctors than others. Is not the purpose to have a standardised and evidence-based approach to staffing, which can be flexible between urban and rural settings, so that we can have a proper basis for developing guidance on safe staffing?

Ann Gow: I think that the bill will enhance some things, for instance in relation to the multidisciplinary issues that the IJBs are dealing with at the moment, and which we have dealt with in both sectors. It is about developing the tools in the right way. If we are developing a multidisciplinary tool for a multidisciplinary team, that relates to safety and quality of outcome for the people who use the service. What can only a social worker do under the regulations that they use? What can only a nurse do? What can only a doctor do? Then, what are the bits that we can blur around the edges? What can support services do?

It should not matter whether someone lives in a rural or an urban area: their right to safe care should be the same. The key will be in local flexibility and in ensuring that people are using their small number of highly qualified staff to do the bits that only they can do.

Keith Brown (Clackmannanshire and Dunblane) (SNP): I thank the panel for their contributions. It has been really useful to hear general support, and to hear examples of where you are not content with the bill and your constructive suggestions for it.

Many previous panellists have mentioned the interests of patients. For the first time, Ann Gow has mentioned the views of patients. How can the views of patients be taken into account, either in the development of the tools or in the implementation of the bill?

Ann Gow: Again, as I said, we have not been responsible for tools up to now, but that would certainly be our intent. Within Healthcare Improvement Scotland we have the Scottish health council and a network of external advisers, who come from various patient groups. As we are developing tools, it will be our intention to ensure that patients and staff are involved in the development of the tools and to consult people within services as we offer assurance and improvements in how the tools are used.

Gordon Paterson: Andrew Strong, who gave evidence to the committee last week on behalf of the Health and Social Care Alliance Scotland, commended the work that the Care Inspectorate and Healthcare Improvement Scotland have done in developing the national health and social care standards. We can very much see how the same collaborative approach could be brought to the development of staffing methodologies.

That involves having a high-level stakeholder group and engaging with the sector. It involves organisations that represent people who experience care and use services, as well as those people themselves, collectively coming together to determine what is needed and how it can best be brought into effect. We would very much take the collaborative approach that we adopted in the context of developing the care and health standards with Healthcare Improvement Scotland, which has been commended.

There are other examples. One of the criticisms that the committee has heard—or one of the cautions that the committee has been asked to consider—concerns the extent to which a regulator would be marking its own homework if it were to design tools and then inspect against

them. We have done that—we do that all the time. We do not think that it is a conflict of interest; we think that it is about our interest in ensuring that care is good.

Jointly with the SSSC, we have developed national guidance about safer recruitment—it is about how to recruit in a way that ensures that people are going through the disclosure process, and in a way that builds in balances and checks. We have brought that guidance to the market, and it is now universally used and accepted as a good practice guide. When we come to inspect, we can tell people, "If you aren't aware of good practice, here's a guide. Maybe you need to think about that in improving your services." We do not see a conflict there.

11:00

The Convener: I take you back to Keith Brown's question: how will you ensure that the views of those who use services are included in the development of tools?

Gordon Paterson: We will do that through the tool development process, by engaging with people directly and involving those who represent them. We do that all the time when we go in to inspect services: we speak to people who use services, and we speak to carers. We have recently developed a new methodology, which is about inspecting through the lens of the new care and health standards; it significantly shifts the focus of our activity towards people's actual experience of care rather than policies and procedures.

The Convener: I thank our witnesses for their evidence this morning, which is much appreciated. No doubt we will hear from you all again as the bill process continues.

11:01

Meeting suspended.

11:04

On resuming—

The Convener: I welcome this morning's second panel of witnesses: Karen Wilson, director of nursing, midwifery and allied health professions, NHS Education for Scotland; Joyce Thompson, chair of the British Dietetic Association Scotland board, and dietetic consultant in public health nutrition, NHS Tayside; Dr Tony Axon, national officer Scotland, the Society and College of Radiographers; and Tracey Dalling, regional organiser for local government, Unison Scotland.

I will begin with the same question that I asked at the start of the previous evidence session. Broadly speaking, the policy memorandum proposes that the bill can help to bring together the different regulatory systems that apply to health and social care and help to cross some of those bridges. Do you believe that that is right and do you think that the changes in the regulatory regime that the bill introduces will help with the process of the integration of health and social care?

Karen Wilson (NHS Education for Scotland): I am speaking on behalf of NHS Education for Scotland, which is a national health board with a crucial role in the education, training and development of Scotland's healthcare staff. NES has been involved in supporting nursing and midwifery workforce planning since 2008, with the co-production and publication of the first edition of the "Nursing and Midwifery Workload and Workforce Planning Toolkit". I have the learning toolkit with me today.

We are currently contributing to the national programme through membership of the steering group and by chairing the education and training sub-group. Although NES stands for NHS Education for Scotland, we have been working very closely with the Scottish Social Services Council and other care providers outwith the NHS to ensure that when we produce educational or development materials they are suitable for all health and care professionals. We will be producing things to support the bill, to ensure that it is suitable for health and care.

Joyce Thompson (British Dietetic Association Scotland): I am here on behalf of the British Dietetic Association Scotland board. For those people who are less familiar with dietetics, I will say a few words about it. It is one of the allied health professions and—unusually—we are a nutrition body that is statutorily regulated. Our function is to translate everything to do with food and nutrition into practical guidance for people. As autonomous practitioners, we are able to assess, diagnose and treat nutrition and diet problems, at both the individual level and the population level.

As we said in our written response, the BDA welcomes the bill's aim to provide safe and high-quality services. Like the previous witnesses, I want to highlight that we are one of the allied health professions and we want consideration to be given to the development of the tools and the application of the methodologies in relation to professions beyond nursing.

Dr Tony Axon (Society and College of Radiographers): Radiographers are mainly hospital based, which makes it slightly difficult to answer the question, as we are not really in the social care sphere. We are keen to see the development of the tools to work with

radiographers and other allied health professionals. We support the principles of the bill.

Tracey Dalling (Unison Scotland): My contribution spans all of the workforce, no matter where or in what setting they are delivering care. In answer to your question about bringing together the different regulatory systems, I am not sure that the bill will do that. The regulatory systems are the regulatory systems. Some of the workforce is not covered by the systems and will not be until 2020—I am thinking specifically of home care, which is personal care that is delivered within the client's house. Each regulatory body will have its own arrangements for the assessment of an individual's fitness to practice.

The integration element is critical in terms of service delivery and contract compliance. We know from our experience of workers delivering social care in a home setting that contract compliance is threadbare, in relation to pay for the individuals and in relation to some of the practices, such as 15-minute visits and a lack of general equipment and time to deliver the service.

I am not sure whether the bill itself will deliver on those issues, particularly as most of them fall under part 3, which is not really prescriptive. However, it is certainly a move in the right direction.

Brian Whittle: As I did with the last panel, I want to examine what is currently in play. In terms of training and continuing professional development, what consideration is given to issues covering patient safety?

Karen Wilson: In relation to the implementation of the workload and workforce planning tools, there is a learning toolkit for people who are actively using that methodology. Within the current nursing and midwifery workforce, that would largely be the senior charge nurses and their equivalents out in the community, who would use the community tools. There is a development process for people who are going to be using the tools. We recognise that, in the case of nursing and midwifery, the senior charge nurses and their equivalents are the linchpins for the delivery of safe and effective care to patients.

We are considering how we can refresh the previous process that we had, which was called leading better care and was specifically focused on ensuring safe and quality care for patients in clinical settings. As I have said, we intend to ensure that all of our educational resources are suitable for health and care, so, as the tools develop, we will produce tools that help to support staff to understand and use the methodologies effectively.

Brian Whittle: Does the bill enhance that process? As I asked the previous panel, is legislation required to enhance the process or are you already on that journey?

Karen Wilson: To a certain extent, we are already on that journey. However, as has been said in various fora, application is a bit patchy. That is where the bill comes in. The bill supports consistency, and that is its key strength, as far as I am concerned.

Brian Whittle: On access to training, will the implementation of the bill put more pressure on the training element?

Karen Wilson: Yes. Infrastructure is already being introduced to support the implementation of the bill, so we are already seeing stronger infrastructure to support the training and development of staff. What is important is that people are given the time and space to undertake the training. The training is available, and the legislative process can bring a greater prioritisation to it. That is an added strength.

Dr Axon: Radiographers are degree-level staff, but they need to be trained in hospitals to get greater expertise and move up in the system. They are also regulated by the Health and Care Professions Council and are required to do a certain amount of continuing professional development every year in order to carry on under that regulation.

We often see that people are not able to take part in training because there is a lack of time, due to the pressure in relation to the rota and waiting lists. Adding in that time is important. If these tools are applied to our staff, they are much more likely to have the time to do the training.

Brian Whittle: The idea of what constitutes safety and risk across professions seems to vary. Are there different views on that, and does the bill account for differing definitions?

11:15

Dr Axon: That is part of the reason why we want an extension of the tools to our practitioners. We are dealing with radiation and giving radiation to members of the public, and we want to ensure that our staff are not overworked and are on rotas that are not too long. There are still rotas of 16 hours in hospitals. We see the extension of those tools as helping with safety and ensuring that staff do not work for too long and get proper rest.

Tracey Dalling: There is a variety of measurement tools out there. That is fine if all that you want to do is measure for statistical purposes, but if you want to ensure compliance we need to go back to the regulatory framework and questions about who is responsible for compliance. A large chunk of the social care network is not governed by any form of regulation, so it will be down to the

employer to undertake that role. That will vary and the 32 local authorities will have different continuing professional development tools and measures. There could, theoretically, be thousands among the private care providers. Our experience would say that that theory cannot be proven.

Our experience would also say that there is very little by way of continuing professional development and staff training. As Dr Axon said, it is often the thing that costs the most and is dispensed with when there are other funding pressures, and I am not sure that the bill builds in that compliance element. It may have the framework for it, but I am not sure that it is there on compliance.

Joyce Thompson: To answer Brian Whittle's question on safety, I would reflect on the fact that the bill is also about high-quality services, and I certainly do not want to lose sight of that. It is another reason why it would be good if the bill was extended to other professions and also took a multidisciplinary or multi-agency approach. Dietetics has historically been a demand-led service, and the reality is that, continuing on that premise, there are more people in need of dietetic intervention than there will ever be capacity to deliver for. To truly get upstream, not just from a preventative point of view but from an early intervention perspective, dietitians are currently working in partnership with other professions to redesign pathways that stretch across systems. My reason for bringing up that example is that it shows that there is a need and an opportunity for professions to extend their scope of practice. That includes the need to look specifically at safety, which enhances the requirement for a multidisciplinary approach.

The Convener: The next question is from Sandra White.

Sandra White: Thank you, Presiding Officer. I am sorry, convener. I gave you the wrong title. I must be dreaming, or maybe I am elevating you to greatness.

I thank the witnesses for their evidence. I was pleased to hear Karen Wilson mention learning toolkits, because witnesses have mentioned in submissions that they felt that people were not trained up or educated enough in using the tools. As the bill progresses, should there be assessment of where staff need more training and education to use the tools properly? Could that be part and parcel of the bill?

Karen Wilson: Absolutely. The more that we prepare senior charge nurses and their equivalents in the community to understand the importance of safe staffing, the better the service will be. As I said, infrastructure is now being put in place because of that. One of the problems before was that, if areas used the tools, they used them once a year, and you cannot remain competent in something if you do it only once a year.

I think that having the infrastructure there and running the tools really regularly over the whole of the health system will mean that expertise will build up and people will become much more confident about the methodology and the information behind it.

Sandra White: Tracey Dalling mentioned the social care workforce, non-compliance and different practices in different local authorities. Will the workforce be getting trained in the tools as well, or will it just be the management level?

Tracey Dalling: I imagine that it would be the management level. It is hard to say at this stage, but that is what I would anticipate.

Sandra White: Okay. Can I take it a wee bit further? Various professions will be involved. It is not just coming from the top; it is going right out into the communities. What bodies will be developing the tools and the new methodologies? Who should be involved? Should it be the professions or the sector regulators? Should everyone be involved or do you need to stop at some level?

Karen Wilson: Certainly, my knowledge about the development of the workload tools is that when you are developing a new tool, you work with the people who are working with the clients or the patients. It is really important that ground-level staff—the people who are in direct contact with the clients or the patients—provide evidence about what the workload is, because nobody knows the workload better than the people who are delivering the service. It is important to involve the right staff for the right levels of decision making.

Tracey Dalling: I completely agree—it needs to be from the ground up. These tools are a long time in development because they have to be evidence based, so you have to involve the people who are providing the services.

One of my concerns is about the procurement element. When you are procuring a service, who do you involve in developing the tool? Some of the services are well established, but a whole range of social care services are procured every day of the week, based on particular needs, so whoever is involved will have to be able to cover the entire social care setting, particularly in homes.

Sandra White: I am not saying that it necessarily needs to be in the bill, but does there need to be something on that in guidance? My concern is that although the management level and professionals might be involved, things might not filter down to the workforce on the ground. I do

not know how you would word that guidance, and I do not know whether there should be a requirement for adequate time to look at whether the new tools are being developed. Should there be some sort of guidance on timescales and the fact that all the workforce should be included?

Joyce Thompson: A timescale would be very helpful. As you will note from some of the comments that I have made so far, although we are supportive of the bill, we have concerns about some of the smaller professions. History shows that frequently there is a focus on the bigger professions and it takes a long time for the needs of the smaller professions to be addressed. I would like to see something that would ensure that there are almost parallel workstreams in addition to a multidisciplinary approach.

Dr Axon: As I said, we certainly support the development of tools for other professions. The advantage of the tools is that they are not just about looking at the numbers of people whom you are treating, which is what tends to happen at the moment.

The professional voice must be considered. The process has to involve the professionals, and the decisions on the tools need to be taken at a reasonably low level, not at department level.

On timescales, there has been some talk about how long it is taking for some of the tools to be developed, but a lot of the tools are already sitting there. It is just a matter of revising them to fit other professions or a matter of creating multidisciplinary tools. However, it would be useful to have some of those points in the bill or certainly in the guidance.

Tracey Dalling: The existing tools are used in an acute or building setting. It is much easier to manage workforce planning in a building. That is why it is helpful that the bill suggests that the social care element starts in care homes. Where it becomes far more complex is when it is out in the community, in people's homes.

Sandra White: I absolutely agree that everyone should be included. Should we have a timescale for reviewing the tools as they are introduced, to ensure that they are fit for purpose?

Tracey Dalling: Absolutely. There will be an opportunity to review the existing tools before we extend to anything beyond what we already have. Therein lies the problem: the provision of care has changed, and the question is whether the current tools are still fit for purpose. They might be, but that needs to be tested.

Emma Harper: Good morning, everybody, and thanks for being here. I welcome the generally positive approach to the Health and Care (Staffing) (Scotland) Bill that we have heard this morning.

The existing tools are under review as the other tools are being developed. We have talked about training and continuing professional development, and there is a lot of crossover work—for example, physios and radiographers might perform similar tasks to those that nurses perform. A standardised approach can be assigned to different job descriptions, whereby the same cannula training is done by radiographers and nurses. Similarly, there are national LearnPro or e-learning modules on hand-washing and infection-control measures. There is a standard approach that can be accessed, and as we introduce the training, all the local authorities should have access to community LearnPro and acute care LearnPro. I assume that that is the way to move forward so that we are not reinventing the wheel.

I take Tracey Dalling's point that the bill has to start somewhere and that we should look at the health and care setting before looking at the individual workers in social care. I would be interested to hear further thoughts on training and development and how we ensure a standard approach.

Karen Wilson: We are looking at how we can modernise the toolkit and make it available for everybody. One platform is LearnPro, and NES is working with social care to implement the Turas Learn platform across the whole sector. We are making information available via social media apps and so on to make it easier for people, especially the members of the workforce whom we are talking about. How do they get access to learning resources when they are working in someone's home? We are working on putting the existing resource in place and making it available for everyone.

Tracey Dalling: I completely agree. It would be great to have a single platform to which everyone had access, but a single training platform does not exist in local government. There is a range of variations on that theme that different local authorities have bought themselves or bought into as part of a consortium. To the best of my knowledge—COSLA would probably be able to say more than I can—there is no single platform within local authorities. That does not mean that such a platform cannot be part of the broader integration discussion that needs to take place.

Brian Whittle: Looking at the complexity of the health and social care landscape, I wonder what the best approach to workforce planning would be, given the multidisciplinary needs within the sector, to achieve whole-system viability. Will the bill enable that sort of thinking and planning?

Joyce Thompson: That is a very good question, which reflects some of our concerns as a professional body. The bill needs to be strengthened if it is to truly apply that whole-system approach.

Within the dietetic profession, we are increasingly trying to address nutrition issues from a whole-system perspective. The example that I use frequently is that almost half the Scottish population has an issue with nutrition, be it overnutrition, undernutrition or a condition that requires therapeutic dietetic intervention, such as a food allergy.

11:30

As I said earlier, historically our profession has been demand led. That means that whoever manages to get through our door gets our support. However, the reality is that there is a much bigger population out there that requires that support.

We have some examples in which we have taken that whole-system approach, one of which is coeliac disease, which affects a significant proportion of the population. It requires an assessment of symptoms, a diagnosis and dietetic intervention. A gluten-free diet is the primary intervention. Over a period of time, we have tested and subsequently completely redesigned that approach on a Scotland-wide basis, such that there is now greater assurance that people who experience symptoms are assessed, are diagnosed, receive dietetic intervention and get access to a gluten-free diet and prescribed gluten-free products in a much more cost-effective way. That has required a whole-system approach. It has involved dietitians, but also general practitioners, consultant gastroenterologists, specialist nurses and community pharmacists.

It was not until we sat down with all those disciplines and individuals who experience the condition that we could look back and reflect on a much better way of doing things, which involves that whole-system approach. If you applied a workforce tool specifically to dietetics, it would not answer the question as to what number of dietitians and what expertise and experience in dietetics are required in order to address that area of nutrition need, unless you took that whole-system, multidisciplinary approach.

Dr Axon: Workforce planning takes place at present. The bill proposes that it be put into legislation so that, we hope, it is done better and staffing—safe staffing—is increased. There would be a slight problem with the bill if it applied only to nurses and midwives, there was too much emphasis on them and their numbers were funded because the tools applied to them. We believe that the tools need to be applied across the system.

On diagnostics, it does not matter how many nurses we have if we do not know what is wrong with the patient, so diagnostics are crucial to the patient journey. That is obviously crucial for cancer treatment and radiotherapy as well. We need to have the right numbers in order to make sure that we get through the waiting lists, plus enough people in accident and emergency departments to make sure that diagnoses are taken through.

Tracey Dalling: One of the benefits of having the integration joint boards is that we can take a more holistic look at workforce planning across the social care setting, rather than just in a local authority sense or an NHS sense. I am keen that the bill delivers that multidisciplinary approach and that we do not continue to do things in silos, because that is not serving us well.

It would be remiss of me not to say, although the bill cannot provide for this—well, maybe it could, if you wanted it to—that we will never have enough staff in the social care setting unless we address pay. The recruitment and retention of staff is a huge problem that has been thrown up time and again. When we do workforce planning, we analyse the ageing workforce that we have, particularly in social care. Certainly in more rural communities, we know how many people live in the local authority setting and how many people work in social care, and the percentages are enormous. People do not travel well to provide that service; they want to do it in their own community. However, they are ageing, and sometimes Tesco opens a new store and pays its staff more than home care workers are paid. In addition, the career pathways can seem limited. Those issues will not go away simply because we have a measuring tool. All that it will do, probably, is throw the issues into sharper focus.

Karen Wilson: On a more general note, there is no doubt that consistent application of a common staffing method will improve workforce planning. If that common staffing method is interdisciplinary, multidisciplinary or even—as it is at the moment in most cases—unidisciplinary, it improves workforce planning and provides more data on which to base workforce planning. Going forward, I think that that is the right direction of travel.

Brian Whittle: To take that a little further, I think that the bill raises a dilemma. It has a reasonable lack of prescriptiveness, if that is a word. Will that be useful in achieving an integrated way of developing the workforce, or does it need to be more prescriptive than it currently is?

Karen Wilson: I do not think so. The strength of the current methodology, as Ann Gow said, is that it takes account of professional judgment and quality issues, because it is possible to have a slightly different staffing level—even a better staffing level—and poorer quality. There is

definitely something to be said for leaving it loose enough to have professional judgment on quality, rather than defining a ratio or a number or making it too tight. That is important for me.

Dr Axon: When I looked at the bill, I was a little bit surprised at how prescriptive the table in proposed new section 12IC of the National Health Service (Scotland) Act 1978 was. I would have thought that that would be something that you would normally see in a schedule. I realise that section 12IC(3) says that ministers can use regulations to change it, but the table seems quite prescriptive, while at the same time the bill is saying that multidisciplinary tools can apply to the professions.

The Convener: If Karen Wilson is right and you need to be able to resort to professional judgment, which might produce a different outcome from simply applying the tool, is the tool therefore necessary at all?

Karen Wilson: It does provide a basic methodology that, if consistently and regularly applied, could provide a much sounder basis for doing things in a certain way. Otherwise, it would just be down to professional judgment, which might work, but we have had professional judgment for a long time and we feel that the workload measurement tools are an improvement, because there is a rationale and an evidence base behind them. I think that the strength of the approach lies in the merging of both aspects, rather than relying on one or the other.

The Convener: If that is the case, is there a risk that, because the bill is coming in at a point when we have workforce tools in a number of areas, but mostly in nursing and midwifery, that could skew the allocation of resources or of time and effort away from other sectors into those sectors where such tools are already used?

Joyce Thompson: There is a risk of that, unless due regard is given to the other groups in the NHS.

Tracey Dalling: The bill is designed to go beyond the NHS, so we need to extend beyond that. We have staffing tools that prescribe staff ratios, particularly in the early years setting. We know how many early years practitioners we have for whatever number of children. It is arguable that we could be prescriptive. The difficulty will be in coming up with something that allows that to happen without losing the professional view about what is appropriate; we could get wedded to something that is simply about numbers, not about quality. It is a very difficult question to answer, but it can be done.

Dr Axon: At the moment, we are not using the tools in our profession, so it tends to come down to an argument about numbers. The advantage of the tools is that the professional view is added into that. A scan does not simply take so many minutes for each person who comes through the door—we know that we need to allow extra time in some cases. For example, scanning takes longer in a children's department, because children will not stand still in front of the machine or they might not be happy on the table. Scanning tends to be easier with adults. Knowing the different positions is useful.

In areas such as rural and satellite settings, there is often a small number of staff, so you need to allow for the fact that, if someone goes off sick, that will account for a greater proportion of the staff. It is important to have a professional view rather than just to say that you only require so many staff; because of that, I spend a lot of time at the moment arguing about how many staff are needed on rotas.

The Convener: In answer to an earlier question, the issue was mentioned of where in a team the responsibility would lie for running the tools. Do panel members see any risks with the way that the tools are currently applied, and might be applied under the bill's provisions, whereby responsibility for quite significant staffing issues is seen to rest with somebody in a relatively junior or supervisory role, such as a charge nurse or the equivalent, rather than with management, which might have wider consequences and implications?

Tracey Dalling: It is less about who runs the tool and more about whether it is run using an ideal standard or taking into account the reality of the situation, and that will come down to frequency. You might have an ideal standard of operating across the year, but you might hit a winter pressure or a flu epidemic. Would we launch the tool back into that setting to re-establish staffing levels based on what was actually happening? Would a reactionary or a planned approach be taken?

If the people who operate the tools understand them and are perfectly capable and competent in their job, it is less about them and more about the stage at which we run the tools and how frequently we do it. There is also the question of whether we are trying to deal with the realities or to deliver some kind of ideal standard.

Karen Wilson: We certainly believe that it is important to empower the person in charge at the front line to operate the measurement tools and be responsible for that. There is enough evidence to suggest that the culture of the clinical area, as it is in our case, is dictated by that person. Therefore, giving them more power and education, and allowing them to be in charge and be the linchpin, is vitally important. We think that the responsibility sits at the right level.

Obviously, a discussion will take place further up the hierarchy, and it is important to make sure that clinical managers completely understand the tools and how to apply them. There is a hierarchical thing, but it is important that front-line leaders are given that leadership role.

Dr Axon: I was going to say similar things. It needs to be possible for the professional view to be implemented, but the bill puts the emphasis on the health board, so the management level in the hierarchy has to look at it, too.

The Convener: Are there any unintended potential consequences of the bill that we have not yet touched on and which committee members should be aware of?

Karen Wilson: I want to mention—this might be part of what Brian Whittle was getting at—that it is important to make sure that the tools allow people time to do CPD. That is the predictable absence in the case of the current tools. It is really important that we get it right for staff, and consider whether there is enough time for CPD or whether it gets eaten away by other things such as sickness absence.

Joyce Thompson: I echo that point. Again, although professions such as dietetics have an important direct patient-facing role, the magnitude of the nutrition issue means that dietitians have an important role supporting others in delivery of care at the earliest point to ensure that people get the right nutrition intervention at the right time and in the right place. One would caution that a workforce planning tool should not look only at patient-facing activity.

11:45

Dr Axon: As was mentioned earlier, there is concern that resources will be taken away from other areas if the tools apply only to nursing and midwifery. That seemed to happen to some extent in Wales when the Nurse Staffing Levels (Wales) Act 2016 was introduced there.

Another concern is that if the tools are not correctly done, there might be issues around people's ideas about the maximum number of members of staff or how many members of staff there should be.

Tracey Dalling: The escalation and enforcement element is not as clear as we would like it to be. We would like more clarity about where the responsibility lies. Is it with the integration joint board? Is it with employers? Where does the buck stop?

Brian Whittle: I want to pick up on the idea of resource management and where the bill and the tools currently sit in relation to that. Who is ultimately responsible for that? What are the repercussions of falling short of what the tools suggest is a safe staffing level? Does that lead us down a dark path?

Tracey Dalling: Individuals are free to make reports to the Care Inspectorate, and it is free to inspect and take whatever enforcement action it feels is necessary, and to continue to monitor the situation until it is safe. However, there is a critical question to be answered. The bill concerns staffing, so who picks up that issue? Is it the IJB in a social care setting and the health board in an acute care setting? Certainly, Unison is aware of thousands of people who work for small employers. Does the responsibility sit with those employers or does it sit with the IJB, because it commissioned those employers to deliver services?

Dr Axon: At the moment, we can see well how staffing levels are very much driven by finances. There is an interesting question about resource management. The duty will be on the board, but whether it can reach the right staffing levels depends on the money that the board receives from the Government. There is an issue with the financial memorandum in that regard. It talks about how much it might cost to introduce the tools, but it does not talk about how many more members of staff would be needed if the tools were to be applied appropriately.

Karen Wilson: It is clear that, for the NHS, the buck stops with the board. There is an important issue about resource versus quality. It is important to put as much emphasis on the quality of care as you put on the number of members of staff. This morning, HIS made it quite clear that what is important is the big picture, which involves safety, the quality of care and the number of staff.

David Stewart: My questions are around accountability and responsibility. They are directed mainly to Unison, and I draw members' attention to the fact that I am a member of Unison.

Unison's submission makes the interesting suggestion that the staffing bill might be ignored. It says that you are concerned about shortage of staff, lack of enforcement and constrained resources. Will the bill resolve any of those factors?

Tracey Dalling: It comes back to the point about compliance. From Unison's experience, there is the example of what happened when the Scottish living wage was applied in the social care setting. Money was released by the Scottish Government for that; it came to IJBs and was then released to various service providers. However, we are still pursuing those providers to pay their employees. The money is sitting with the providers and has not been passed on appropriately.

This could be a parallel situation. It worries me that we could have another piece of legislation that could be ignored—we have had the Health and Safety at Work Act 1974 for decades and we still have employers who ignore it. It is about compliance. If we are putting something in place and looking for adherence to it, we need to know who is responsible for that adherence and—frankly—what the penalties are for non-compliance.

David Stewart: At a simplistic level, everyone in this room wants to see better staffing levels and better care, but what is your assessment of what the world of care provision and staffing provision would look like if the bill were to be enacted?

Tracey Dalling: I am not sure that it would look different to how it looks now, to be honest. I do not think that the bill is a panacea. We are desperately short of staff. They are not well paid: they are low-paid workers who live in their local communities. I am not sure where we will get people from to work in social care. Perhaps it would look better if it was a safer environment, with more people providing the service, who were better paid and better supported and trained and they knew that when things went wrong, there was a degree of enforcement. Perhaps if we pieced all those parts of the puzzle together, it would look better. However, I cannot see the bill in itself making an enormous change to the social care setting.

David Stewart: The Americans have a line, "Where's the beef?" when they are trying to verify whether there is real substance to something. Are there elements of that? Certainly, some of our witnesses—not all—suggested that we do not need legislation to have workforce tools because they are internal management issues.

Tracey Dalling: I agree. I will never say that you should not legislate for something if I firmly believe that that something is the right thing to do, but it must come with an element of enforcement. I am going over the same ground here. Legislation might give us that if it is couched in the right way. However, colleagues are absolutely correct; you do not need legislation to introduce workforce planning tools.

David Stewart: There are existing provisions across the public sector and beyond for whistleblowing, which everyone supports. Let us take a future scenario in which care sector staff are upset about staffing rotas, for example. Will the bill do anything to empower staff to come forward to the appropriate agency and say, "This is not good enough—this is putting patients at risk"?

Tracey Dalling: The bill as it is currently written will not do that. It does not include enforcement. The required degree of comfort for people to come forward is not there.

Alex Cole-Hamilton: I would like to pick up on David Stewart's line of questioning about the impact on staff. When we introduce tools, we are telling staff, "This is how things ought to be done." I am concerned that that communication flow goes only in one direction. Are panel members confident that the bill will build in mechanisms to allow staff who know their onions in their day-to-day work to provide information on and suggest meaningful changes to how the tools operate?

Karen Wilson: When we first introduced the tools for nursing and midwifery, that empowered charge nurses. It gave them information that they did not have before, a methodology that they did not have before, and a language with which to talk to the clinical nurse managers and beyond, up to the nurse directors. To that extent, consistent tools can help.

Alex Cole-Hamilton: I will ask about the corollary: how responsive will the strata of tools be to suggestions for change coming up from ground-level staff?

Karen Wilson: Again—I apologise to my colleagues for going on about nursing and midwifery—the nurse directors are really interested in the outcome of running the nursing and midwifery tools. It matters in relation to the quality and safety of clinical care delivery, so where the tools are available, they are used.

Alex Cole-Hamilton: Are you content that a feedback loop is built into the bill to allow the tools to be nuanced and changed based on practice and their application on the ground?

Karen Wilson: As colleagues have said, I am not sure whether the bill has the teeth that it needs.

Tracey Dalling: It comes back to governance. Different employers have different arrangements on staff engagement. We have asked the question about how far down the level of staff engagement in using the tools will be. I am not convinced that in a social care setting engagement will go right down. We could miss a trick by not having that level of engagement.

The bill encourages employers to seek views, but I think that the wording needs to be stronger than that. There needs to be absolute engagement at all levels of the organisation, particularly with the front-line staff. They know their onions and should be engaged in the process. Even if they do not use the tools, there should be a mechanism to elicit their view of what is happening so that they can engage in the process.

Joyce Thompson: I agree with those comments. A key thing that we have learned over

the past few years is that we cannot "do to"; we have to "do with". That means that everyone, irrespective of profession, grade or whatever, should be engaged in the process. Engagement in the development, testing and application of the tools is essential. Not all dietetic services consist only of dietitians, and not all dietitians are in a dietetic service. Dietitians sit in different places in organisations, which puts different types of pressures on those individuals, and it is important that that is taken into consideration.

Dr Axon: There is a professional element to the tools—it is not just about the numbers. Sections of the bill relate to training, the consultation of staff and so on, and it would be helpful if professional bodies were included in the bill.

Alex Cole-Hamilton: That is useful.

Keith Brown: I am interested in Unison's approach. In Unison's written submission, it was unable to identify any strengths in parts 2 and 3 of the bill, and it raised a number of other concerns, including pay, which we have discussed a fair bit. I should say that I speak as a former shop steward and branch officer for Unison.

On pay, I am not sure how the Scottish Government could have enforced compliance on the living wage, because it does not have the legal power to do so. Tracey Dalling said that she fears that implementation of the bill's provisions will throw into sharper focus the issue of pay, particularly in relation to recruitment. Is that not a good thing? If the various tools in the bill set out a particular standard that is backed up by professional judgment, and if that demonstrates that there is a shortfall in the current staffing, would there not be pressure on the system to enforce higher levels of pay, greater recruitment and adequate staffing?

Tracey Dalling: Absolutely. However, I am not sure where we would get the bodies and money from to address that shortfall. That point is linked largely with workforce planning. We are seriously short of people who see care—not nursing but care—as a career. Young people are not coming into the profession, because they do not see it as a profession or a career, and they certainly think that, as things stand, they will never make more than the living wage or thereabouts. Therefore, there is a cultural aspect to the issue.

The bill's provisions and the staffing tools might well throw the issue of pay into sharp focus because we will see the issue in stark terms rather than through anecdotal evidence, as we see it now. A range of things will need to happen to address the problems that the bill will throw up.

12:00

Dr Axon: Retention is crucial. It varies from year to year, but the vacancy rate for radiographers is about 4 per cent. There is also a cap on the number of people who can be trained, because trainees need to go through the hospital system and there is a limited number of spaces.

In hospital and NHS settings, there has just been a change to the pay scales. I was heavily involved in developing the new pay scales, which might help with retention. If there is not so much pressure on staff to cover for other people, that will certainly help with retention. At the moment, a lot of people are going off on sick leave with stress because of the pressures to cover rotas and do weekend and overnight work. If we manage to increase the numbers of staff and make the workplace better, that will help to keep people in post.

Emma Harper: I do not think that Karen Wilson needs to apologise for talking about the nursing tools, because they have existed for 10 years and we can build on them. How can the panel engage in the future development of the tools that will apply to the multidisciplinary teams, including the community care, care in the home and acute care teams? You are all articulating well the need for a multidisciplinary approach, so will you engage in the development of the tools for your disciplines? Will there be a pigeon-holed or a multidisciplinary approach?

Dr Axon: The simple answer is that we want to engage in the development of the tools. I have already spoken to some of my colleagues who use the tools and who are looking at how they could be moved across to other areas. It might be slightly easier for radiographers, because, in the main, they tend to be employed in hospitals and deal with waiting lists and A and E departments, which is quite similar to nursing roles. As Emma Harper said, some of the training modules would apply to radiographers. Therefore, there might be an easier gain for radiographers, whereas there might be more difficulties for other colleagues and professionals. However, we are certainly looking to engage in the development of the tools.

Joyce Thompson: We would welcome the opportunity to engage in the development of the tools, particularly from a multidisciplinary perspective. In order for us to do so, that engagement needs to be made an explicit priority. Appropriate resources will also be needed to support the development of the tools.

The Convener: I thank our witnesses for a very useful session.

12:02

Meeting suspended.

12:04

On resuming—

European Union (Withdrawal) Act 2018

Tobacco Products and Nicotine Inhaling Products (Amendment) (EU Exit) Regulations 2018

The Convener: We move on to agenda item 2, which is our first consideration of a proposal by the Scottish Government to consent to the United Kingdom Government legislating using the powers under the European Union (Withdrawal) Act 2018 in relation to a UK statutory instrument.

Colleagues will have seen the paper by the clerks, which sets out the protocol that is in place between the Scottish Parliament and the Scottish Government on obtaining the Scottish Parliament's approval for the exercise of powers by UK ministers under the withdrawal act in relation to proposals that fall within the legislative competence of the Scottish Parliament.

The provisions in the regulations, to the extent that they are within devolved competence, are considered by ministers to fall within category A as described in the protocol—in other words, they are relatively minor and largely technical in detail. What is exceptional is that the UK Government proposes to lay the regulations on 10 October. It is keen to do that in order to provide sufficient lead-in time for all concerned. With our October recess starting on 6 October, the Scottish Government is, as an exception, seeking approval to proceed within a shorter timescale than the 28-day period that is outlined in our protocol.

The paper invites the committee to consider the notification from the Scottish Government and to decide whether we are content for the Scottish Government to give consent to UK ministers in the way described. Do members have any views on the matter that they wish to raise?

Sandra White: I am content.

Keith Brown: I have a question about the timing. I am more than willing to accept that the UK Government wants to do this to give as much lead-in time as possible, but I am more concerned about why, given that it is more than two years since the referendum, it has taken this long to do it and we are having to do it in a truncated process. The paper says that the Scottish Government has to

"ensure that the UK Government is aware of Scottish Parliament recess periods".

It is a fairly obvious question, but can I just check that that has been done? Is the UK Government aware of our recess periods?

The Convener: Yes, indeed.

Keith Brown: It is less than satisfactory that it has taken this long for the matter to come to us.

I may be the only smoker here, but I note that on page 5 of the paper, it mentions that one effect is

"to decrease maximum emission levels".

That seems to be more than just technical. I presume that it could have an impact on stakeholders and producers. I should declare an interest, as a company in my constituency produces the filters and packaging for cigarettes, which is its only business.

I do not know enough about this, so I am just asking the question. Is that possible change more than a technical or minor one? I understand the stuff about advertising, packaging and so on, but "maximum emission levels" seems to be a different thing.

The Convener: In the sense of substituting for existing regulations, "minor and technical" would apply. However, we have enough time to take evidence on the matter next week if you wish to get to the bottom of that and be clear about whether it is a change in substance.

Keith Brown: It depends on how the committee feels. Maybe the question can be answered now.

The other thing that I am wondering is what will happen to the powers if this is agreed but, for whatever reason, Brexit does not happen, or at least does not happen on schedule? Would the powers just not be used?

The Convener: Yes. My reading of it is that they will come in at the point when the EU regulations cease to apply.

Keith Brown: And only then?

The Convener: Yes. That is my understanding.

Members may think that the proposal is late, but it is the first one that we have had. Members should be aware that we might have quite a lot of regulations coming through over the next few months. The decision that we make about this one—which is, I think, the only one that we will see before the October recess—is a stand-alone decision, but we will have to think carefully about how closely we wish to interrogate other matters that come before us, because after October there could be quite a lot of regulations coming quite quickly.

Do members feel the need to explore the matter further before giving assent? We can certainly do that if members are keen.

Keith Brown: No.

The Convener: If members are happy to do so, we will indicate to the Scottish Government that we are content.

Members *indicated agreement.*

The Convener: We should record that we accept its assurance about the truncated timescale and that we expect it to hold to its commitment that this is exceptional and will not become standard. We want to see such proposals with enough time to take evidence, should we so wish. In relation to what comes before the committee, that is the Scottish Government's responsibility, although there are clearly back stories to all of that as well.

We will notify the Scottish Government accordingly and let it know that we are content for it to proceed as described.

12:10

Meeting continued in private until 12:15.

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